JENSEN HUGHES

POST-INCIDENT ANALYSIS
Brookhollow Apartment Fire

Presented to Sedgwick County – Board of County Commissioners and the City of Wichita – City Council

JOHN MAMMOSER & VERNON CHAMPLIN | **DECEMBER 16, 2024**

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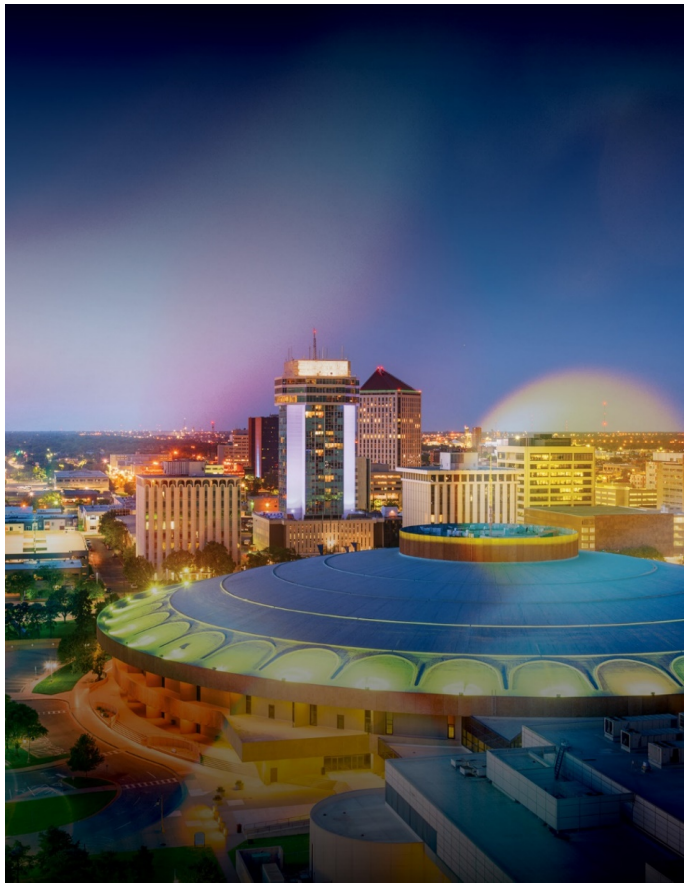
Post-Incident Analysis: Brookhollow Apartment Fire

Agenda

- Our Assignment and Our Approach
- Report Outline
- Review the Incident
- Incident Analysis and Recommendations
- Key Incident Findings
- Moving Forward
- Questions



The following is a condensed presentation of a comprehensive Post-Incident Analysis Report. Not all findings and recommendations are included herein.

Post-Incident Analysis: Brookhollow Apartment Fire

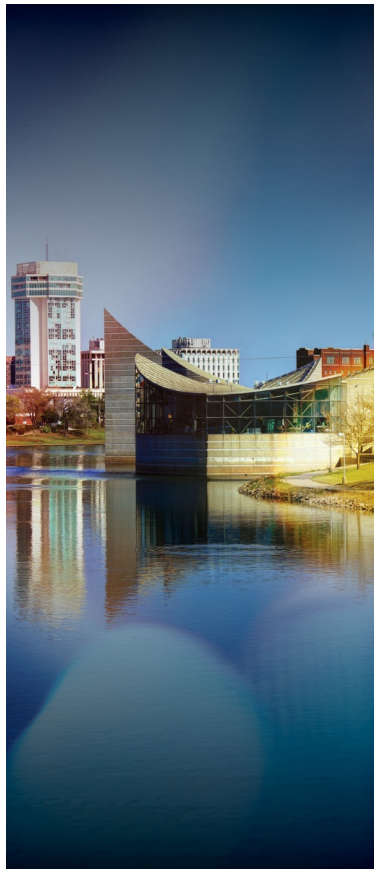
Purpose and Assignment

Why Are We Here?

The Brookhollow Apartment Fire, which occurred on October 13, 2023, tragically took the life of Ms. Paoly Bedeski, injured several other occupants, and could have harmed many others, including first responders.

Our Assignment

+ Obtain a thorough evaluation of the emergency communications and involved public safety-first response agencies in comparison to accepted best practice and industry standards.
+ Establish a clear understanding of how the emergency communications and involved public safety-first response agencies affected the fatal apartment complex incident.
+ Comprehensively compile incident information and data, obtain objective incident analysis, and draw conclusions which meet the parameters, conditions and mandatory requirements presented in the document.
+ Identify strategies and create a plan to improve system outcomes and help restore public trust and confidence.

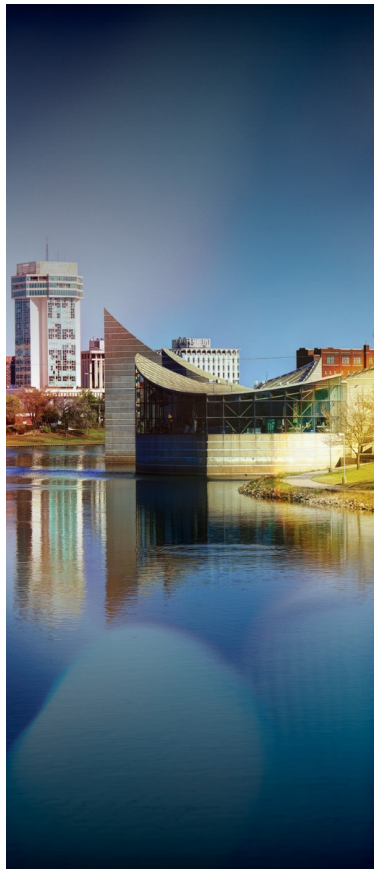


Post-Incident Analysis: Brookhollow Apartment Fire

Our Approach and Process

To provide an overview of the incident, contributing factors resulting in the incident outcome, and recommendations to improve the agencies' training SOPs/SOGs. The report identifies overarching themes and gaps in administrative and operational processes as well as where agencies policies and procedures are considered adequate.

- For all agencies involved, we analyzed:
  - organizational frameworks for all agencies involved,
  - applicable Standard Operating Procedures (SOP) and Standard Operating Guidelines (SOG),
  - Wichita Fire and Wichita Police incident reports,
  - past and current training materials for Sedgwick County Emergency Communications dispatchers,
  - applicable building construction permits, original building design drawings, lease agreements, and other documentation associated with the Brookhollow Apartment Complex, and
  - the actions taken and not taken before, during and after the incident.
- We conducted two site visits and numerous phone calls interviewing:
  - Sedgwick County Management
  - Sedgwick County Metropolitan Area Building and Construction Department
  - Sedgwick County Emergency Communications
  - Sedgwick County EMS
  - Wichita City Management
  - Wichita Fire Department
  - Wichita Police Department
- Followed up with agencies when we had additional questions or requests for materials.



