

Executive Summary

On July 23, 2018, a lightning strike at approximately 01:20 hours ignited a fire within the residence located at 7005 Woodscape Drive, Clarksville, Maryland. Smelling smoke, the residents called 911 to report the lightning strike and visible smoke in their home at 01:52:14. The Howard County Communication Center, which serves as the Public Safety Answering Point for Howard County, then dispatched a Local Box Alarm 5-62 to the residence. The Local Box Assignment from Howard County Department of Fire and Rescue Services (HCDFRS) included Paramedic 56, Engine 101, Engine 51, Tower 10, and Battalion 1.

The residential structure at 7005 Woodscape Drive was a uniquely shaped single-family dwelling spanning approximately 8,400 square feet. There are no fire hydrants on Woodscape Drive, however the residence included a swimming pool at the rear of the property. One aspect of 7005 Woodscape Drive that contributed to this incident's complexity was the grade change along the rear of the residence (referred to as Side C throughout this report).



Figure 1 Side C of 7005 Woodscape Drive

HCDFRS established command at 02:00:29 and upgraded the dispatch assignment to a full metro-box alarm. While en route, Battalion 1 (Incident Commander) instructed Engine 51 to use the pool at the rear of the property to establish a water supply, unaware that the first two arriving engines had not initiated a water supply plan. At 02:07:51, Engine 51 entered the structure on the upper level of Side C (laundry room door) but did not advise command of either their level of entry or the conditions they encountered. Repositioning to the lower level of Side C, Engine 51 re-entered the structure but did not make the Incident Commander aware of

the grade change along Side C. At 02:12:41, the Incident Commander advised all units that residents had evacuated the structure.

At 02:15:48, Engine 101A advised the Incident Commander of visible fire on the upper level of Side C and that they needed to redeploy back up to their initial entrance (upper level of Side C) to reach the fire. Advancing a pre-connected hose line from Engine 51, Engine 101 entered the structure through the laundry room door located at the upper level of Side C. At approximately 02:20:11, FF Flynn had fallen through the first floor into a basement level crawlspace containing active fire and high heat conditions.

Engine 101A, recognizing that FF Flynn had fallen through the floor, declared a MAYDAY emergency on Bravo 1, the radio talk group used for operations during this incident. While clarifying the MAYDAY emergency with Incident Command on Bravo 1, FF Flynn transmitted his own MAYDAY statement including a clear “Who, What, Where” on Bravo 2—an unmonitored radio Talk Group. The Incident Commander quickly deployed the Rapid Intervention Crew (RIC), which entered the basement at approximately 02:27:17 in search of FF Flynn. Overcoming numerous obstacles, including multiple crew members becoming entangled in wiring, the RIC located and extricated FF Flynn by 02:43:39—fifteen minutes and five seconds after their initial entry.

After FF Flynn was removed from the dwelling, those on scene followed and exceeded all BLS, ALS, and ACLS protocols as FF Flynn was transported to Howard County General Hospital. Tragically, FF Flynn did not survive.

On August 2, 2018, Howard County Department of Fire and Rescue Services Fire Chief established an Internal Safety Review Board (ISRB) to review the fire incident at 7005 Woodscape Drive and examine HCDFRS’s response and actions to determine the underlying causes for factors that contributed to FF Flynn’s death. Tasked to “look beyond the immediate causes to discover all factors that impacted the event…[including]: equipment, policies, procedures, training, available resources, or other safety and health program deficiencies,”³ the ISRB conducted a thorough review of all available data from the incident as well as analyses of HCDFRS policies, procedures, and cultural norms.

The subsequent report examines fourteen broad topics related to HCDFRS’s response to the 7005 Woodscape Drive incident, with each detailed in subsequent chapters of this report. While all areas merit attention by the department, the ISRB determined the most critical issues for HCDFRS leadership to address are:

1. Establishing a clear and consistent Philosophy of Command throughout the department;

³ Howard County Department of Fire and Rescue Services, Special Order 2018.44 Internal Safety Review Board for Incident F18025041 (2018).

