Yakima County Fire District 12– Standard Operating Guidelines
SOG 1-3 – Line of Duty Death Investigations

1. General

1.1 Purpose. The purpose of this guideline is to provide guidance to those members who are called upon to investigate the line of duty death of a District member.

1.2 Scope. This standard operating guideline shall apply to all members of Yakima County Fire District 12

1.3 Enforcement. Enforcement of this standard operating guideline is the responsibility of the District's officers. Any person deviating from the provisions of this guideline may be required, at the discretion of the officer in charge, to submit in writing, within five (5) calendar days, an explanation for such deviation to the requesting officer who will forward the explanation up the chain of command for further review.

1.4 Note. The guidelines of a line of duty death investigation can and should be applied to other situations, particularly accidents that result in serious injuries or incidents that could have resulted in death or serious injury under slightly different circumstances.

2. Objectives

2.1 Primary Objectives. The investigation of a line of duty death may serve several different purposes. The following are the primary objectives of any line of duty death investigation.

2.1.1 To determine the direct and indirect causal factors that resulted in a line of duty death, particularly those factors that could be used to prevent future occurrences of a similar nature, including:

- Identifying inadequacies involving apparatus, equipment, protective clothing, standard operating guidelines, supervision, training, or performance.
- Identifying situations that involve an unacceptable risk.
- Identifying previously unknown or unanticipated hazards.
- Identifying actions that must be taken to address problems or situations that are discovered.

2.1.2 To ensure that the lessons learned from the investigation are effectively communicated to prevent future occurrences of a similar nature. When appropriate, this should include dissemination of the information through fire service organizations and professional publications.

2.2 Secondary Objectives.

2.2.1 To satisfy the requirements of Death Benefit Programs and other entitlements.

2.2.2 To identify potential areas of negligence and causal factors that could result in criminal prosecution or civil litigation.

2.2.3 To ensure that the incident and all related events are fully documented and evidence is preserved to provide for additional investigation or legal actions at a later date.

2.2.4 To provide factual information to assist those involved who are trying to understand the events they experienced.

2.2.5 To provide the information to other individuals and organizations that are involved in the cause of fire service occupational safety and health.

3. Investigative Team Members

3.1 The investigative team for a line of duty death shall consist of the following members of Yakima County Fire District 12

Chief of the District
Deputy Chief
Safety Officer

** If any of the above members were the Incident Commander at the incident in question, another officer that was not the Incident Commander must replace them.

3.2 Other members of the investigative team shall include:

- Washington State Patrol (functions as the primary fire cause investigator)
- City of Yakima Detective or Yakima County Sheriff's Office Detective depending on jurisdiction
- A Chief Officer from a Fire District that was not involved in the incident.

3.3 Other members of the investigative team may include:

- Vehicle accident reconstructionist
- NIOSH Investigator
- NFPA Investigator
- Individuals with specialties pertinent to the investigation

4. Immediate Actions

4.1 Isolate the scene. The scene of the incident shall be secured and guarded; only those individuals who have a specific reason to enter should be allowed inside the perimeter. The scene will remain isolated until all physical evidence has been documented, photographed, and measured.

4.2 Impound evidence. All items that could have a bearing on the investigation shall be impounded and protected until they can be turned over to the investigation team. In the case of a fire fatality, items such as protective clothing and breathing apparatus will be extremely important to the investigation. Physical evidence shall be handled in the same manner as evidence from an arson or criminal investigation. A qualified fire investigator or police officer would normally be the most appropriate member to manage the physical evidence.

4.2.1 Every reasonable effort should always be made to rescue, treat, and transport a victim to a hospital if there is any possibility of preserving life. In this process protective clothing, breathing apparatus and other items may be removed from the victim and could easily be misplaced. The Incident Commander should immediately assign someone to take custody of any items that are removed from the secured area and to turn them over to the investigation team. Any necessary movement of evidence shall be noted and recorded.

4.3 Document the condition of safety equipment. Information relating to the performance of protective clothing, breathing apparatus and other safety equipment is extremely significant in fatalities that occur during fire suppression operations and hazardous materials incidents. This information should be documented by written notes and supported by photographs. If the victim must be moved, or if it is necessary to remove protective clothing and equipment before the investigation team arrives, it is imperative to note the condition of pertinent items.

4.4 Photograph the scene. The scene should be diagrammed and photographed in the same manner a crime scene would be documented. Large color prints are the preferred method of documentation, however video and voice recording are alternative means of documentation

4.5 Arrange for an autopsy. An autopsy shall be conducted for every line-of-duty death. If the death was fire related, the medical examiner shall be directed to look particularly at blood gasses, including carboxyhemoglobin levels and other products of combustion. An alcohol test is also necessary

4.6 Identify witnesses. It is often impossible for the investigation team to interview all of the witnesses at the scene or immediately after the incident. The

immediate priorities should be to obtain essential information from individuals who were directly involved and to identify witnesses for later follow-up.