Post-Incident Analysis: Brookhollow Apartment Fire

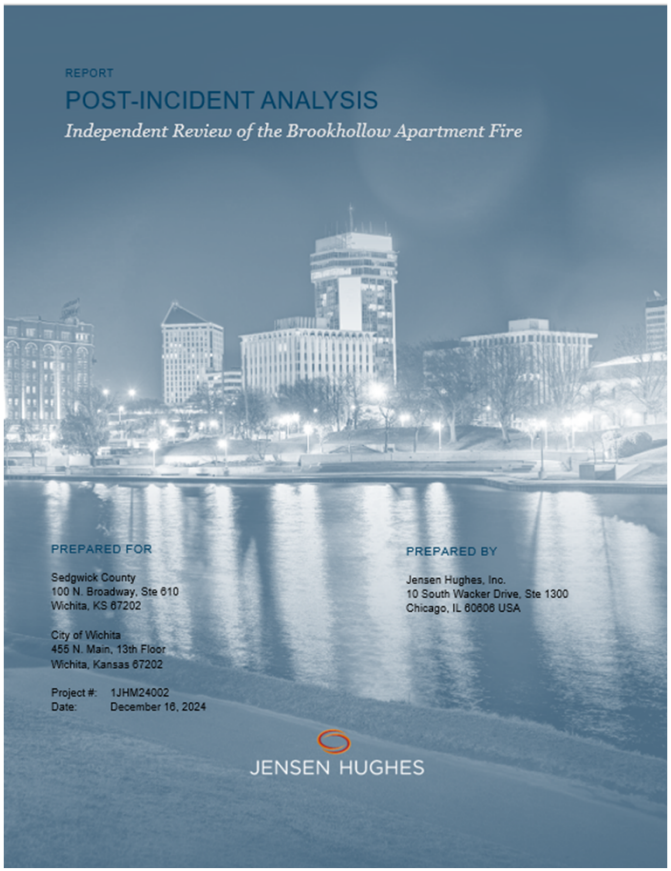
Limitations of this Analysis

- Relied upon the availability and accuracy of the data provided.
- Jensen Hughes stands behind these findings as:
  - objectively determined
  - accurately reported
  - legally acquired
  - compliant with all relevant regulations
  - comprehensive in scope to the best of our ability
  - collected with discretion, investigative diligence and professional respect
- Findings and recommendations are subject to change if additional, relevant, and factual information is provided.

Post-Incident Analysis: Brookhollow Apartment Fire

Report Structure

- Background
  - Introduction and overview of all agencies involved.
  - Overview of the Brookhollow Apartment Complex.
- Incident Overview
  - Narrative of the incident.
- Incident Analysis and Recommendations
  - Agency-by-agency review of relevant actions (or inactions) taken during the incident.
  - Relevant SOP's, SOG's, National Standards and Industry Standard, and best practices are reviewed and cited where appropriate.
  - Findings and recommendations are provided or each agency.
- Moving Forward
  - Path forward and overall conclusions.
- Appendices
  - Selected incident timelines
  - PSAP consolidation history
  - Additional Areas of Study
  - About Jensen Hughes and author bios



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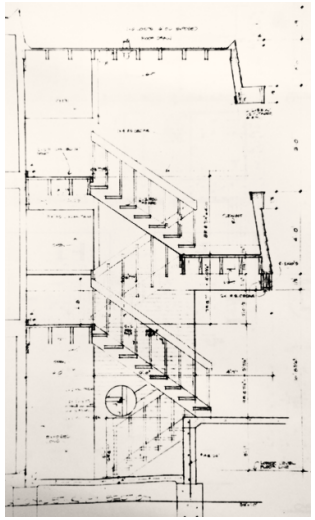
The Brookhollow Fire Incident

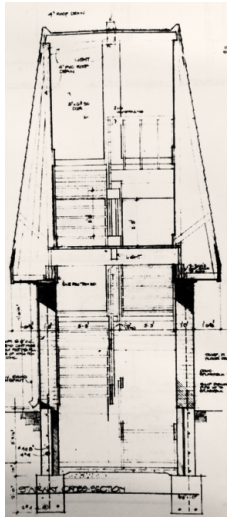
October 13, 2023

Post-Incident Analysis: Brookhollow Apartment Fire

The Complex

- Brookhollow Apartment Complex – 8165 E. Central Ave.
  - Single vehicle entry/exit to complex
  - Comprised of 12 two-story “buildings” (garden-style apartments) with approximately 72 units total
  - Each building has a single exit to a common weather-protected but open stairwell

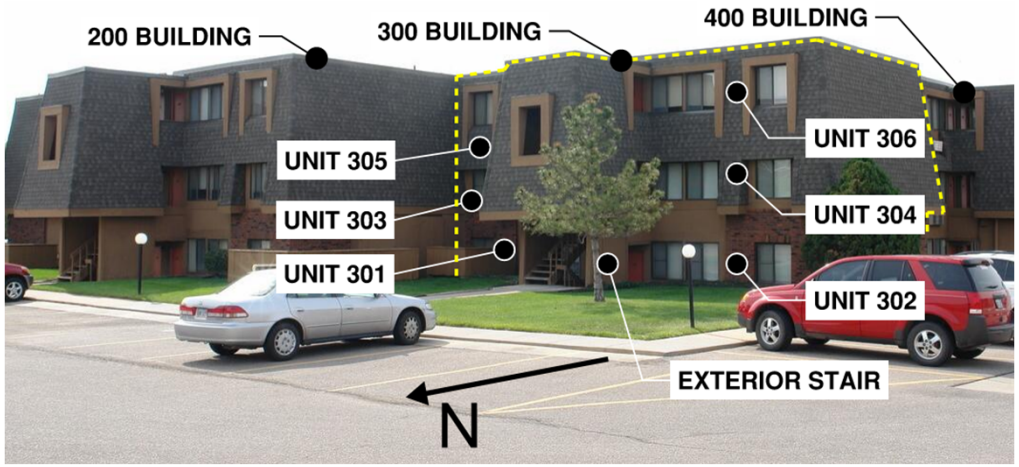




Post-Incident Analysis – Brookhollow Apartment Fire

The Complex

- Building 300
  - Six ~580 sq.ft. single bedroom units (two per floor)
  - Units provided with ABC fire extinguisher, smoke alarm
  - Fire alarm system not provided and not required
- Building permit from 1977 – likely constructed to1973 or 1976 UBC
  - Original construction complied with building and fire code
  - Constructed today, automatic sprinklers are required



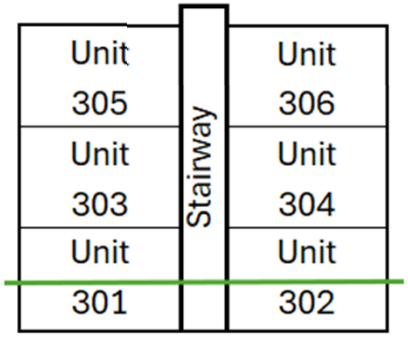
Post-Incident Analysis – Brookhollow Apartment Fire

The Fire

- **3:58 a.m.** Ms. Paoly Bedeski calls 911
  - Tells the call taker/dispatcher that her apartment is on fire, lives at the Brookhollow Apartments, unsure of the building address, but she is in Unit 306 and provides her name. Ms. Bedeski asks for help.
  - Forty-eight (48) seconds after her call is answered, she does not speak again on the 911 call.
- **3:59 a.m.** WFD is dispatched.
- **4:00 a.m.** Residents in Unit 304 report fire.
- **4:02 a.m.** E15 on requests second alarm,
  - Ms. Bedeski's 911 call disconnects.
- **4:03 a.m**. E15 and SQ15 are on the scene; report heavy fire from the second floor; they start a fire attack and search operation.
- **4:05 a.m.** B3 takes Incident Command
- **4:06 a.m.** Unit 302 friend (not present) calls 911 and reports resident can not self-evacuate.
- **~4:06 a.m. – ~ 4:11 a.m.** Additional fire companies arrive
- **~4:07 a.m.** Dispatch reports person trapped in Unit 302; M2 hears this, responds and asks for two ambulances.

