Volunteer fire fighter dies during training

Dear editor:

For those of you that know me well, you know that I have a passion for training in the fire service. On Sunday February 8th I learned of yet another death of a student during a training exercise in Ontario. To say I was stunned is an understatement. It wasn't until a few hours later that I learned that the same rescue training provider directly involved in Point Edward was directly involved in this training incident as well. Now it hit home and I'm not afraid to say I struggled with some emotions. Here is why:

In 2010 I was employed by the Office of the Fire Marshal at the Ontario Fire College as an instructor. One of the areas that I was responsible for was the water and ice rescue program. On January 30, 2010, Gary Kendal was killed in the Line of Duty during a water / ice rescue training session. The training was taking place with the Point Edward Fire Department and was provided by a third party trainer. Shortly after the incident in Point Edward I had the opportunity to assist the Ministry of Labour in the investigation into the events surrounding the events that led to the Line of Duty Death of Gary Kendal.

I'm a proud trainer and I take my profession seriously, as such I participated in what personally was a very challenging time in my career. I tend to get emotionally invested in my job and I take pride in the fact that the safety of students in my charge is my highest priority. Don't get me wrong, I believe that tough, realistic training in the environments that a first responder is likely to work is critical. But it has to be done safely. Let's take a look at the events leading up to Gary Kendal's death.

Some history about the incident in Point Edward:

There was the only instructor present for a water / ice rescue training session in the St. Clair River that on the day in question was estimated to be flowing at approximately six to eight knots (11-14 km/hour).

There were 18 students including Gary Kendal participating in the training. The instructor gave the order to swim out to an ice flow when a moving football sized ice flow overcame several of the firefighters. Gary Kendal was overtaken by the ice flow. It is estimated that Gary Kendal was underwater for upwards of four minutes.

The instructor and other firefighters made their way back to the shore, knowing that a student was still missing in the water. Later, testimony in court heard that the instructor was in a state of disbelief on the shore saying ?no, no this can't be happening?.

During the investigation it was determined that several key safety considerations were not followed, including but not limited to:

1. No training safety plan
2. No identified safety officer
3. Lack of a manageable student to instructor ratio of 5:1
4. No RIT in place
5. No medical station established / documented
6. No lesson or training plan

I was one of two people that were conditionally qualified as expert witnesses; as such I provided opinion testimony in the areas of training records, training safety plans, NFPA Standards and water and ice rescue. In court, the facts surrounding the death were not contested by the Village of Point Edward, The Fire Chief or the defense; the defense maintained that instructor was not the supervisor because the Fire Chief had not formally handed over his authority.

The Fire Chief testified that the training provider was the lead instructor and as such had the responsibility of a supervisor of the training. The instructor was charged under the Occupational Health and Safety Act for not taking every precaution reasonable in the circumstances for the protection of a worker, specifically that as supervisor he failed to take precautions, including having adequate rescuers and rescue equipment available, as well not having an adequate training plan.

Justice Michael O'Dea acquitted the instructor because he felt that the evidence never reached proof beyond a reasonable doubt that he was the supervisor of the training session. Justice O'Dea went on to say common sense would dictate that there needed to be someone on shore watching the firefighters.

So, yes the third party training provider was acquitted of the charges in court, but only because the Crown couldn't prove beyond a reasonable doubt that he was the supervisor, the facts of the case surrounding the death still remain undisputed. There were several safety considerations that were not followed.

So, where did we go from here? I was asked after the trial to speak at various mutual aid meetings, OAFC zone meetings etc. regarding the legislation and requirements for safety plans. I developed a presentation, but before delivering it publically, I met with Chief Mackenzie and showed him the presentation. He approved of the content. It was never meant to be critical of the Point Edward Fire Department, but only to explain the requirements for training safety plans, standards and safe training practices. I truly believe that if you take the time to plan training, develop lesson plans, follow the 5:1 student to instructor ratio for practical training

scenarios and complete a comprehensive training safety plan that there would never be a training fatality in the Province again (excluding sudden medical emergencies).

In addition to making several presentations to whoever would listen, I put a motion on the floor at the OAFC Zone 1 meeting that the OAFC ensure that all third party training providers in the Province be qualified and vetted by the OAFC to ensure that training companies that train firefighters in this Province meet the minimum safety requirements. Unfortunately the OAFC turned down that motion and the status quo remains today.

This brings us to February 8, 2015 in Hanover. Durham College Student Adam Brunt dies during ice water rescue training, training provided by the same training provider and instructor directly involved in Point Edward. Nothing is proven in court at this point, but let's review some of the early reported information from the incident:

1. 12:1 Student to Instructor Ratio
2. Training new students in swiftwater / ice conditions

Several other questions need to be asked and answered:

1. Was there a safety plan?
2. Was there a lesson plan with instructor assignments?
3. Were there adequate instructors on site?
4. Was there an accountability system in place?
5. Was there a RIT team in place (that didn't include students)?
6. Was there downstream safety personnel?

If instructors would take 30 minutes and complete a training safety plan, hazard assessment and plan for an emergency, incidents like this wouldn't happen. It couldn't happen because hazards would be identified and plans would be in place to mitigate or eliminate the hazard. By completing a safety plan and following the general safety principles outlined in guidance notes; instead of a fatality we may have an injury, instead of an injury we may have a near miss, all are better than the fate that Adam Brunt faced.

I just finished instructing an NFPA Instructor Level I course on Saturday February 7, 2015. One of the key lessons and area of focus was that we, as instructors, we are members of a profession, and as such we have obligations to our students, ourselves, our departments and our profession as a whole; and our first priority is our student's safety. Our students, their families and the public don't know the hazards like we do, they entrust us to protect their loved ones, we owe it to them to do our jobs right!

So now I need to figure out my next steps. I'm totally open for suggestions. For now I am going to do the following:

1. Make a personal commitment to safety during all training activities and ensure training safety practices are always followed
2. Petition my MPP to push for an inquest into the deaths during training of Gary Kendal and Adam Brunt
3. Petition the Ontario Association of Fire Training Officers to work with partners to ensure that third party trainers in Ontario meet minimum qualifications and follow minimum safety standards
4. Petition NFPA to develop a document similar to NFPA 1403 ? Live Fire Training for Technical Rescue Training (I'm going to need help with this one).

Nothing above will bring back Gary or Adam, if we don't learn from our mistakes we are bound to repeat them, and as a profession in Ontario, we didn't learn from Gary Kendal's death. Let's not make that mistake again.

Gord Roesch
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