

Fire Department's Culture, Store's Code Violations Created Time Bomb

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A Charleston Fire Department overconfident in its ability to aggressively extinguish fires and totally lacking in modern tactics and equipment. A sprawling furniture store in violation of fire and building codes. The combination proved a deadly mix at the Sofa Super Store fire, according to a report from a city-appointed panel of firefighting experts.

Fire Report Released

A report from a city-appointed panel of firefighting experts regarding the Sofa Super Store fire was released to firefighters, victims' families, Charleston City Council and the news media Thursday. Firefighters were presented the report at the Gaillard Auditorium.

Insufficient training, inadequate staffing, obsolete equipment and outdated tactics contributed to an ineffective response and effort to control the June 18 fire in its early stages, the 272-page report released Thursday stated. Firefighters were outgunned from the start because their undersized hoses and other problems left them without the water they needed while the fire burned hidden in the ceiling over their heads.

The department's time-tested, one-size-fits-all approach to battling fires in downtown Charleston's historic homes and buildings was no match for a raging blaze at a massive suburban furniture outlet stuffed full of flammable couches.

"The culture of the Charleston Fire Department promoted aggressive offensive tactics that exposed firefighters to excessive and avoidable risks and failed to apply basic firefighter safety practices," the report said. "The strategy and tactics attempted by Department members were inappropriate for the situation and exposed the firefighters to extreme and unnecessary risks."

Charleston Mayor Joe Riley said there was no connection between Chief Rusty Thomas' announcement Wednesday of his decision to retire June 27 and the report's findings. But some experts said the report is so damning that they have no doubt it influenced Thomas' abrupt announcement. The panel pointed to command failures and the water problems as predominant factors in the Fire Department's "unstructured and uncoordinated" response to the blaze.

Chief takes responsibility

Thomas sat stone-faced with arms crossed during the city-appointed panel's presentation to City Council. He attended the briefing with his wife, Carol, who sat by his side.

After the presentation, Thomas said he had not had a chance to study the report in detail, but he's not sure any document could fully capture what occurred at the fire. "No one, no expert in this country, will ever know what took place in that building that night," he said.

Still, Thomas said he accepts responsibility for what happened as the chief commander at the fire. "I'm so sorry that myself or somebody could not have done something different that night to bring back those nine guys."

The report provided a comprehensive and frank account of a fast-moving trash fire that spiraled into a raging inferno, warped steel and sent the roof crashing down on firefighters within 40 minutes of the first 911 call. The suspected cause of the fire was the careless disposal of "smoking materials" near a heap of discarded furniture, packaging materials and highly flammable solvents that the store was not permitted to stockpile.

The report described a chaotic scene in which firefighters charged into the building with no clear strategy for how to attack an intense fire that they were completely unprepared to fight. The report concluded that the immensity of the fire and sheer volume of flammable materials demanded that firefighters back away and battle the blaze defensively from outside the building with aerial ladders and other resources.

The department's command system was virtually nonexistent, the report said, leaving firefighters without supervision or clear instructions and leaving commanders with no idea of who was where and what they were doing. No one was monitoring who was in the building, how long they were inside or how much air they had left in their tanks. Key tasks were left undone and stand-by rescue teams were never established in the rush to funnel as many people inside as possible.

Command failure

"The predominant factor identified in the analysis of Fire Department operations is the failure to manage the incident according to accepted practices," the report stated. "There was no structured incident command system in place, and the essential duties of an Incident Commander were not performed.

Fire Timeline

7:00 p.m.: Approximate time the fire began.

7:07: A passer-by reports the fire using 911.

7:10: The first firefighters arrive at the store.

7:16: Charleston Fire Chief Rusty Thomas arrives.

7:25: Firefighters inside the showrooms have zero visibility. St. Andrews Fire Department offers assistance and use of a thermal imaging device. Thomas initially declines offer.

