Significant Incident After Action Report

MAYDAY

Augusta County
Residential Structure Fire
716 North Mountain Road
January 7, 2025

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Executive Summary

On January 7th, 2025, at 10:12 Augusta County ECC dispatched a fire company for debris on fire at 716 North Mountain Road located in Swoope, Virginia. This was the third response to this location in a fifteen-hour period. Due to previous fire damage to the structure, partial roof collapse, and no threat of trapped occupants, crews primarily worked from the exterior of the home to identify areas where debris was still burning/smoldering. One crew was directed inside the structure on the first floor to locate the origin of material still burning and to extinguish any fire found. The crew located fire burning below them and attempted to apply water through an opening in the floor, but the handline had little effect on the fire. As the crew relocated to the perimeter of the room at the basement steps, the floor beneath them partially collapsed, initially impacting two firefighters. One firefighter was able to hold onto the railing and regain his footing while the other found himself trapped and initially unable to move. The firefighter remained calm and freed himself by removing one of his boots. He was then quickly removed by the remaining members of the crew. He was treated for minor injuries and returned to his assignment shortly thereafter.

An after-action review was conducted at the request of Augusta County Fire and Rescue leadership to identify contributing factors and opportunities for improvement to prevent another occurrence of this kind in the future. The extensive training, physical fitness, and mental resolve of the firefighters involved most certainly contributed to the positive outcome of this near-miss incident.

Acknowledgements

The Virginia Fire Chiefs Association would like to recognize the following individuals and organizations that assisted in the process:

Fire Chief Greg Schacht	Augusta County Fire and Rescue
Lieutenant Colten Lotts	Augusta County Fire and Rescue
Deputy Chief Chris Shaver	Augusta County Fire and Rescue
Deputy Chief- Bryan Mace	Augusta County Fire and Rescue
Deputy Chief Brian Butler	Staunton Fire and Rescue
Tammy Shultz, Dispatch Supervisor	Augusta County Emergency Communications Center
Lt. Bunch and Firefighters Unroe, Mercer, and Patterson	Squad 10 C-Shift, Augusta County Fire and Rescue

Incident Analysis Team

Deputy Chief Abbey Johnston (Lead)	Bedford County Fire and Rescue
Deputy Chief Todd E. Lupton	Loudon County Fire and Rescue
Battalion Chief Michael Carter	Virginia Beach Fire Department
Lieutenant Colten Lotts	Agency Representative/Liaison

Methodology

The Chief of Augusta County Department of Fire and Rescue contacted the Virgina Fire Chiefs Association and requested assistance in conducting an after-action review of a significant incident that occurred, resulting in a firefighter declaring a MAYDAY. The VFCA assembled a team of three (3) Board Members who had applicable experience conducting after-action reviews and who have served in Combination Systems. The Incident Analysis Team conducted research and analysis by gathering numerous data points to include documents related to the incident, dispatch audio, helmet camera footage, Computer Aided Dispatch (CAD) reports, NFIRS reports, interview audio, photos, drone footage, and all relevant policies and procedures.

On March 5, 2025, the team conducted a site visit where they spoke directly with those involved in both the incident and the MAYDAY and gathered valuable insight from the Command Staff. Additional supporting documents to include training records, response times, staffing and deployment models, recordings, radio transmissions as well as other system specific information was provided by Augusta County Fire and Rescue Staff.

A second in-person meeting of the team took place in Augusta County on March 21, 2025, to develop a draft report. Additional virtual work was completed thereafter, and a draft was submitted to the Chief of Augusta County Department of Fire and Rescue on April 23, 2025, for technical edits. After minor technical edits were made, the final report was submitted to the Chief of Augusta County Department of Fire and Rescue on May 27, 2025.

Incident Overview

On January 6th, 2025, Augusta County Emergency Communications Center (ECC) received a 911 call reporting a structure fire at 716 North Mountain Road located in Swoope, Virginia. The caller reported that his attic was on fire. Augusta ECC dispatched a working residential structure fire response. Road conditions were extremely poor due to a snowstorm earlier in the day and temperatures were below freezing. The incident was dispatched at 19:37. The first unit arrived at 19:59 and reported a chimney fire that had extended to the roof with visible flames. Interior fire attack was initiated with crews advancing to floor two to gain access to the attic space. Crews reported that they were working on fire extinguishment when they lost water pressure. This resulted in crews being pulled from the residence until the water supply could be reestablished. Due to the rural geographical location of the residence, and road conditions, there was an extensive delay reestablishing the water supply, which allowed for rapid fire spread throughout the entire attic. Once the water supply was secured, crews worked in defensive and offensive modes to extinguish the fire and cleared the scene at 00:44. At 02:35 Augusta ECC dispatched a single company response to the same address reporting debris on fire. Crews worked to extinguish a small amount of fire and returned to service at 04:00. On January 7th, 2025, at 10:12, Augusta ECC dispatched debris on fire for a second time making this a third response to the residence. The first unit arrived on scene reported fire showing from the Charlie side and asked to fill the appropriate response for a working residential structure fire.

