From Tragedy to Triumph: Lessons Learned in Charleston

BY DAVID GRIFFIN

EVERY MORNING I HEAR THE SAME WORDS ECHO in my mind as I get ready for the day: "The situation that occurred in Charleston on June 18, 2007 was predictable and the outcome was preventable."[1] Powerful words, yes, and powerful motivation to ensure that innovative practices are exemplified in all that we do in the fire service. Unfortunately, I did not always feel this way about this quote from *The Routley Report* or the many other quotes included in the Sofa Super Store firefighter fatality investigative report. It identified lessons learned from the June 18, 2007, fire in which nine firefighters perished in a warehouse in Charleston, South Carolina.

When *The Routley Report* was first published for the nation to view in 2008, I read a paragraph of it and said, "This is crap, I'm not reading this. These guys have no idea of what we do here." I tore it up, threw it on the ground, and walked away in disgust. Big mistake! My closed attitude was dangerous. According to Laurence Gonzales, author of *Deep Survival*, a closed attitude reduces the chances of including new perceptions into a model; this type of attitude can kill you. His research indicates that successful operators in a system are "open to the changing nature of their environment. They are curious to know what's up."[2] Little did I know that my mind would begin to go back to the words that I read in *The Routley Report* and become curious to know what's up.

Let's rewind to June 18, 2007, at 1900 hours. It was a normal day at the station; we were getting ready for dinner and washing the rig. Nine minutes later, all that would change. The national fire service and the Charleston (SC) Fire Department (CFD) would never be the same. In the events that unfolded in the next few hours, nine great firefighters' lives would be lost; the CFD would spiral into an organizational crisis; and many of its members would go down a dark, lonely road that they never anticipated going down, especially me.

An organizational crisis is an extraordinary condition that is damaging and disruptive to an organization's operations. Although a high-impact event with a low probability of occurring, it threatens the organization's accountability and reliability. Under specific conditions, the negative impacts stemming from one organization's crisis can spread to another organization in the same industry.[3]

But what does this have to do with the loss of nine firefighters' lives and the impact of that loss on the national fire service? Over the past six years, the CFD has dramatically changed its operations. We now stay ahead of the curve with proactive operations, equipment, and training. We have the late, great Chief Thomas Carr to thank for this. God bless his soul.

High-impact/low-probability events—that sounds like Gordon Graham's high-risk/low-frequency events. This makes perfect sense! For the CFD, since we had never experienced this type of event before, our organization's accountability and reliability were in question afterward. Of course, I did not see this, since I was not open to change or new innovative approaches. I had an expected world in my mind from which I would not deviate.

Sociologist Charles Perrow indicates in *Normal Accidents*, "We construct an expected world because we can't handle the complexity of the present one and then process the information that fits the expected world and find reasons to exclude the information that might contradict it. Unexpected or unlikely interactions are ignored when we make our construction." (2, 75) I ignored every unexpected or unlikely interaction as I ran from the truth.

The organizational crisis spread to other agencies in our area as they looked into their operations, training, and equipment after reports came out regarding the CFD following June 18, 2007. With all of the negative connotations an organizational crisis brings, this tragedy effected changes not only to the CFD but also to the departments with which we would eventually respond. More importantly, the national fire service was in tune with our mistakes and took a hard look at its agencies as well.

I sure wish I had known this before I fell into my personal abyss in search of what I was looking for. I placed a lot of blame on myself because I did not have my apparatus in the

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position directed by my captain on that hot June day. I had just been promoted to assistant engineer, a backup driver, about a month before June 18, 2007, and I was detailed to Engine 11 as the operator that day. I had been anxiously awaiting my first fire to pump. Well, the wait was soon over.