Before any fire department companies are on the Brookhollow Apartment scene, two residents in Unit 304 and two residents from Unit 305 jump from their respective windows, one resident in Unit 303 runs down the exterior stairs through fire, and one resident from Unit 301 exits through their front door to escape.

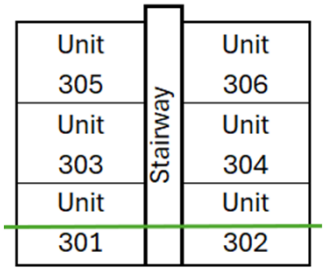
About 4-1/2 minutes from when WFD arrived on scene, dispatch reports on the Ops channel that a person is trapped in Unit 302. [~4:07 a.m.]

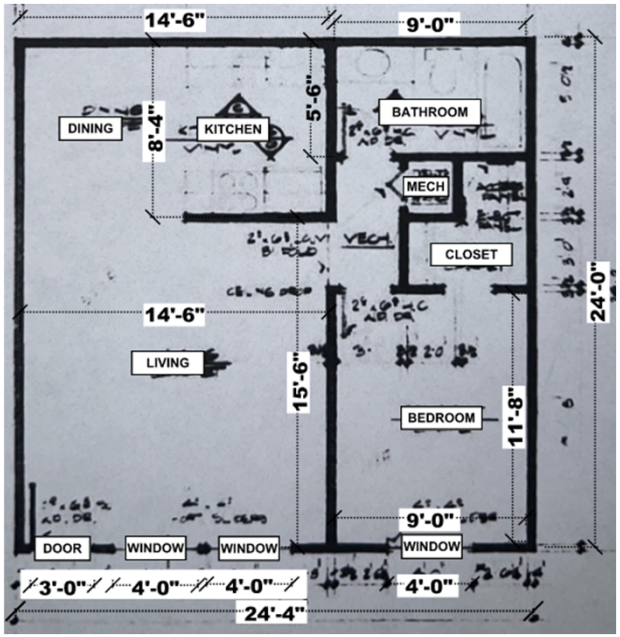


Post-Incident Analysis: Brookhollow Apartment Fire

The Fire

- The fire is reported in front of Units 303, 304, 305, and 306 inside the exterior stair.
- **4:10 a.m. – 4:13 a.m.** Portions of stairway roof collapsed on E15 and SQ 15.
  - Mayday is transmitted over radio; Command reports everyone out – going defensive.
  - Resident in Unit 302 is evacuated by SQ14 and T3 as stairway is collapsing.
- Engine 15 officer bailed out of the opening in the stair enclosure and Engine 15 nozzle was removed via a ground ladder from the front opening in the stairway enclosure.
- **4:16 a.m.** Personnel Accountability Report (PAR) completed by Incident Command (Mayday over).
- **4:20 a.m.** SCEC transmits the 2nd alarm.
- **4:21 a.m.** Fire companies going to check the top floor, which had not been searched before the stair collapse.
- **4:21 a.m. – 4:24 a.m.** Rescue 2 breaks the bedroom window in Unit 306 and three firefighters enter the bedroom. They find smokey conditions (smoke to the floor) and moderately hot conditions. After searching the bedroom, two firefighters move into the living room area.



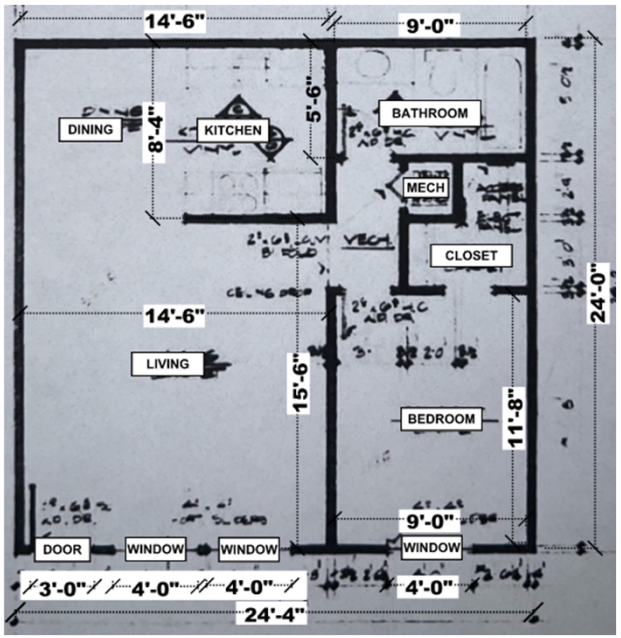


Post-Incident Analysis: Brookhollow Apartment Fire

The Fire

- **4:22 a.m. – 4:26 a.m.** A firefighter searching identifies a bathroom and finds a victim in the bathtub.
  - The three firefighters work to get the victim to the bedroom window.
  - E10 firefighter at top of ladder to the bedroom window and is handed the victim.
  - Once down the ladder, E10 starts CPR on the patient, Ms. Bedeski, at about ~4:26 a.m
- **4:34 a.m.** SCEMS transports first patient to hospital.
- **4:36 a.m.** WFD Fire Investigator on scene.
- **~4:32 a.m**. SCEMS with WFD treating Ms. Bedeski.
- EMS to triage, treat, and transport four patients to the hospital, including Ms. Bedeski at ~4:54 a.m. and arrives at the hospital ~8 minutes later.
- **4:58 a.m.** SCEMS transports last patients to hospital.

Unit 305	Stairway	Unit 306
Unit 303		Unit 304
Unit 301		Unit 302



Post-Incident Analysis: Brookhollow Apartment Fire

The Fire

- WFD Fire investigators photograph and document the scene.
- **10:10 a.m.** WFD fire investigators left the scene for the final time that day.
- **11:05 a.m.** E15, the last WFD unit on scene, cleared the call.

Figure 9: Post-fire damage to the exterior of Building 300. Left: Units 305 (top) 303 (middle) 301 (bottom) and east facing side of exit stairway enclosure. Right: North-facing side of exit stairway enclosure. (Credit: WFD FIU)

Figure 10: Post-fire damage to the exterior of Building 300. Living room windows seen for Units 306 (top) 304 (bottom). (Credit: WFD FIU)