Crews worked to extinguish the fire resulting in a floor collapse and Mayday incident at 11:17. Fire was marked under control at 14:40 with one firefighter transported with minor injuries.

Incident Timeline

Fire Response Timeline – January 6 - January 7, 2025 (716 North Mountain Road)

First Incident (January 6, 2025)

- 19:34 – 911 call received
- 19:37 – Initial dispatch
- 19:59 – First unit arrives on scene (Engine 47)
- 22:29 – Fire marked under control
- 00:44 – Last unit cleared (Engine 47)

Second Incident (January 7, 2025)

- 02:35 – Dispatch for second incident (Debris on fire) (Company 14)
- 02:42 – No response from Company 14, next due added Company 4
- 02:46 – E-47 & T-45 responded
- 03:05 – Units arrive on scene reporting a small fire from the previous incident
- 04:00 – Fire marked under control; last unit cleared

Third Incident (January 7, 2025)

- 10:11 – 911 Call received from passerby reporting “lots of smoke” from previous fire
- 10:12 – Dispatch for third incident (debris on fire) (Company 14)
- 10:15 – Deputy Chief 14 calls ECC and advised to place next due on the assignment due to their availability
- 10:16 – Company 4 dispatched
- 10:18 – Engine 47 responds
- 10:29 – Engine 47 requests to add Tanker 45 to the assignment
- 10:37 – Engine 47 arrived on scene reporting fire on “c-side” and to “fill the box”
- 10:40 – Confirmed fire assignment dispatched
- 10:45 – Engine 47 requests two additional tankers to be added
- 10:48 – FF Simmons from E-47 advises ECC that he will be in command
- 10:53 – Tanker task force requested
- 11:02 – Augusta 3 arrives on location and assumes command
- 11:17 – Mayday called
- 11:21 – Mayday cleared
- 11:33 – Lt. Bunch transported (medic-43)
- 12:09 – Squad 10 clears scene enroute to hospital
- 14:09 – Command transferred to BC-13
- 14:40 – All units cleared

Weather

- Time: 10:12
- Temperature; 22F
- Dew Point: 9
- Humidity: 58%
- Wind: 5 mph NW
- Conditions: Fair

Structure

- Two-story single-family dwelling
- Type V wood frame construction
- Walk out basement (Side Bravo)
- Total square footage: 5,717; livable space: 2,872
- Attached breezeway to the two-car garage
- Solar panels with battery back up

Findings, Contributing Factors, and Recommendations

A. Command and Control

Findings

- First due Engine established command effectively and noted smoke and fire which prompted the upgrade for the appropriate residential structure fire response.
- There was a lack of tracking and accountability from the incident command perspective. While there is a regional and County policy, the use of the Command board, common terms, passports and unit tracking was not consistently utilized.
- Crew members were given a face-to-face assignment by the defacto Operations officer, but that information was not communicated to the incident commander and therefore was also not relayed to other crews operating on scene.
- Divisions were informally assigned causing potential confusion of where companies were assigned. The use of rank/names rather than formally identifying riding positions could have caused further accountability issues.
- Common terminology is not utilized throughout the system. Most notably, there is confusion on several terms. Examples include call typing, referring to floors as divisions and other nomenclature that needs to be reviewed.
- Lack of clear crew roles and responsibilities caused confusion. Company officers were performing the roles of driver pump operator and firefighter.
- A safety officer position was not established for the incident. This is not uncommon in the system.
- The System and region have an up-to-date policy on Mayday's and on check/sheet command boards. However, only portions of this policy were followed.
- A personnel accountability check was not completed after the Mayday was transmitted
- No RIT was established or identified before or after the Mayday.
- Following the collapse of the interior stairwell, the crew promptly recognized and transmitted the Mayday. Self-rescue efforts and quick action amongst the crew contributed to the swift removal of the downed personnel. These actions likely facilitated the positive outcome of this incident and reduction of firefighter injuries.

Contributing Factors

The incident was the third dispatch to this residence in less than 24 hours. The call type was dispatched as a debris fire, not a residential working fire response. This set a tone and contributed to a mindset that this was not a response to a working fire incident. Several crews indicated in their reports and interviews that this was the third call to this address and believed it to be more of a nuisance, possibly minimizing the acuity of the incident. On the arrival of the first Engine Company, Engine 47, command was established, and the alarm was upgraded to a residential working fire response based on reported conditions.