7:26:35: An employee calls 911 and states he is trapped in the rear of the store.

7:27:44: Firefighter Melvin Champaign radios the first indication of distress from inside the store. The first of a series of more than a dozen radioed calls for help from firefighters in the showroom will go unheard by commanders at the scene.

7:31:19: The trapped store employee is rescued.

7:30: An off-duty battalion chief rushing to the fire hears panicked distress calls and tries to call Thomas, but can't get through on the overworked radio channel.

7:33: The battalion chief arrives at the scene and tells Thomas about the distress calls.

7:34:18: Last word from a firefighter in trouble inside the store.

7:35:25: Thomas directs men to break the front windows in hopes of providing visibility for firefighters still inside.

7:37:37: Flames boil from the store's front windows.

7:38:09: Thomas orders "Everyone abandon the building."

"The operation was conducted in an unstructured and uncoordinated manner, without overall direction and with inadequate supervision. The Charleston Fire Department was inadequately staffed, inadequately trained, insufficiently equipped, and organizationally unprepared to conduct an operation of this complexity in a large commercial occupancy."

The report also contains new details about the earliest minutes of the fire. Alerted by a passer-by that a fire had broken out at the back of the building, a store employee grabbed a fire extinguisher and trained it on a small fire near the loading dock. He ran back into the store for a second extinguisher, but by the time he returned, the smoke had overtaken the loading dock and swept inside the building.

The first crews of firefighters began arriving about that same time, the report said.

Thomas was not the initial commander on the scene. He arrived as the blaze was spreading into the store and before the first distress calls were made from firefighters lost or trapped inside. He and Assistant Fire Chief Larry Garvin failed to follow nationally recognized standards that call for commanders to stay put so they can monitor changing fire conditions and coordinate manpower and equipment, the report said.

Instead, they were all over the place, barking independent and simultaneous orders and inserting themselves in front-line operations. This left no one with an outside overview of the rapidly changing conditions as the store filled with superheated smoke and toxic vapors

needing only fresh oxygen to erupt.

The report said fire commanders did not hear pleas for help from firefighters who were lost in the store's maze-like layout, running out of air and struggling to navigate through coal-black smoke and super-heated air. Fragmented communications from lost and disoriented firefighters continued for approximately seven minutes.

Fallen firefighter Melvin Champaign called for help over his radio numerous times from inside the store.

"We need some help," he pleaded. "Can you hear me, dispatcher?"

A moment later, he prayed. "In Jesus' name, Amen."

No one responded to his calls.

"The radio messages indicating that firefighters were in distress were not heard by anyone at the incident scene," the report said.

Champaign's cousin, Carl Champaign, was devastated after learning of his relative's desperate, unanswered calls for help. "Right now, my heart is broke," he said Thursday.

The department did not adhere to accepted radio communication protocols designed to provide orderly instructions and to ensure that "mayday" calls from firefighters are heard and immediately acted upon, the consultants found.

"The communications process was not controlled. The Fire Chief, the Assistant Chief, and Battalion Chief 4 were all issuing orders and providing direction independently, using a single overloaded radio channel. Critical messages, including distress messages from firefighters inside of the structure, were not heard," according to the panel, headed by former Shreveport, La., Fire Chief Gordon Routley.

Roger Yow, president of the local firefighters union that represents about half of the city's 250 firefighters, said that while the report touched on numerous issues, just about all of them tie back to poor management at the scene. "Any incident commander who has any training doesn't commit 16 firefighters inside a building without an adequate water supply established."

Randy Hutchinson, a former Charleston firefighter who lost his brother, Capt. Billy Hutchinson, in the fire, said the report underscored problems that were known early on but few wanted to talk about, namely the failure of commanders. "It definitely points out there was no command structure whatsoever at the fire. Period."

Janet Wilmoth, editorial director for Fire Chief magazine, said the report was an impressive piece of work that will provide important lessons for the fire service. It also proved what she has known all along: The department depended on antiquated and backward methods that cost nine men their lives, she said. "They were out of touch and in over their heads."