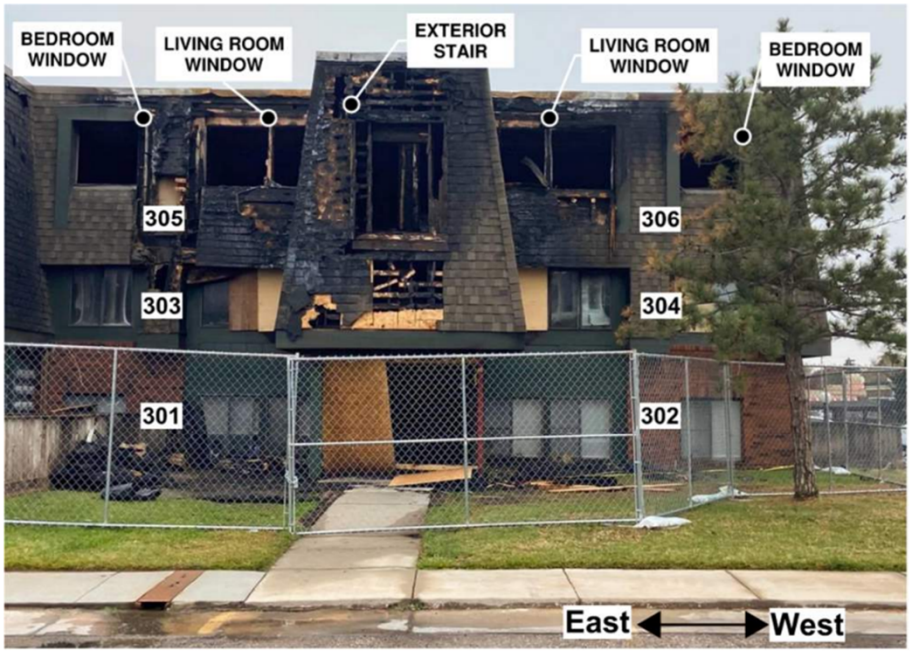


Figure 8: Post-fire photo of Building 300. (Credit: Jaime Green/The Wichita Eagle; annotations by Jensen Hughes)

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Incident Analysis and Recommendations

Post-Incident Analysis: Brookhollow Apartment Fire

Introduction to Analysis

- After a comprehensive review, Jensen Hughes found no single point of failure by any of the agencies involved that could be solely attributed to the fatality of Ms. Paoly Bedeski.
- Instead, Jensen Hughes identified a number of systemic shortcomings that, when combined, contributed to an unorganized rescue effort. Had these significant shortcomings not occurred, it would have provided Ms. Bedeski with a better chance of early rescue and subsequent increased potential for survival, provided she was still alive.
- The last known time Ms. Bedeski was alive was when she stopped speaking on the 911 call, which occurred before the Wichita Fire Department was dispatched. Her call disconnected before the Wichita Fire Department arrived on the scene.

Jensen Hughes cannot conclude that the shortcomings identified would have absolutely changed the ultimate outcome of this fatal incident.

Post-Incident Analysis: Brookhollow Apartment Fire

Sedgwick County Emergency Communications

- Dispatch Technology
  - Systems employed by SCEC are considered best-of-breed by industry standards.
- SOPs and SOGs
  - Reviewed and compared to APCO and NENA Standards
  - Thorough, well organized, up-to-date
- Training – Well-planned training and quality improvement program.
  - 4-week academy, then Call Takers start on-the-job training
  - 3 to 6 months Call Takers may promote to Dispatch I
  - Fully trained Dispatcher II: 9 to 12 months of training
- In the past few years, compensation and COVID-19 has led to staff turnover.
  - Recently, Sedgwick County has been aggressive in setting higher pay rates for employees. This has been effective in the recruitment and retention of employees.

APCO - Association of Public-Safety Communications Officials
NENA – National Emergency Number Association

Post-Incident Analysis: Brookhollow Apartment Fire

Sedgwick County Emergency Communications

Dispatch Human Factors

- Ms. Bedeski's 911 Call answering, entry, and dispatching times reviewed:
  - 911 call from Ms. Bedeski was answered and processed correctly according to APCO Standard 1.113.2-2024.
- Other 911 Call answering, entry, and dispatching times reviewed:
  - Reviewed the performance of SCEC Dispatch for other calls from residents inside Building 300.
  - Calls from Unit 304 and for the person calling on behalf of the resident in Unit 302 were both answered within the standard benchmarks in APCO 1.113.2.
- Ms. Bedeski's 911 call audio recording reviewed:
  - Call taker/dispatcher indicated he could not understand the apartment unit number she provided and therefore did not provide this information to WFD.
  - Hearing and understanding speech are affected by many factors (age, genetics, environment, cognitive factors, language, …).
  - Jensen Hughes listened to the recording released – can hear and understand Ms. Bedeski provided "Unit 306" twice.

Table 1: SCEC Dispatch performance on Ms. Bedeski's 911 call vs APCO 1.113.2 benchmarks for Fire/EMS calls.

Metric	*75% of the Time*	*90% of the Time*	*Actual Performance*	*Result*
Call Answer Time 4.6.3	10 Seconds or less	20 Seconds or less	12 Seconds *03:58:04 AM – 03:58:16 AM*	**Achieved**
Call Answer to Entry Time 4.6.4.3	NA	60 Seconds or less	3 Seconds *03:58:16 AM – 03:58:19 AM*	**Achieved**
Call Entry to Dispatch 5.7.1.3	NA	90 Seconds or less	65 Seconds *03:58:19 AM – 03:59:24 AM*	**Achieved**

APCO Standard 1.113.2-2024: Public Safety Communications Incident Handling Process

Post-Incident Analysis: Brookhollow Apartment Fire

Sedgwick County Emergency Communications

Dispatch Human Factors

+ Ms. Bedeski's 911 call review (cont.)
  - Hearing and understanding speech also affected by technology (quality of audio, quality of playback device,…)
  - Reviewed the technology and hardware associated with live call taking/dispatching, recording, and playback.
  - Determined quality of audio recording is "pure" - signal captured prior to hardware connected to dispatcher's headset.
  - We listened to live calls and listened to recorded playback of those live calls. What can be heard in recorded audio is not the same as what is heard in the headset.
  - Instant recall feature (allowing instant playback of audio) was not used by dispatcher. This could have allowed the unit number to be understood and to relay this information to WFD.

Jensen Hughes can confirm that the recorded 911 call audio released from SCEC Dispatch is of higher quality than what a call taker/dispatcher hears in their headsets…

We believe it's entirely possible, and likely that the call taker/dispatcher did not understand the apartment unit number given by Ms. Bedeski despite what can be heard in the released recording.

Post-Incident Analysis: Brookhollow Apartment Fire

Sedgwick County Emergency Communications

Dispatch Human Factors

+ Delay in dispatching 2nd Alarm (upgrading the alarm)
  - Several dispatchers and a supervisor were unsuccessful in assisting the dispatcher in dispatching the requested second alarm.
  - Another dispatcher across the room overheard the conversation and was able to get the recommended fire unit recommendations to appear in CAD to dispatch the alarm.
  - Issue was brought to the attention of the SCEC administration later that morning. They found multiple dispatches on multiple shifts could not recall how to dispatch a second alarm.
  - Within days of the incident, the administration arranged re-training for all staff on this issue.

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Sedgwick County Emergency Communications

Technical Contributing Factors

+ Dual headsets
  - Dispatchers wear two independently operated headsets with two microphones.
  - Listening and understanding to different sounds coming into each ear (dichotic listening) was thought to be one area that may have created confusion for dispatchers in this incident.
  - We sat at dispatch consoles and our observing and listening to phone calls and radio traffic in different ears was very difficult and almost impossible to completely comprehend both, preference to one ear seemed to always need to be given.
  - Regardless, SCEC Dispatch has operated with dual headsets for many years, and undoubtedly call taker/dispatcher there have become better at dichotic listening through practice.