The incident commander directed a Chief Officer to side Alpha, or the front of the structure, to formulate an incident action plan but did not formally assign him an official Incident Command System (ICS) position. Squad 10 was directed to enter "Division 1" (Floor 1) of the structure to further investigate with a 1.75" handline. Their direction was to stay vigilant on Floor 1 and not proceed further. Once the crew located fire, there was a change in the crew mindset, but their actions were not relayed to the defacto division supervisor or the incident commander prior to the initiation of the Mayday.

Recommendations

1. The System, career and volunteer, need to utilize and follow the current County, and regional response policies.
2. Formalize the use of ICS functions to include divisions and groups.
3. The System needs to create system-wide guidelines and operational manuals/playbooks.
4. Command board use and accountability needs to be followed and utilized consistently across the system.
5. Command should designate an On Deck and/or Rapid Intervention Team (RIT).
6. Designate a Safety Officer on each working incident.
7. The System needs to have comprehensive incident command training for volunteer and career providers to ensure all system personnel are consistently following County and regional guidelines.
8. The System needs to train on firefighter rescue survivability (formerly Mayday firefighter down/RIT) to include command, communications, and the Emergency Communications Center.

9. The Incident Commander (IC) should determine and communicate the incident strategy or mode of operations (investigative, offensive, defensive, etc.) to all personnel on the scene.

B. Risk Assessment

Findings

- Delayed response times were due to the first due Company not responding in a timely manner.
- The subsequent dispatches for the rekindle were dispatched as "debris fire" and not as a structure fire.
- An initial complete 360 size-up was not completed/communicated.
- Crews did not utilize the thermal image camera (TIC) as part of the size-up.
- An incident strategy or mode of operations was never declared.
- A proper risk benefit analysis was not completed by the IC.
- This was the third response to this incident for two (2) rekindles. The original call strategy was offensive, then transitioned to defensive and exterior only due to lack of water supply.
- Several personnel admitted to second guessing why they were inside of the structure but never communicated this concern to the IC or defacto Division Supervisor.
- The structure was significantly compromised due to the amount of fire and water damage.

- The structure was never placarded following the initial or subsequent fires.
- The firefighters impacted by the floor collapse and those involved in the removal of the trapped firefighter had significant training on record and were physically fit.

Contributing Factors

This was the third time that crews responded to this address. This incident was dispatched as a debris fire. This set the tone that this may not be a significant event. However, this mindset shifted based on conditions encountered while inside on Floor 1. This was never communicated until there was a collapse. The lack of a 360 report or a basement check of conditions, as well as a structural assessment, was never properly checked, or if it was checked, it was not communicated. This led to crews unknowingly operating above the fire. The prior training and physical capabilities of the firefighters involved in the near-miss incident contributed to a successful outcome following the floor collapse.

Recommendations

1. A size up and 360 report should be completed and communicated on any incident.
2. The System should utilize thermal imaging cameras on all incidents to facilitate incident size ups, and the location of potential fire.
3. Personnel operating in the System, as the Incident Commander, should conduct a risk benefit analysis, regardless of the call type.
4. All personnel are responsible for maintaining situational awareness and relaying significant changes/pertinent information through the ICS structure.
5. Regularly utilize the County Building Official to placard unsafe structures and/or adopt the Statewide fire code.
6. Formalize a physical fitness program and standards to promote firefighter wellness.
7. Establish minimum training standards for all firefighters and officers operating in Augusta County that are consistent with those outlined in NFPA 1001 and 1021.

C. Communications

Findings

- Communications dispatched the second and third incidents to the address as “debris fires.”
- Communications between Incident Command, officers and crews occurred face-to-face but not all directives and assignments were shared over the radio for the awareness of everyone operating on scene.
- Personnel did not maintain radio discipline after the Mayday was transmitted.
- Personnel do not utilize common ICS terminology.
- Size-up reports were not communicated via radio.
- The command statement was incomplete or needed additional details.
- The Emergency Communication Center does not have clear Mayday guidelines.

Contributing Factors

While Central Shenandoah Valley Regional Fire and Rescue Response Policies for MAYDAY and ICS have been adopted, they were not strictly followed at this incident. Given this was the third response to this address, that no life safety hazards existed for occupants, and that the home had suffered significant damage in the main structure already, it is likely that comprehensive ICS and communications practices were foregone, and a more relaxed approach was taken by everyone operating on scene.

Recommendations

1. Dispatch procedures should be reviewed. This incident was dispatched as a debris fire and should have been coded as a residential structure fire.
2. Command statement should be made to all personnel on the incident scene after Command is established.
3. The Augusta County Emergency Communication Center needs to create a policy aligned with the regional response policy on how to manage a Mayday event.

