



COUNTY OF PRINCE WILLIAM

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DEPARTMENT OF
FIRE & RESCUE

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**Prince William County
Department of Fire and Rescue
Line of Duty Death (LODD) Report for Technician I Kyle Robert Wilson
Fact Sheet**

The Prince William County Department of Fire and Rescue is releasing the comprehensive line of duty death report for Technician I Kyle R. Wilson on Saturday, January 26, 2008. Technician I Wilson was the first line of duty death in the Department's 41-year history. The Department is sharing the LODD Investigative Report to honor Kyle, and in an effort to reduce and prevent firefighter line of duty deaths at the local, region, state, and national levels.

Technician Kyle Robert Wilson was 24-years old and was born in Olney, Maryland. He grew up in Prince William County and graduated from Hylton High School and George Mason University. He was an avid baseball and softball player. Technician Wilson joined the Prince William County Department of Fire and Rescue on January 23, 2006.

Technician Kyle Wilson died in the line of duty on April 16, 2007 while performing search and rescue operations at a house fire on Marsh Overlook Drive, located in the Woodbridge area of Prince William County. On that day, Technician Wilson was part of the firefighter staffing on Tower 512 which responded to the house fire that was dispatched at 0603 hours. The Prince William County area was under a high wind advisory as a nor'easter storm moved through the area. Sustained winds of 25 mph with gusts up to 48 mph were prevalent in the area at the time of the fire dispatch to Marsh Overlook Drive.

Initial arriving units reported heavy fire on the exterior of two sides of the single family house and crews suspected that the occupants were still inside the house sleeping because of the early morning hour. A search of the upstairs bedroom commenced for the possible victims. A rapid and catastrophic change of fire and smoke conditions occurred in the interior of the house within minutes of Tower 512's crew entering the structure. Technician Wilson became trapped and was unable to locate an immediate exit out of the hostile environment. Mayday radio transmissions were made by crews and by Technician Kyle Wilson of the life-threatening situation. Valiant and repeated rescue attempts to locate and remove Technician Wilson were made by the firefighting

crews during extreme fire, heat and smoke conditions. Firefighters were forced from the structure as the house began to collapse on them and intense fire, heat and smoke conditions developed. Technician Wilson succumbed to the fire and the cause of death was reported by the medical examiner to be thermal and inhalation injuries.

Virginia Occupational Safety and Health (VOSH) and the National Institute for Occupational Safety and Health (NIOSH) performed independent investigations of the Marsh Overlook fire incident. VOSH's investigation is complete and closed with no citations or corrective orders being issued. NIOSH's investigation results are still pending.

The Department of Fire and Rescue immediately formed a multi-dimensional investigation team following the incident. The investigation team was comprised of five Department of Fire and Rescue uniform personnel and two external members from area fire departments. For eight months, the team thoroughly examined the events that occurred at the Marsh Overlook fire incident and identify the factors involved with the line of duty death of Technician I Kyle Wilson. The resulting report represents thousands of hours of effort to analyze fire and rescue operations and is a factual representation of the events that occurred. The report also provides a frame work for organizational level improvements.

The major factors in the line of duty death of Technician I Wilson were determined to be:

- The initial arriving fire suppression force size.
- The size up of fire development and spread.
- The impact of high winds on fire development and spread.
- The large structure size and lightweight construction and materials.
- The rapid intervention and firefighter rescue efforts.
- The incident control and management.

The weather conditions and construction features resulted in the rapid and catastrophic progression of fire conditions. The organizational preparation and response to incidents of this nature can and are recommended to be improved with the majority of recommendations focused on staffing, training, procedures, and communications.

Highlighted examples of improvement are:

- Staffing related:
 - Increase the minimum staffing on all engine companies from three to four qualified firefighters.
 - Increase the minimum staffing on all specialty pieces from four to five or six qualified firefighters and/or addressing the deployment of specialty unit crews on an incident scene.
 - Increase the amount of resources that are dispatched and adopt a standard structure fire dispatch complement for all types of structures and address modifications to those resources during extreme environmental conditions.
 - Perform a specialty unit resource allocation study.

- Training related:
 - Address training needs related to:
 - Operations in extreme environmental conditions and the adjustment of strategy and tactics in extreme environmental situations.
 - Building construction methods, materials, and designs.
 - Strategy and tactics, decision making, and institute structured officer development training.
 - Ensure the Training Division has resources to develop, coordinate, and provide the needed training curriculums.

- Procedure related:
 - Comprehensive review and revisions of all procedures.
 - Address operational procedural changes for:
 - Operations in environmental extremes.
 - Rapid intervention practices.
 - Different types of building construction methods, materials, and designs.
 - Standardization of apparatus, equipment, and procedures.

- Communications related:
 - Development of a standard method for communicating important weather related information to all personnel.
 - Radio technology improvements.

The LODD Investigation Team had the advantage of examining this incident over a period of months. This is in stark contrast to what was faced by the responding personnel on that fateful day. The Marsh Overlook fire incident was an immense fire fueled by extremely flammable building material products and a vicious wind. It was an environment where information gathering and decision making had to be performed in the time measurement of seconds. During the chain of events that occurred and under severe circumstances, fire and rescue personnel performed at exceptional levels. During the repeated attempts to reach and rescue Technician I Wilson, personnel displayed heroic efforts and jeopardized their own safety. The Department will never forget the sacrifice that Technician Wilson made in an attempt to ensure others were safe. By sharing the knowledge gained from this very tragic and painful incident, the Department will ensure his sacrifice was not in vain and hope that other fire and rescue departments can avoid another similar occurrence.