The department's policy at the time of allowing firefighters' air tanks to be only partially filled left some firefighters inside the store running out of air in as little as 12 or 13 minutes,

according to the panel. As a choking blanket of smoke filled the showroom, frantic firefighters scrambled to find a way out before their air tanks ran dry. One firefighter described how his comrades collided with him in the rush to escape. One desperate firefighter even crawled between his legs.

At least 16 firefighters were inside at the time. But Thomas was unaware of this “critical situation” inside the showroom until an off-duty battalion chief arrived and told him about the distress calls, the report said. Thomas didn’t have an overall grasp of the operation and had assumed that things were going well and that Garvin was “conducting a successful operation to keep fire from extending into the showrooms.”

Breaking out the windows

As conditions worsened, Thomas, and later Garvin, ordered firefighters to smash the front showroom windows to clear away smoke and help the men inside, witnesses told the panel. That action had almost immediate consequences.

“There is ample evidence that breaking the windows provided air to the fire and accelerated the ignition of the showroom contents,” the report stated. “The windows were broken at approximately 19:35 (7:35 p.m.) and the interior of the main showroom became fully involved within three to four minutes.”

The panel stated that breaking the windows likely accelerated the flashover that occurred. However, they noted that there were very few viable options at that point. “If the windows had not been broken, the atmosphere probably would have become ripe for a backdraft to occur within a short time,” the report stated.

Neither Thomas nor Garvin recalled giving orders to break the windows, the report stated. But St. Andrews firefighter Steven Beasley told The Post and Courier this week that he clearly recalls Thomas giving the order to smash out the glass spanning the front of the store. “That’s not the way you are supposed to do it, but (Thomas) was the incident commander. He’s the one who calls the shots.”

Moments later, Beasley and fellow St. Andrews firefighter Daniel Bilton entered the store in one last-ditch effort to rescue downed firefighters. They managed to get hold of two firefighters just inside the showroom.

About the report

The nearly 300-page report on the Sofa Super Store fire released Thursday is a culmination of hundreds of hours of work and the examination of hundreds of documents that began in August, two months after the fatal June 18 blaze that killed nine Charleston firefighters. The six-member, city-appointed panel, headed by former Shreveport, La., Fire Chief Gordon Routley, was tasked with independently reviewing every aspect of the response. Panel members pored over radio chatter and interviewed scores of firefighters, studied building

documents, equipment, photographs and video.

On Aug. 17, after less than a week of work, the panel announced its initial list of findings, saying the department's outmoded tactics and dated equipment must undergo significant change in order to catch up with basic fire-service standards followed throughout the country.

Those findings were reinforced Thursday.

Still to come is a long-range strategic plan for the department.

In addition to Routley, other team members are:

- Kevin Roche, assistant fire marshal and assistant to the fire chief in Phoenix.
- Tim Sendelbach, former chief of training for Savannah Fire and Emergency Services.
- Brian Crawford, assistant to the fire chief in Shreveport and resident instructor at the National Fire Academy.
- Mike Chiaramonte, a fire inspector and former fire chief in Lynbrook, N.Y.
- Pete Piringer, spokesman for the review panel.

But the air rushing in through the broken windows fed the hungry flames and a ball of fire shot through the store, thrusting Beasley and Bilton back outside and causing them to lose their grip on the downed firefighters. Hours later, recovery crews would find the bodies of fallen firefighters Earl Drayton and Brad Baity, just a short distance from the front doors.

Ann and Mike Mulkey, the parents of fallen Capt. Louis Mulkey, said they believe their son died needlessly because of command failures and water problems. The report said Mulkey died in an office near the back of the building, not far from a blocked exit door.

"They died not really knowing why they were dying," Mike Mulkey said. "I pictured my son making it to that door and standing there burning to death."