D. Staffing and Deployment

Findings

- Company Officers do not consistently ride in the Officer position.
- The first due Company failed to respond due to lack of personnel, therefore this increased response times for additional companies to arrive at the incident.
- The majority of the fire companies in Augusta County are staffed with 2 personnel.
- There is one Operational Chief Officer on duty for the entire system 24/7/365. Working fires and/or additional incidents require the response of Administrative Command Officers. This is not sustainable long-term for Administrative Command Officers and is not adequate for meeting the needs of field operations.
- There is not a designated Fire Marshal and investigations are not routinely conducted on all fires.
- There is not a designated Health and Safety Officer

Contributing Factors

The Lieutenant was originally assigned to the Engine but jumped over to the Squad for this call. He did not assume the Officer position on the Squad. This is a practice that occurs because of cross staffing but is not followed consistently across shifts and between stations. Inconsistent or changing officer roles and riding positions can contribute to confusion, particularly when fireground assignments are being made.

Recommendations

1. Conduct a review of current staffing and deployment models to minimize response times and increase operational effectiveness.

2. Deploy a staffing model that meets or exceeds the effective response force (ERF) of the NFPA 1720 standard. (Ten trained firefighters within ten minutes 80% of the time)
3. Consider the addition of a second Chief Officer position and divide the County into battalions to improve span of control. Call volume and geography present significant challenges for effective supervision and operational effectiveness for one Chief Officer.
4. Utilize Admin Command Officers in a Duty Officer role as a point of contact rather than as part of automatic incident response.

E. Post Incident

Findings

- Augusta County Fire and Rescue did not report the Mayday as a near-miss to the Firefighter Near Miss Reporting System.
- Many personnel the Incident Analysis Team spoke with were still having difficulty processing the Mayday event.
- Augusta County Fire and Rescue does have a formal Peer Support Program but was not utilized nor was a Critical Incident Stress Debriefing (CISD) conducted following this incident.
- Augusta County Fire and Rescue did not have a Policy or Procedure on when and how to conduct an After-Action Report.

Contributing Factors

Augusta County Fire and Rescue Command staff and members admitted that this was the first time that a Mayday event has occurred in the County. Since the organization has not dealt with this in the past, they did not have policies and procedures in place to guide their actions. Staff were forced to make the best decision they could during a high stress time with no policy direction. Behavioral Health in the Fire and Rescue Service has taken center stage over the past 5-10 years due to the intense traumatic exposures our members face daily. The Fire and Rescue Service understands the importance of taking care of the whole responder. Despite the prevalence of these issues over time, there has been a stigma surrounding mental health in the Fire and Rescue Service, inhibiting members from seeking the support they need.

Recommendations

1. Consider reporting to the Firefighter Near Miss Reporting System when a close call occurs to help Fire and Rescue personnel turn shared lessons learned into applied actions. The Firefighter Near Miss System is managed by the International Association of Fire Chiefs.
2. Further develop the Peer Support Program, include a Behavioral Health component, and develop a policy for when and how CISD will be conducted for the System.
3. Develop Policies and Procedures on when and how to conduct an After-Action Report.

Conclusion

This report was a collaborative effort by members of Augusta County Fire and Rescue and the Incident Analysis Team who researched facts, reviewed data, and interviewed personnel that were involved in the incident. Augusta County Fire and Rescue demonstrated their commitment to improvement by requesting this after-action review and should be commended for maintaining complete transparency and team accommodation throughout the process. This Significant Incident After Action Report is based upon unbiased data, as well as important information provided by firefighters and officers assigned to the incident. Some of the factors analyzed as part of this process were found to have contributed to an injury sustained by an Augusta County Fire and Rescue member. This report is not to place blame or subject anyone to disciplinary action. The purpose of this report is to identify and consider findings and contributing factors that led to the Mayday event, and to make recommendations of measures to prevent similar reoccurrences.

While specific findings, contributing factors, and recommendations have been provided in the previous sections of this report, the importance of creating an element of standardization pertaining to training, operations, and SOG's and/or operational playbooks cannot be overstated. Establishing common training and operational expectations for all firefighters and officers provides an element of predictability that contributes to a higher probability of success on incidents that sometimes present unpredictable factors.

References

- National Fire Protection Association (NFPA) 1720
- Augusta County Fire & Rescue Strategic Plan 2024
- Firefighter Rescue Survivability: FIREFIGHTER RESCUE SURVEY - For Them
- International Association of Fire Fighters (IAFF): Staffing.Cover
- National Fallen Firefighter Foundation: https://everyonegoeshome.com/16-initiatives/
- Insurance Services Office (ISO)