4.7 Agency Notifications. The following agencies shall be notified in the event of a line of duty death:

- Washington State Fire Marshal's Office
- National Institute for Occupational Safety and Health (NIOSH)
- National Fire Administration
- Local Departments and Districts

5. Second Stage Actions

5.1 The immediate actions will generally require several hours and should be conducted according to a documented and established plan. The second stage will usually begin on the following day, when the full investigation team meets to plan the remainder of the investigation and to make assignments for different functions. It is up to the team leader to identify the resources that will be needed and to establish a plan to manage the investigation. There will be information to gather and analyze, witnesses to be interviewed, references to be checked, and a report to be prepared

5.2 Conduct Interviews. Full interviews should be conducted with every fire district member involved in the event. At a major incident, this may have to be confined to those who were at the scene at the time of the fatal event or who were in any way involved with the victim before or during the event. All interviews should be recorded, with the consent of the witness (record that, too), and notes should be documented. The list of witnesses to interview will often grow as different leads are followed. Anyone who has information that could be significant should be encouraged to inform the investigation team and every contact should be interviewed, including members of the public or media. Parties to the investigation have right to union or legal representation during the interviews.

5.3 Obtain records of the incident. The investigation team should obtain recordings of all telephone and radio traffic pertaining to the incident, as well as photographs, videotape, written reports and other information. All of these should be thoroughly reviewed to determine if there is anything to suggest contributory causal factors or to fill in missing information.

5.4 Develop a time line. The compilation of records, radio tapes, and other data should allow the team to establish a basic time line for the incident. The time line establishes the sequence of events chronologically, sometimes to the second. Additional information should be added to the time line as it is obtained, until the

time line can be used to fully describe who did what, and who saw what, at what location, and at what time?

5.4.1 In establishing a time line it is important to synchronize the time base for different records. Misleading information may result if times are compared from different sources, assuming that the clocks were synchronized at the time of the incident. The investigation team should verify the times that are recorded for a verifiable simultaneous event and apply the appropriate correction factor to all other time measurements.

5.5 Examine physical evidence. All physical evidence, including protective clothing and equipment that was impounded at the scene, should be thoroughly examined by qualified personnel. All findings should be thoroughly documented and photographed. It may be necessary to have certain items inspected or tested by qualified experts or by testing laboratories. It is important to maintain the chain-of-custody for all physical evidence as different individuals examine it and to ensure that reports are obtained and the items are returned to a secure area.

5.6 Research documents. All existing District standard operating guidelines, training materials, and similar sources of guidance that would apply to the situation should be reviewed to determine:

- How the situation "should" have been handled.
- Whether or not it was handled in the expected manner.
- Whether or not this would have had an impact on the outcome.

Records should be examined to determine if the individuals involved has received the proper training in the relevant topics.

5.6.1 Where equipment or apparatus is involved, specifications and maintenance records should be obtained. Operators should be asked if any problems were previously noted and a determination should be made if required inspections and repairs had been completed on schedule. Maintenance personnel should be interviewed wherever possible.

6. Data Analysis and Report Development

6.1 There is no magic formula for how to compile and analyze all of the data necessary to conduct a thorough investigation and prepare a report. It requires time and effort to fully understand, prepare, and develop a comprehensive report on this devastating incident. All team members should work towards a full understanding of the events that occurred, the responsibilities and actions of key individuals, the factors that made the District vulnerable to a fatal incident, and

the actions that should have been taken or should be implemented now to prevent a similar occurrence in the future.

6.2 Every component of the incident should be followed back to its root cause. Every contributing or suspected contributing factor should be followed back to a conclusion and tied in with all of the other factors to develop a complete report. The investigation team should continue its efforts until the team members are satisfied that they fully understand what happened, why it happened, and what steps need to be taken to prevent a similar occurrence in the future.

6.3 The information should be compiled into a written document, supported by photographs, diagrams, and supporting data to fully present the facts of the incident. Additional supporting information should be maintained in the investigation files.

7. Report Presentation

7.1 Upon completion, the investigation report shall be presented to the Board of Commissioners in a closed session. In most cases, the presentation of the document should occur at a meeting with all of the investigative team members present. The Team Leader should present an overview of the report, including all conclusions and recommendations, using audio-visual aids to illustrate the presentation. Members of the investigative team should be prepared to answer any questions presented by the Board of Commissioners.

7.2 Upon the approval of the District's counsel, the investigative report shall be released to the public. The concern over discovery shall not restrain the District from taking those corrective actions dictated by the investigative report. The courts have generally found that taking action based on knowledge gained from an adverse incident is not an admission of responsibility for the original event. Conversely, corrective actions that were recommended, but not implemented, prior to the incident may be construed as evidence of negligence.

7.3 A special presentation of the report to the members involved in the incident should be considered. In most cases, the presentation and discussion of the report will help bring closure to the incident. Prior to the release, critical incident stress personnel should be consulted to determine if there are individuals who would have a difficult time attending such a presentation.

7.4 The final report shall be distributed to all Yakima County Fire Districts and Departments and shall be made available to any requesting party.

7.5 As line of duty deaths generate considerable media attention, a press conference should be considered to release the report findings to the media. Members of the investigative team should be present at this press conference to answer any technical questions that arise.