

St. Matthews Fire Protection District

Apparatus Incident

1/17/2010

North Oldham Fire Department—Goshen, KY

This is one of many sections that contain information, documents, letters, newspaper articles, pictures, etc. of the St. Matthews Fire Protection District. They have been collected and arranged in chronological order. These items were collected, organized and entered into a computerized database by Al Ring with the help of the St. Matthews Fire Department Alumni Association, Inc. The Association's members are Rick Albers, A. E. "Bill" Andriot, III, E. Gar Davis, Clarke Fenimore, Jack Monohan, Mike Noon, Russ Rakestraw and Al Ring.

The purpose of this "collection" was to create the background and research for the book *St. Matthews Firefighters, 84 Years of Firefighting in St. Matthews, Kentucky*, written by and published by Al Ring in 2004. The collection is continuing today, so if you should have old or new information on the St. Matthews Fire Department, please contact Al Ring.

All graphics have been improved to make the resolution as good as possible, but the reader should remember that many came from copies of old newspaper articles. This also applies to other items such as documents, letters, etc. Credit to the source of the documents, photos, etc. is provided whenever it was available. We realize that many items are not identified and regret that we weren't able to provide this information. As far as the newspaper articles that are not identified, 99% of them would have to be from one of three possible sources. *The Courier-Journal*, *The Louisville Times* or one of the *Voice* publications.

Please use this information as a reference tool only. If the reader uses any of the information for any purpose other than a reference tool, they must get permission from the source.

The Association would like to thank the St. Matthews Fire Protection District and various newspapers including *The Courier-Journal*, *The Louisville Times*, and *The Voice-Tribune*. Our appreciation is also extended to the various citizens and firefighters who contributed to the gathering of this information.



Explanation

January 17, 2010, Quad 1441 driven by Chief Rick Albers was involved in a very serious single vehicle accident. There were 3 firefighters on board. All three were injured but all survived and are back actively in the fire service. The following is a Power Point Presentation the department uses for training and fire safety seminars where the above mentioned incident is discussed in detail. Because this is a PDF the voice transmissions of the accident are not heard but are played at the slide marked NOFD 1441 Quad Incident. (In the Power Point Presentation) The voice recording may be hard in another section.



Apparatus Incident
1-17-2010
North Oldham Fire Department - Goshen, KY



Department Demographics

- Est. 1951
- Combination Dept approx 60 members
 - Daytime paid staffing
 - Night and weekend volunteer staffing
- 47 square miles from two stations (Goshen & Skylight)
- 1.3 M operating budget
- Operate 1 Aerial, 1 Quad, 2 Engines, 2 Tankers, 4 auxiliary and 2 reserve units

Quad 1441

- Purchased new in 2007
- Manufactured by Custom Fire Apparatus Rescue Quad on Spartan Gladiator Chassis
 - 1500 GPM
 - 1000 gallon tank
 - Seating for six (2 front, 4 rear)
 - Full compliment of hydraulic rescue tools
 - Fully NFPA compliant at time of incident



Quad 1441 being used at a live burn training summer 2009

The Incident

- Weather conditions were mild for January
- Visibility was good
- Roads were damp but decent
- NOFD was dispatched for a residential fire alarm system activation in Paramount Subdivision (Goshen District)

NOFD Quad 1441 Incident

The Aftermath

- Recovery of the apparatus involved 7 major steps
 - Taking care of our people
 - Removal of power lines and upper pole sections
 - Removal of apparatus
 - Removal of hose and equipment from scene
 - Removal of salvageable equipment from apparatus
 - Removal of remaining pole bases
 - Reinstallation of utilities and cleanup of roadway

Apparatus Recovery



- All personnel removed from scene to Goshen Station
 - (except essential Command Staff)
- Wires and poles removed by utility company
- Completed by sunrise

Apparatus Recovery



- Two heavy-duty wreckers used to upright and remove apparatus
- Utility came back in afterward to
 - Remove pole bases
 - Reestablish utilities

Apparatus Recovery



Apparatus Recovery

- Removal of hose bed contents
- Had to bring a crew back to scene with pick-up truck(s)



Apparatus Recovery

- Investigation by
 - OCPD
 - NOFD
 - Outside panel commissioned



Apparatus Recovery



- Salvageable equipment was off-loaded at Goshen Station
- Most (99%) was in good shape
- Initially staged on floor
- Eventually stored or put on reserve apparatus

Disposition



- Apparatus stored off site for a short period
 - Desire to keep access controlled
 - Retained for Investigation
- Eventually shipped to manufacturer
- Determined to be total loss
- Insurance coverage replacing rig

Recovery Process

- Liaisons sent immediately to both medical facilities to link between patient status and ICS at scene
- State resources tapped to conduct CISD for all members at next regular training night
- Employee Assistance Program utilized
- Outside panel selected to investigate and make recommendations
- “Near Miss” report generated

Lessons Learned

- #1 – Seatbelts work!
- Driver training is critical (over-correcting would have made this much worse)
- Minimize the potential for flying objects in the cab area
- NFPA requirements for new cab design work
 - This incident reinforced our commitment to replace open jump-seat cabs ASAP
- Have a procedure in place to deal with member injury prior to an event
- Found some need for cross-training and access for workers comp, etc
- Have up to date personnel and training records at all times.
- Consider the ability to be “seem-less” if the Chief of Department is out of the picture
- CISD is critical and ALL members likely to be affected by an incident should be present
- Use of an outside investigation panel was very helpful

“What If”

Risk Factor

- Older Apparatus
- Open Jump Seats
- Inadequate driver training
- Lack of seatbelts

Probable Outcome

- Probable Cab Impingement
- Lack of protection – probable serious injuries
- Likely attempt to overcorrect – worsening accident
- Probable severe injury or death



Everyone Goes Home!

SEATBELTS EVERY
TIME
NO EXCUSES!