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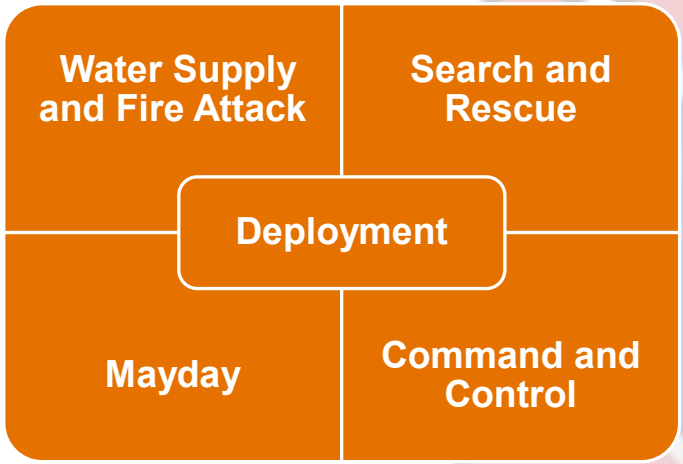
Wichita Fire Department

- Policies and Procedures
  - We evaluated WFD policies and guidelines against NFPA Standards, other policies and guidelines, and industry best practices.
  - We found the WFD's Operations Manual (OM) thorough, well-organized, and up-to-date relative to most current practices in today's fire service.
  - However, we found numerous WFD operational policies were not followed at this incident.
- Fireground operations of this incident were assessed in five general areas:
  - Deployment
  - Water Supply and Fire Attack
  - Search and Rescue
  - Command and Control
  - Mayday



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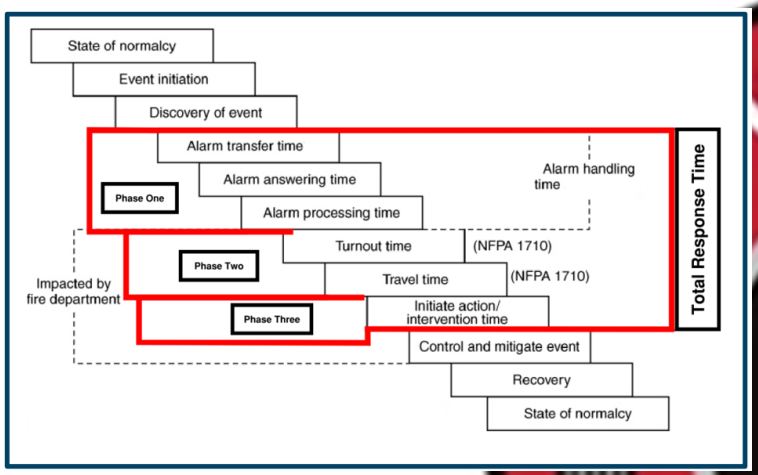
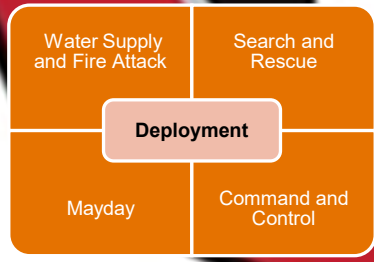
Deployment

+ NFPA 1710, *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments*, is the internationally recognized standard for career fire department response and deployment.
  - Total Response Time (TRT)
    - First Engine, Second Engine, and the Total Effective Response Force
  - Total Effective Response Force (ERF)
    - Number of firefighters required to complete critical task assignments on the fireground based on general hazard type. (ie. Garden-Level Apartment)



Occupancy Type: Garden-Style Apartment
Deployment: Minimum of 27 members or 28 if aerial device is used

The initial full alarm assignment to a structure fire in a typical 1200 ft² (111 m²) apartment within a three-story, garden-style apartment building must provide for a minimum of 27 members (28 if an aerial device is used).

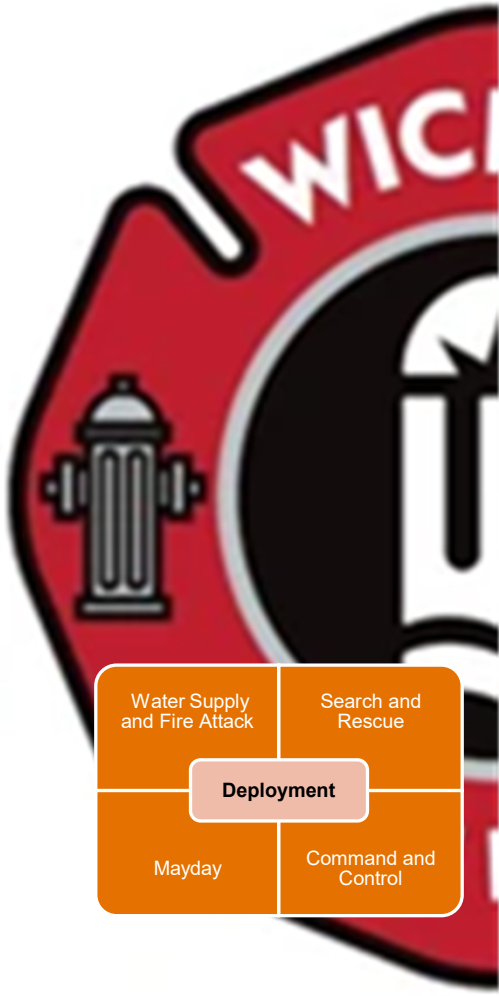


Post-Incident Analysis: Brookhollow Apartment Fire

Deployment

+ Response Time Assessment:
  - First Engine, Second Engine, and the Full Alarm Assignment
    - WFD responded to this incident within each of the benchmark standards
+ Effective Response Force Assessment:
  - Garden-Style Apartment
    - WFD assembled the Total Effective Response Force within the benchmark standard

Metric	*Benchmark Turnout Time*	*Benchmark Travel Time*	*Benchmark (Turnout + Travel)*	*Actual Performance (Time from Turnout to Arrival)*	*Result*
First Engine Arrival	80 Seconds	240 Seconds	320 Seconds	214 Seconds	**Achieved**
Second Engine Arrival	80 Seconds	360 Seconds	440 Seconds	290 Seconds	**Achieved**
Full Alarm Assignment Arrival	80 Seconds	480 Seconds	560 Seconds	519 Seconds	**Achieved**