"Dispatch to Engine 11, Engine 10, Ladder 5, Battalion 4, respond to ...." As we pulled out of the station, I could see the smoke plume in the distance. I thought, "Here we go; let's do this." As I got closer and closer, my hands and feet began to shake from the nervousness of performing in a new role on the fire scene. We went to the rear of the structure to combat the trash fire, but as we approached, we realized that we could not gain access to it. We proceeded around the block to the front of the store, where my captain told me to lay a supply line to Engine 10. I said, "Yes, sir," and had a plan; however, the plan did not turn out the way I had wanted it to.

As I was passing the front of the store, I saw another captain waving me back to the entrance of the structure. Being the young firefighter that I was, I broke a cardinal rule and I ended up in a position that I should not have been in. The first lesson I learned in rookie school was to always listen to YOUR captain. I knew better than this! I live with that every day; for a long time, that thought turned me into a person I was not raised to be.

I looked for a way to self-medicate to get through the pain. I found the perfect combination for me, I thought—mixed martial arts fighting, deadly doses of workout substances, alcohol, and painkillers. It started off harmlessly, but the deeper and deeper I went, the more I relied on this self-prescription to get me through the days. My family, friends, and co-workers saw a change in my attitude, demeanor, and appearance. I covered myself in tattoos and decided a Mohawk was a good idea, a pink one at that. Yes, I was as lost as anyone could be.

As I continued to fight, I improved very quickly because of the six to eight hours I trained on my off days from the CFD. Waking up in a fog, I would ingest lots of supplements to train and block the pain of the trauma that I was putting myself through physically. However, I loved the pain from the beatings I took every day, so why did I think I had to take these deadly doses of supplements to fight if I liked the pain so much? Easy—I wanted to feel invincible inside and outside of the cage because then I wouldn't feel the true pain that I had deep inside of me. I lived for that 15 seconds at the end of a fight where I could finish off an opponent, but as I climbed the cage in celebration, I realized the pain came right back. Something was missing—but what?

I would come home, pour myself a nice-sized nightcap, pop a few painkillers, and sit there in a daze until I fell asleep. I never did this to intentionally harm myself—that never entered my mind. I did it because I needed a way to come down from the day of continuous trauma my body was going through but also to become "comfortably numb," as Pink Floyd sang in the 1970s before I was even born. Wake up, let's do it again. I went through this vicious cycle for more than three years.

During this time, I had enrolled in a master's degree pro-

gram in executive fire service leadership at Grand Canyon University in Phoenix, Arizona. Amazingly enough, despite all of this craziness in my life, I did very well in the program. The knowledge that I was attaining every day was starting to open my mind to the causal factors of June 18, 2007. I became intrigued and started focusing on my education more. As I did this, the pain and anger started to subside. As I entered my last fight with Ultimate Fighting Championship fighter Houston "The Assassin" Alexander, coincidentally enough, I had just graduated with my master's degree. I was more and more intrigued by organizational learning and the importance it can play in the fire service.

Research indicates that organizational learning is a collective process where individual and group learning experiences regarding an organization's improvement are transferred into organizational operations that can significantly impact the future learning of an organization's members.[4] This intrigued me because the CFD, its members, and the national fire service could benefit from this type of learning. I had read previous studies that found evidence that helped organizations recover and grow from the grave consequences of an organizational crisis with organizational learning. One in particular focused on the National Aeronautics and Space Administration's crisis following the 1986 Challenger disaster and how the organization learned from this event. Studying this event gave them the knowledge to combat a future organizational crisis following the Columbia disaster. As I read on, my mind started to correlate this to the CFD's state of operations and how we could use organizational learning to combat the organizational crisis that we were experiencing.

Following the Houston fight, I lay on the couch for more than three days with both of my eyes swollen shut and my sweet wife taking care of me. Bless her heart, she was there for me through all of this and never wavered, stating to anyone who would listen, "The David I love will come back to me." I lost the fight in a unanimous decision, even though on some judges' scorecards I had won the first and maybe even the third rounds. I did some serious soul searching over those three days and realized that I had a responsibility to the Charleston 9 and the national fire service to produce long-lasting research that could improve firefighter safety and performance. I had been thinking about beginning a doctoral program, but I was unsure if I could do it. As I had these unsure thoughts, I got upset at myself because I had never run from anything in my life.