Families of the fallen firefighters were briefed on the report Thursday morning, followed by presentations for firefighters later in the day. Firefighters filed into the Gaillard Auditorium for the panel's afternoon presentation. Within 20 minutes, some had heard enough and left the auditorium. Outside, they hugged, smoked cigarettes and tried to make sense of the overwhelming report.

Capt. Jamie Greene, of Engine Co. 6 on Cannon Street, was among those who left early, unable to listen to the unsettling account. "I didn't read the whole report and I doubt I ever will. It's pretty upsetting."

Some who read the report expressed continued support for Thomas, and said the findings made it clear that much of the tragedy was out of the chief's hands.

Holly Gildea, daughter of fallen Capt. Mike Benke, said she was saddened by the report, particularly the problems firefighters ran into with lack of water and running out of air in their tanks.

But she said Thomas should not shoulder all the blame; there is plenty to go around. "We can't

point our finger at Rusty. It was not all him. It was such a mixture of things. I wish him all the best. He has his own nightmare as well as us.”

Death trap?

The report painted a picture of the sofa store as a time bomb waiting to be lit. It described the store as a death trap, identifying its dense layout of furniture, padlocked doors and poorly maintained or identified exits. “The inadequate number of exits, locked exits, and obstructed paths to exits significantly reduced the potential for firefighters who were inside the showroom buildings to find a path to safety.

“The fire could have been prevented. If the property had been constructed and maintained in accordance with state and local codes the fire would have been quickly controlled; no lives would have been lost and the fire would have been of little consequence,” according to the report.

Richard Rosen, attorney for sofa store owner Herb Goldstein, did not return calls seeking comment.

Jean Dangerfield, sister of fallen firefighter Michael French, said the numerous violations at the store highlighted in the report should not go unnoticed. Building owners need to ensure their properties are safe and up to code “so these guys aren’t walking in on a suicide mission.” Capt. Art Wittner, the lone surviving member of the Engine 16 crew that responded to the fire that night, said the Fire Department now needs to move past the blame game and find a way to come together once again. “I don’t want the city of Charleston Fire Department to hurt like it’s been hurting,” he said. “Let’s start healing.”

KEY FINDINGS

Based on previous recommendations from the city-appointed review panel, the Charleston Fire Department is undergoing a massive overhaul of its training, staffing, tactics and equipment. The city also has improved its building- and fire-inspection programs. The review panel’s report said the following key factors existed at the time of the Sofa Super Store fire June 18:

Building and property

- The Sofa Super Store was a high-risk occupancy that presented several specific risks to the health and safety of firefighters, the store’s employees, customers, neighbors and the surrounding community.
- The level of fire risk exceeded the limits prescribed by established regulations and would have — or should have — been mitigated if the applicable codes and standards had been followed, applied and enforced.
- The fire could have been prevented. If the property had been constructed and maintained in accordance with state and local codes the fire would have been quickly controlled. No lives

would have been lost and the fire would have been of little consequence.

Fire department operations

- The fire-suppression operations that were conducted by the Fire Department at the Sofa Super Store did not comply with federal occupational health and safety regulations, with national consensus standards, or with modern fire service expectations.
- These deviations from standard operational and safety practices exposed firefighters to excessive risks and failed to remove the nine firefighters from a critically dangerous situation.
- The predominant factor identified in the analysis of Fire Department operations is the failure to manage the incident according to accepted practices. There was no structured incident command system in place and the essential duties of an incident commander were not performed. The operation was conducted in an unstructured and uncoordinated manner, without overall direction and with inadequate supervision.
- The Charleston Fire Department was inadequately staffed, inadequately trained, insufficiently equipped, and organizationally unprepared to conduct an operation of this complexity in a large commercial occupancy.
- The department attempted to compensate for the limited resources and organizational inadequacies by engaging in dangerously aggressive and uncoordinated firefighting operations.