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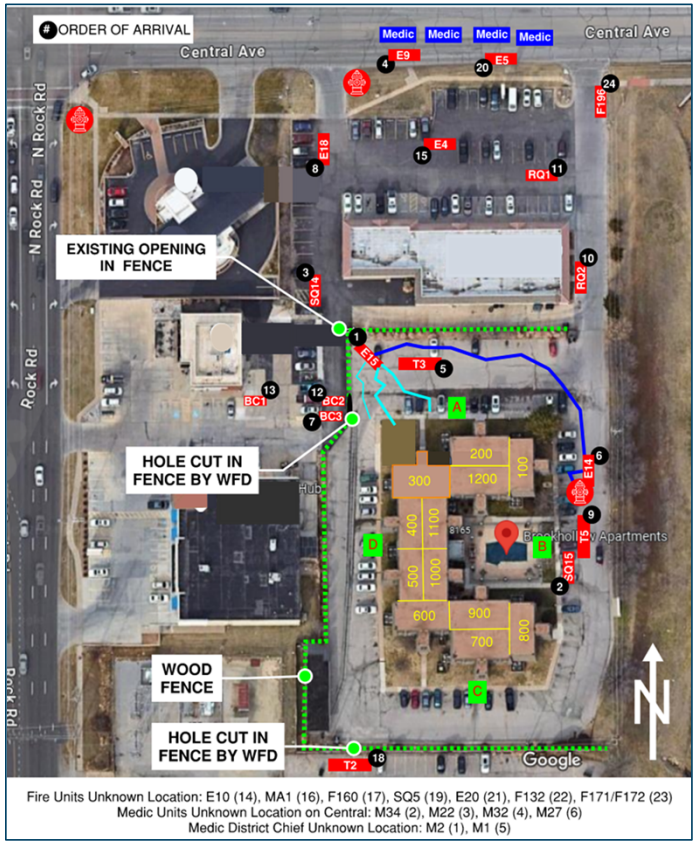
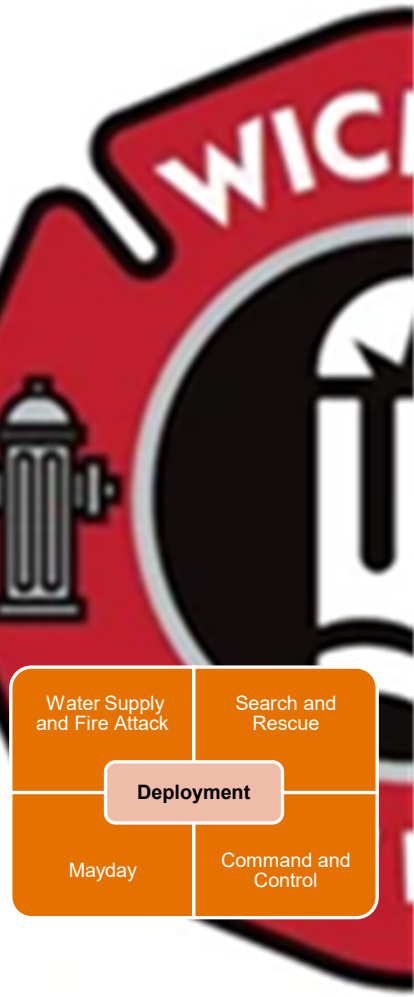
Deployment



Fire Units Unknown Location: E10 (14), MA1 (16), F160 (17), SQ5 (19), E20 (21), F132 (22), F171/F172 (23)
Medic Units Unknown Location on Central: M34 (2), M22 (3), M32 (4), M27 (6)
Medic District Chief Unknown Location: M2 (1), M1 (5)

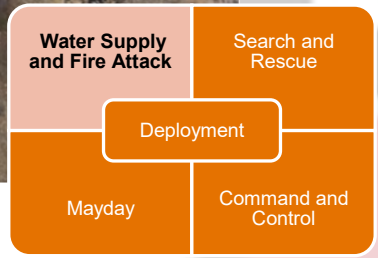
	Engine Arrival		*Truck/Rescue Arrival*		*Squad Arrival*		*BC/Other Arrival*	
1st alarm dispatched (03:59:24)								
1	E15 **(3)**	04:02:58						
2					SQ15 **(2)**	04:03:07		
3					SQ14 **(2)**	04:03:23		
4	E9 **(3)**	04:04:14						
5			T3 **(4)**	04:04:33				
6	E14 **(3)**	04:05:02						
7							B3 **(1)**	04:05:21
B3 establishes *Central Command* (04:05:21)								
8	E18 **(3)**	04:06:02						
9			T5 **(4)**	04:06:38				
10			RQ2 **(3)**	04:08:03				
28 WFD personnel on-scene per NFPA 1710 minimum recommendation (04:08:03)								
11			RQ1 **(3)**	04:08:43				
12							B2 **(1)**	04:08:45
13							B1 **(1)**	04:11:14
14	E10 **(3)**	04:11:16						
15	E4 **(3)**	04:12:09						
16							MA1 **(1)**	04:16:03
17							F160 **(1)**	04:18:44
41 WFD personnel on-scene when 2nd alarm was dispatched (04:20:16)								
18			T2 **(4)**	4:22:09				
19					SQ5 **(2)**	04:25:34		
20	E5 **(3)**	04:25:36						
21	E20 **(4)**	04:28:43						
22							F132 **(1)**	04:29:26
23							F171/ F172 **(2)**	04:36:38
24							F196 **(1)**	4:43:01
58 WFD personnel on-scene								



Post-Incident Analysis: Brookhollow Apartment Fire

Water Supply and Fire Attack

- This wood frame, non-sprinklered, high-density, residential occupancy is served by a dead-end water main with one fire hydrant, on a dead-end road.
  - These conditions warrant extensive pre-incident planning. However, the WFD's provided pre-plan is weak.
- The first arriving engine (E15) did not lay a supply line (forward or split lay) per OM, thus requiring others to hand-jack large-diameter hose... a time-consuming process.
- The OM directs the second arriving engine to "*not stage*" and establish a water supply. E9 arrived and staged at a hydrant on Central, and E14 initiated a water supply plan.
- E14's access was blocked by the privacy fence, so they attempted to take the hydrant within the Complex. However, TK5 was parked in front of it. TK5 was deploying outriggers when they were directed by E14 to reposition, causing additional water supply delays.



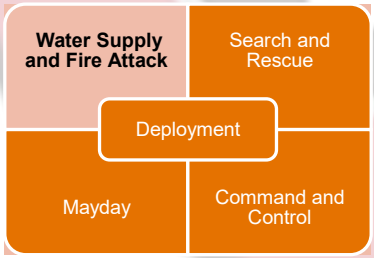
Post-Incident Analysis: Brookhollow Apartment Fire

Water Supply and Fire Attack

- Initial crews (E15, SQ15, S14) deployed three attack lines (two 2-½" and one 1-¾") simultaneously from E15's 600-gallon tank without a continuous water supply being established.
  - Fire suppression was stalled, and crews were put at risk when E15 ran out of *tank* water.
- Firefighters were in the stairway without water when the roof partially collapsed, and the Mayday was transmitted.
- The rapid advancement up the stairway suggests crews were operating in *Fast attack/Rescue mode* despite a *Fire Attack mode* being declared by SQ15, which requires an IRIC/RIC per the OM.
- A continuous water supply was eventually established from the onsite hydrant by engine E14.
- The chosen approaches to water supply and fire attack impacted the timing in which the victim may have been removed from her apartment.
- **Recommendation:** Consider limiting the number and size of handlines permitted to flow water from a booster tank before a water supply is established.

Establish Incident Command early in the incident to establish and communicate effective incident priorities.

So goes Initial Command… So goes the Incident.

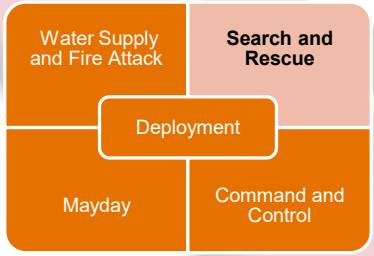


Post-Incident Analysis: Brookhollow Apartment Fire

Search and Rescue

- Per the OM, *"searches should generally begin closest to the fire area and work back from there".*
- Interviews with WFD confirmed that firefighters knew there was a high life hazard on floors above the first floor (garden level) when they arrived, given the time of day, they assumed every apartment was occupied until it was confirmed not to be.
  - With only one way in and out of each apartment via a single stairway that was blocked by fire, Vent, Enter, Search (VES) is an effective method to conduct quick searches per the OM.
- The first 911 caller was Ms. Bedeski in Unit 306, who reported needing "*help*" but did not indicate that she was "*trapped".*
- Approximately three minutes after WFD arrived on the scene, SCEC announced over the Ops channel that one person was "*trapped*" (Unit 302).
- Some fire companies self-assigned or were directed by Command to search uninvolved buildings before crews completed the search of Building 300.
  - Durning Interviews, those crews stated they believed other crews were searching Building 300.
- Crews searching uninvolved buildings diluted the number of resources available to search Building 300. The stairway roof collapse and subsequent Mayday further interrupted the search and rescue efforts.