I went to the hospital to get my face and head checked out because of the intense swelling and discoloration. I went through many tests and was given the green light to start training again, but I realized I had a greater calling. It had been calling me for a long time, but I just didn't know how to answer. Finally, I answered, and my mission began.

The next month I enrolled in a doctorate of organizational

leadership and development program. I have completed my dissertation, "Crisis in a Fire Department in South Carolina: An Organizational Learning Approach," which will soon be published. The purpose of this study was to ascertain how an organization like the CFD learned following an organizational crisis at the individual, team, and organizational levels. The participant sample for this research was 21 out of the 27 firefighters who had officially responded on June 18, 2007, and are still employed with the CFD. Not all participated because of the sensitivity of the subject.

The methodology used was a triangulation method in which three sources of data were correlated to produce more rich and in-depth qualitative research. First, all of the participants completed *The Dimensions of the Learning Organization Questionnaire (DLOQ)*, created by Dr. Karen E. Watkins and Dr. Victoria J. Marsick. Following this, five randomly selected participants were interviewed with five open-ended questions created by an expert panel of three fire service command level officers, each with more than 30 years of fire service experience, respectively. These two sources built the foundation for the research with the third source of the triangulation consisting of artifact data analysis from internal and external sources. The artifact data included newspaper articles and the following from the CFD: its strategic plan, memos, standard operating procedures, and policies and fire service journal articles related to the CFD following June 18, 2007.

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Results of the study indicated that the CFD has learned substantially following June 18, 2007, and instituted specific changes for organizational improvement. Recognize that these changes are the result of the loss of nine great firefighters.

Fire inspection. The fire marshal division has expanded from two inspectors to a division with a fire marshal, an administrative specialist, two deputy fire marshals, two assistant fire marshals, and three fire inspectors.

Dispatch center. Our consolidated dispatch center now serves the Charleston, St. Johns, St. Andrews, James Island, and North Charleston fire departments, which are dispatched to respond on mutual and automatic aid. Formerly, each entity had its own dispatch system that had to reroute responses to each other.

Command. Our command staff now includes a logistics officer, a safety officer, and a public information officer/community educator. Before June 18, 2007, command consisted of one chief. The CFD has three deputy chiefs now.

Fireground accountability. A passport accountability system replaced the previous accountability system.

Personal protective equipment. All firefighters are equipped with rapid egress equipment for bailing out of windows, safety vests, and lapel microphones. We replaced our self-contained breathing apparatus with the most up-to-date version available that has 45-minute instead of 30-minute cylinders.

Training. The training division now has six members instead of just two and incorporates four field training instructors per shift. The training facility was upgraded with new props and classrooms.

A flashover simulator has been added with the coinciding training for departmental members.

A 26-week recruit academy has replaced the previous nine-day training. A physical fitness test is required for all employees in the hiring process. Four employees attend the Fire Department Instructors Conference annually at the CFD's expense.

Special teams (e.g., hazardous materials, urban search and rescue) have been reconstituted and retrained.

Staff development and promotion. All employees were retrained to the Fire-

fighter 2 level. An officer development program has been created, and promotional practices now include specific educational requirements. Rapid intervention team and rescue the rescuer training is required for all members. Computers are in place in all stations for higher learning opportunities.

Staff support. Committees help develop the department's vision and direction. The Firefighter Support Team assists members with behavioral health issues.

Facilities. Three new stations with state-of-the-art fitness equipment and the purchase of a station alerting system have been approved.

Apparatus staffing and equipment. The CFD has made use of grants to purchase apparatus, improve training, and increase the number of its personnel. The department now has mandatory four-person staffing and REQUIRES overtime to ensure that this mandate is met. Before, we had three-person apparatus staffing, but on some days only two personnel would respond on an aerial—a captain and one firefighter.