2. Creating a competency-based training program, in which all HCDFRS personnel complete hands-on training in realistic conditions with an emphasis on practical error prevention and error trapping;
3. Enhancing fireground communication, with an emphasis on establishing closed-loop radio communications;
4. Enhancing crew accountability on the fireground; and
5. Cultivating the ability of HCDFRS officers to clearly establish incident strategy and the global ability of all department members to carry out effective tactics.

First—as detailed in [Sections III.B Strategy and Tactics](#) and [III.L Training](#)—HCDFRS must establish a clear command philosophy throughout the department. Drawing from military terminology, there are two philosophies of Incident Command: Befehlstaktik (order-based) and Auftragstaktik (mission-based). Befehlstaktik (pronounced bë-feel-stack-tic) is a centralized command and control structure in which the command chain prescribes why, when, and how operations will be conducted. For example, some HCDFRS officers are trained in the “Blue Card” method which employs order-based tactical philosophy. Auftragstaktik (pronounced auf –tra-stack-tic) is less regimented, with the Incident Commander providing instruction on the why and when of operations (commander’s intent) but delegates how operations are executed to lower level leaders. This command philosophy is often employed by the United States Marine Corps, however HCDFRS officers do not receive explicit training in this command philosophy. Both command philosophies are woven throughout HCDFRS General Orders and neither are explicitly stated in department training. This results in confusion among HCDFRS personnel, hindering task accomplishment and team cohesion.

Second, HCDFRS must restructure its current training program to shift its focus away from prioritizing classroom or online course completion to hands-on training in realistic conditions. As detailed in [Section III.L Training](#), while the material covered in the current training program is undisputedly valuable, the department does not verify that personnel can apply the material learned in courses to their position in realistic conditions (with the exception of the paramedic specialization). This was most clearly demonstrated during this incident by veteran personnel entering a structure above a fire, despite acknowledging situational cues and patterns that indicated a basement fire.

Third, HCDFRS must train all fireground personnel to use closed-loop communication methods to ensure that communications are received accurately and to address current shortcomings of radio equipment programming. Each of these issues is detailed in [Section III.C Communications](#).

Fourth, there was a consistent lack of crew accountability on the fireground during the 7005 Woodscape Drive incident. The specific issues related to this incident are explained in [Section III.G Accountability](#), but, in general, the entire department needs to improve accountability of personnel to ensure that all crews on the fireground are operating within the command structure.

Fifth, as detailed in [Section III.B Strategy and Tactics](#), HCDFRS must rethink its current use of Command Modes, command philosophy, and process for implementing strategy and tactics on the fireground. During this incident, the Incident Commander established an Offensive Strategy at the outset, in accordance with current HCDFRS General Orders. A complete 360-degree survey and situational assessment should be completed before declaring a strategy.

The ISRB identified many systemic issues within HCDFRS during the investigation. Current HCDFRS General Orders are often contradictory, unclear, or too cumbersome for personnel to glean operational value. To address this issue, HCDFRS must review all current and applicable General Orders, revise them for consistency across the department, and conduct comprehensive training of HCDFRS personnel on the updated orders.

Lastly, through the informal interviews conducted by the ISRB for this investigation as well as discussions among HCDFRS personnel, the ISRB identified a widespread belief that department leaders are not promoted or assigned based on merit or experience. Whether this belief is true or not, it has a negative effect on unit cohesion and trust in leadership. This lack of trust with department leadership has been exacerbated by previous decisions to not widely publish previous safety reports, which has led to rampant conjecture and rumors. During this incident, this belief and lack of trust between officers and firefighters likely had a deleterious effect on tactical decision making, impacting overall safety on the fireground. Moving forward, HCDFRS must take steps to regain trust between firefighters and leadership.

As a foundation for rebuilding this trust, the ISRB strongly recommends that Howard County have an independent organizational review of the HCDFRS to make recommendations on improving overall department structure, policies, and procedures. Ideally, the team conducting the department review will have no personal or professional connections to HCDFRS personnel and will include a trained Organizational/Industrial Psychologist to make specific recommendations for improving trust between firefighters and leadership.

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