A victim's survivability potential decreases as the time of exposure (fire) increases.

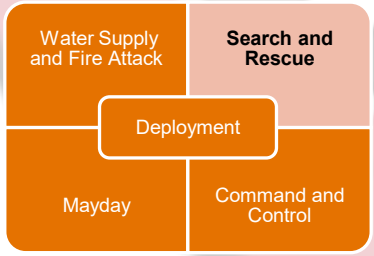


Post-Incident Analysis: Brookhollow Apartment Fire

Search and Rescue

- Per the OM, "…*During a Mayday, no fire ground assignment should be abandoned. The Incident Commander will direct and/or redirect all operations*…".
- It's reasonable to assume that Incident Command needed some time to gain control of the situation and start to work through the Mayday checklist
- Search and rescue was reprioritized after the Mayday was stabilized, and the primary search was completed for the remaining Building 300 units (305 and 306).
  - Ms. Bedeski was found unresponsive in Unit 306 by RQ2 and brought down a ladder by E10 where triage and treatment began.
- Since SCEMS is not automatically assigned to structure fire response unless someone is "reported trapped", WFD must be prepared to triage and treat victims until they can be transferred to SCEMS.
  - WFD must assume that victims may be found during searches. However, the OM does not address how to triage victims found during search and rescue operations.
- **Recommendation:** Searches should begin closest to the fire area, as per the OM.
- **Recommendation:** Upon the immediate arrival of truck companies to a residential structure fire, employ prioritized search and rescue as an immediate action of opportunity that targets a known (or high probability) area of a trapped subject, as per the OM.

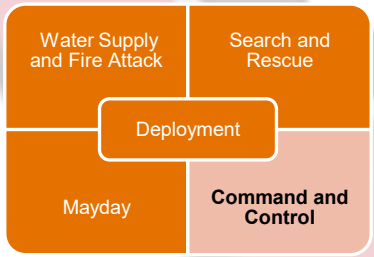
The search and rescue of Building 300 was not reinitiated for over 11-minutes after the Mayday was called… despite the Mayday being resolved quickly.



Post-Incident Analysis: Brookhollow Apartment Fire

Command and Control

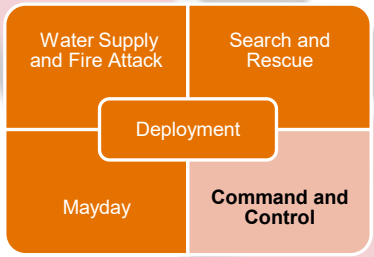
+ Command and control of an apartment fire involves the organized management and coordination of firefighting efforts through the Incident Command System (ICS), which defines a clear hierarchy and chain of command. It begins with a size-up, where the Incident Commander conducts an initial assessment of the situation to gauge the fire's extent, identify potential hazards, and understand the building layout.
+ Effective resource management is critical, as personnel and equipment must be allocated appropriately, with priority tasks assigned to firefighters and coordination with additional emergency services as needed.
+ The Incident Commander determines the incident strategy which may include coordinated ventilation, fire attack, and search and rescue priorities.
+ The first arriving units (E15, SQ15) did not assume Command, as they engaged in a Fast Attack/Search mode… However, as additional units arrived, no one established “Initial Command,” per the OM.
  - Six units (E15, SQ15, SQ14, T3, E9, and E14) arrived on the scene before Command was eventually established by the seventh unit (B3).
+ Effective communication between Incident Command and fire ground operations is essential.
+ Once, interior searches were underway, neither an Initial Rapid Intervention Crew (IRIC) nor a Rapid Intervention Crew (RIC) was formally established, as required by the OM



Post-Incident Analysis: Brookhollow Apartment Fire

Command and Control

+ The Incident Command's *action or inaction* can have a significant impact on the outcome of any incident.
  - In this incident, Command was not well organized and appeared more reactive than proactive.
+ Examples of deficient command and control actions:
  - Directing the engine staged at a *contingency* water supply (as required per the OM), to reposition and search the uninvolved Building 200.
  - Numerous units were allowed to freelance without a clear assignment or incident coordination.
  - Allowing companies to search uninvolved buildings before the high-priority areas closest to the fire.
  - When Mayday occurred, switched to *defensive* operations, deprioritized search operations, and did not manage Mayday/Tac radio communications per the OM.
  - Did not broadcast critical fire incident benchmarks, (Water Supply Established, Primary/Secondary Search Complete, Fire Under Control, etc) as required per the OM.
+ **Recommendation:** Examine recent fire incidents and determine if Incident Command is effective.
+ **Recommendation:** Failure to communicate fire scene benchmarks results in a lack of adequate fireground management. Announce incident benchmarks to the dispatcher via the OPS channel

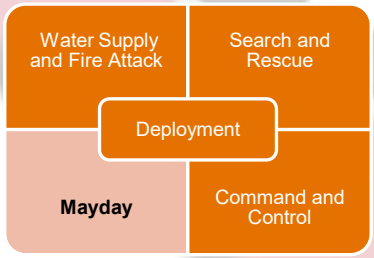


Post-Incident Analysis: Brookhollow Apartment Fire

Mayday

- A Mayday is an emergency incident occurring within an emergency incident. It represents a critical moment when a firefighter is in distress and requires assistance due to life-threatening circumstances.
- A Mayday must be treated with the same level of priority and structured response as the initial incident.
  - A dual focus is necessary to manage the Mayday while maintaining the ongoing incident, ensuring a comprehensive response to both challenges.
- When the Mayday occurred, there was no Initial Rapid Intervention Crew (IRIC), or Rapid Intervention Crew (RIC) formally established.
- Incident Command did not upgrade the alarm when the Mayday occurred as required per the OM.
- There was no direction from Command regarding if the Mayday incident was to remain on the TAC channel and other units change channels per the OM.
  - As a result, there were numerous times that other non-critical traffic "walked on" the Mayday incident.

A Mayday is an "incident" within an "incident"

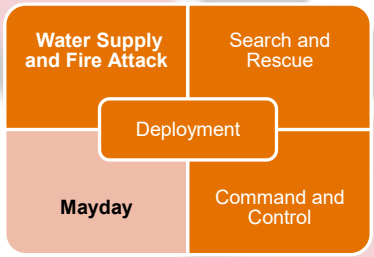


Post-Incident Analysis: Brookhollow Apartment Fire

Mayday

- Command did not provide status updates as the incident progressed on the Ops radio channel nor did Command announce when the Mayday was complete per OM.
- WFD's handling of the Mayday impacted the timing in which the victim may have been able to be removed from her apartment.
- Although the Mayday was quickly resolved, there is evidence that managing a Mayday is not well practiced by WFD incident commanders or firefighters.
  - Interviews with firefighters associated with this incident revealed that most could not recall the last time multi-company Mayday training was completed.
- **RECOMMENDATION:** Conduct Mayday training. Design complex training scenarios that include multi-company operations where search and rescue, fire suppression, and rescue operations are being conducted when the simulated Mayday occurs.