Twelve of the CFD's response apparatus now carry rapid intervention equipment; none carried any before. All aerial apparatus now carry positive-pressure ventilation fans. Apparatus now have air-conditioning. Crosslays use 1¾-inch hoselines. The department uses large-diameter hose and the appropriate appliances; previously, it used 2½-inch supply lines. There are reflective materials on the apparatus.

Apparatus. The CFD has supplemented its fleet substantially since the tragedy with the following:

—A new style of command vehicle.
—A fireboat and associated training.
—An air and light truck.
—A rehabilitation truck and trailer.
—Five new engines with computerized pumps.
—A tiller apparatus is in production.
—A hazmat response unit purchased using grants.
—A fourth aerial apparatus was ordered.
—A water tender purchase was approved.

Why are these results so important not only to the CFD but also to the national fire service? Simply, the Charleston 9 who gave their lives on June 18, 2007. We are responsible as firefighters to learn from this event and cannot allow such accidents to occur. We must focus on proactive solutions to our ever-changing external environment.

In *Deep Survival* Laurence Gonzales states, "What we call 'accidents' do not just happen. There is not some vector of pain that causes them. People have to assemble the systems that make them happen. Even then, nothing may happen for a long time." Gonzales continues, referencing *Normal Accidents* by Charles Perrow, in which the author states that "in certain kinds of systems, large accidents, though rare, are both inevitable and normal. The accidents are a characteristic of the system itself .... In system accidents, unexpected interactions of forces and components arise naturally out of the complexity of the system. Such accidents are made up of conditions, judgments, and acts or events that would be inconsequential by themselves. Unless they are coupled in just the right way and with just the right timing, they pass unnoticed."

Perrow's point is that "most of the time nothing serious

happens, which makes it more difficult for the operators of the system .... They begin to believe that the orderly behavior they see is the only possible state of the system. Then, at the critical boundaries in time and space, the components and forces interact in unexpected ways with catastrophic results." (2, 106-107) The loss of nine firefighters is one example of a catastrophic result.

When you arrive at the station some days and you do not feel like working or training that day, remember that WE assemble the systems that cause these catastrophic accidents. "Hey Cap, let's train," a firefighter says. "Nah, I'm tired," you say. Well, you've just begun the process of inconsequential events. Your not training today or resisting change may not have an immediate effect. However, you are assembling the conditions and acts that pass unnoticed right now; at the least expected time, all of these inconsequential events can lead to catastrophic results. It's in your hands. Can you lay your head down after each shift and say that you did EVERYTHING that you could do for your crew today, no matter your rank, to improve their safety and operational readiness? If the answer is not 100-percent "yes," then you are doing a disservice to your fellow firefighters.

We are in this together, and we must learn from each other's mistakes. We have all made them, and we will continue to make them because of the external environment that we respond to. However, we can reduce the deadly impacts of these mistakes if we work tirelessly to perfect our skill set and our situational awareness. I am honored to serve with all of you in this great profession. Let's do great things every day we wake up. If not, what's the point? I'm on a mission that I hope all of you will join. ●

ENDNOTES

1. Routley, JG, Chiaramonte, MD, Crawford, BA, Piringer, PA, Roche, KM, and Sendelbach, TE. (2008). Firefighter fatality investigative report: Sofa Super Store, 1807 Savannah Highway, Charleston, South Carolina. City of Charleston Post Incident Assessment and Review Team. Phase II Report. Retrieved from http://www.dps.state.ia.us/fm/fstb/NewWebStuff2012/TrainingResources/PDFs/PhaseIIReport.pdf.

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3. Tieyang, Y, Sengul, M, & Lester,RH. (2008). "Misery loves company: the spread of negative impacts resulting from an organizational crisis." *Academy of Management Review*, 33(2), 452-472. doi:10.5465/AMR.2008.31193499.

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