Interviews with firefighters associated with this incident revealed that most could not recall the last time multi-company Mayday training was completed.



Post-Incident Analysis: Brookhollow Apartment Fire

Fire Origin and Cause Investigation

- Jensen Hughes was provided with limited information regarding the investigation. Findings and recommendations should be considered as complete as possible at this time.
- FIU noted origin in the exterior stairwell of Building 300, in and around the landing for Units 303 and 304, and the cause of the fire remains *Under Investigation*.
- The FIU may lack adequate training to perform investigations in accordance with internationally accepted practices and procedures (NFPA 921).
- Examples of inadequacies:
  - Scene photograph is not systematic nor complete.
  - Evidence sent for testing did not include a control sample.
  - Photographs of samples tested not in context of exact location taken.
  - No scene diagram provided.
  - Lacking supplemental reports on follow-up investigatory actions.
- Origin and Cause investigation report should have been completed by now, even if *Undetermined* with discussion of competing cause hypothesis.

Fire investigators should attend continuing education training hosted by the National Association of Fire Investigators (NAFI) and/or the International Association of Arson Investigators (IAAI) and become certified by one or both organizations.

NFPA 921: "Guide for Fire and Explosion Investigations"

Post-Incident Analysis: Brookhollow Apartment Fire

Sedgwick County EMS

- Provided triage, treatment and transport of four (4) patients.
- First arriving SCEMS units had a difficult time identifying an area to access scene and identifying victims.
  - Limited vehicular access to the Brookhollow.
  - SCEMS not being dispatched to fires unless reports of someone trapped.
  - Triage area either not setup or not communicated – nothing in SCEMS protocols or WFD's OM on responsibility of determining patient triage area or initiating a Medical Branch on a fire scene
- This put SCEMS at a disadvantage.
- EMS District Chief was listening to incident and did self-dispatch himself and two medic units, shortening their response time.
- SCEMS should provide an ambulance on fires where there is high life safety risk (i.e. apartment fires, high-rise buildings).

NFPA 1710 Apartment Fire Initial Full Alarm assignment:

"...establishment of an initial medical care component consisting of at least two members capable of providing immediate on-scene emergency medical support, and transport that provides rapid access to civilians or members potentially needing medical treatment..."

NFPA 1710: Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments

Post-Incident Analysis: Brookhollow Apartment Fire

Wichita Police Department

- WPD not automatically due on WFD structure fire calls like Brookhollow.
- WPD played a relatively small role in the incident:
  - Assisted with belligerent induvial,
  - Traffic management,
  - Assisting FIU with interviewing incident victims.
- However, this is a missed opportunity: WPD actively patrols 24 hours a day, has specific geographic areas of responsibility.
- If due on reported structure fires, with training WPD could:
  - offer initial size-up and traffic control/scene safety,
  - assist in alerting occupants of the danger,
  - identify potential witnesses or make other critical observations.
- WPD and WFD should work together to develop policies and procedures for assisting on fire scenes following the IACP Model Policy – Law Enforcement Fire Response.

IACP - International Association of Chiefs of Police

IACP Model Policy offers excellent guidance on specific ways police personnel can assist responding fire companies in mitigating hazardous situations and communicating potentially life-saving information.

Equally important, the policy outlines specific actions police officers should not take when at the scene of a working structure fire.

3

Key Incident Findings

Post-Incident Analysis: Brookhollow Apartment Fire

Key Incident Findings

1 Jensen Hughes believes that the Sedgwick County Emergency Communications call taker/dispatcher could not understand what Ms. Bedeski was saying when she stated her apartment unit number. However, the dispatcher did not use the instant recall feature to replay the audio. This may have allowed him to better understand her and relay the information to the Wichita Fire Department.

2 Sedgwick County Emergency Communications dispatched the requested second alarm after a significant delay. However, we found that the Wichita Fire Department had an adequate number of firefighters on scene to conduct fire ground operations of a garden-style apartment before the second alarm was dispatched.

3 We found the Wichita Fire Department's decisions associated with the initial fire attack, an uncoordinated search and rescue effort, ineffective command and control, in addition to the partial collapse of the stairway and subsequent Mayday delayed search efforts.

Other Factors Outside Agencies Control

+ Past evidence of inappropriately discarded smoking materials on and around Building 300's exit stairway.
+ Exit stairway combustible construction and geometry.
+ Wind conditions the morning of the fire.
+ Evidence found on Ms. Bedeski's social media in the weeks leading up to the fire indicated that a smoke alarm in her apartment had a low battery. It is unknown if the detector was working properly at the time of the incident.
+ In reviewing the available fire scene photographs provided by the Wichita Fire Department, patterns of fire impingement on the exterior doors and subsequent heat/smoke damage to the interior walls suggest the exterior door of Unit 306 may have been open during a portion of the incident while other apartment unit doors remained closed.
+ Ms. Bedeski's decision to retreat to her (windowless) bathroom is a contributing factor that resulted in her fatality. Despite the fire exposure to the adjacent apartment, Unit 305, being more severe, those residents survived by going to the front bedroom and jumping from the window prior to the arrival of the Wichita Fire Department.

4

Moving Forward

Post-Incident Analysis: Brookhollow Apartment Fire

Opportunities for Improvement

In this presentation, we provided only some of the recommendations and opportunities for improvement for each agency.

County Emergency Communications Dispatch: We noted opportunities for additional training in the available technology and familiarization with the operations of the agencies they serve.

Wichita Fire Department: We identified opportunities for enhancing training programs, improving fireground operations, strengthening command and control during incidents, and achieving effective fire investigations.

Sedgwick County EMS: We noted opportunities to better serve the overall public safety system by working more closely with the Wichita Fire Department on fire incident response.

Wichita Police Department: We noted opportunities to better serve the overall public safety system by working more closely with the Wichita Fire Department on fire incident response.

Post-Incident Analysis: Brookhollow Apartment Fire

Underlying Challenges

The Post-Incident Analysis identified several longstanding challenges affecting the public safety system.

Trust and Collaboration

Tensions and animosity between the Sedgwick County Emergency Communications and some of the agencies it serves have persisted for years, undermining trust and respect. To foster strong working relationships and better serve both the County and the City, it is crucial to move past previous grievances—whether real or perceived—and focus on building a foundation of mutual understanding, trust, and cooperation.

Enhanced Public Safety Systems

Public safety services thrive when collaboration exists between neighboring agencies, driving improvement and innovation. However, in the case of the Wichita Fire and Police, as well as Sedgwick County Emergency Communications and EMS, the lack of nearby comparable advancing agencies fosters complacency. Due to this geographic isolation, agencies must intentionally seek out professional relationships that will contribute to improved service delivery. The public safety system should seek out benchmarking and accreditation as methods to continuously evaluate itself against similar systems.

Fire Department Culture and Accountability

The fire department appears to lack an emphasis on self-reflection and accountability within its culture. By fostering a culture rooted in humility, collaboration, and continuous improvement, the department can enhance its services and strengthen its ability to meet the City's needs effectively.

The path forward starts with Sedgwick County, the City of Wichita and the other local public safety system agencies putting prior differences aside and working together to develop strong working relationships and rebuild trust to better serve the citizens of these communities.

Questions?