

Wedgewood Senior Apartments

3rd Alarm (Mutual Aid to Castle Hills)
Post Incident Analysis

Introduction

The Wedgewood Senior Apartments building was constructed in 1962 and is located along Blanco Road just south of Loop 410 on San Antonio's North side. The Wedgewood building sits just inside the Castle Hills city limit. It is an 11-story residential building with Type I fire-resistive construction. There are 297 apartments within the building. Sprinklers were located only on the sublevel floor leaving all of the occupied living space from the 1st floor to the 11th floor without sprinkler system protection. The building itself is composed of a central core with three distinctive wings extending outward. Each wing has an enclosed stairway at the distal end which is vented to the exterior through a type of louvered vent system. The central core of the building is where the elevator bank is located along with an enclosed stairway. Standpipes are located at the end of each wing with no standpipe in the center stairway. On each floor, all three wing corridors are freely open to each other with no type of partitioning. On roughly three sides, the building is surrounded by a large parking lot area. An outdoor park area with a pool is located on the back side of the building. No exterior exposures are proximal to the building. A detailed fire department pre-plan was not available to responders during this emergency.

Occupancy

The Wedgewood Senior Apartments serves as an independent living facility for adults over the age of 55. Many of the elderly residents are mobility-impaired and/or suffer from chronic ailments associated with their age. A number of residents were staying with family members during the winter holidays and were not home at the time of the fire. This decreased the number of occupants in the building needing assistance, but also made accounting for the condition and whereabouts of all the residents of Wedgewood a more difficult task.

The situation

According to Castle Hills Fire Chief Jerry Reidel, "Castle Hills Fire Department (CHFD) received alert at approximately 0610 hours for a smoke alarm activation at the Wedgewood Senior Apartments located at 6701 Blanco Road. CHFD Engine 1 (E1) and Ladder 1 (L1) responded with a four man crew at approximately 0612 hours. Captain Harold DeHart was the Officer in charge and requested a first alarm which initiated automatic aid from the Balcones Heights and Shavano Park Fire Departments. Castle Hills Dispatch (CHD) notified CHFD E1 that they were receiving multiple 911 calls regarding activated fire/smoke alarms and pull stations on multiple floors of the structure. CHFD E1

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and L1 arrived on scene at approximately 0615 hours and saw light smoke exiting the 11-story building. Captain DeHart requested CHD to call for a second alarm which would notify the Fire Chief (CHFD 1-0) along with all off-duty CHFD personnel. CHFD personnel entered the building through the main lobby and went up the center stairwell. At that time, the lobby and center stairwell were clear of smoke. Upon opening the stairwell door to the 3rd floor, firefighters encountered heavy smoke that had banked down to approximately 12 inches off the floor. Crews began removing residents from floor 3. Fire appeared to be located in Room 302. CHFD requested assistance from the San Antonio Fire Department (SAFD) at approximately 0624 hours. As units arrived from Olmos Park, Alamo Heights, Balcones Heights, Shavano Park, Bexar-Bulverde, Leon Valley as well as SAFD, a hose line was attached to the standpipe in the B stairwell and (connection) was established from CHFD E1 to the (Fire Department Connection) on the B wing. SAFD Battalion Chief (BC) Wally Yates arrived on scene and called for a Unified Command (January 2015)."

On scene actions

1. SAFD units staged on their arrival until they were given an assignment.
2. BC8 established Unified Command (UC) with CHFD. The building manager was present in the Incident Command Post (ICP) as well as a representative from Acadian Ambulance Services, who was serving as the Medical Group Supervisor.
3. SAFD E28 was assigned Lobby. They used firefighter manual override to recall both elevators to the ground floor (Phase I).
4. Alamo Heights FD and SAFD ladder companies were tasked with rescuing residents via aerial ladders on the Alpha side.
5. On scene companies and additional SAFD units continued to rescue occupants from various floors and brought them to the lobby. Acadian and SAFD Emergency Medical Services (EMS) personnel began triage, treatment and transportation of victims.
6. Additional radio channels were requested and assigned as follows (this was also listed on the Data 911 system for responding companies to view):
 - a. Mutual Aid 8 – Operations
 - b. Mutual Aid 9 – Medical
 - c. Mutual Aid 10 – Logistics/Staging
 - d. Mutual Aid 11 – Rescue (Rescue channel was never utilized)

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7. SAFD units E17 & E31 were assigned to assist CHFD units with fire attack on Division 3.
8. The SAFD Fire Shift Commander's Incident Command Technician (FSC-ICT) was assigned Occupant Services which was located in the lobby.
9. Three additional SAFD BC's were requested.
10. The Division 3 Attack Group reported no water pressure on their attack line and found safe refuge in the apartment opposite from the room of origin.
11. BC8's ICT (BC8-ICT) was assigned to Water Supply and worked with Balcones Heights FD to establish a supply line.
12. A Second Alarm was requested.
13. BC5 arrived and was assigned Attack Group Supervisor (AGS) and moved to Division 3 to coordinate fire extinguishment.
14. BC1 arrived and was assigned Rescue/Search on Divisions 4 and 5.
15. BC4 arrived and was assigned to setup the Command Bus and subsequently assisted Unified Command with fireground operations as the Support Officer.
16. BC6 arrived from the 2nd alarm and was assigned Rescue/Search on Divisions 6-11.
17. BC7 arrived and was assigned to Rescue/Search on Divisions 1 and 2.
18. AGS reported that the main body of fire had been knocked down.
19. BC1 reported that his assigned companies were not on Division 4 and smoke conditions were increasing. A short time later, he found a small fire on Division 4 that had extended from Division 3. It was extinguished with a house line from a nearby hose cabinet. The missing companies from Division 4 were trading out self-contained breathing apparatus (SCBA) bottles after rescuing victims and taking them to the lobby. Fresh companies were assigned to Rescue/Search Divisions 4 and 5 (BC1).
20. Engineers from Base were assigned to pressurize the stairwells with PPV fans.

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21. Rescue/Search Divisions 6-11 (BC6) checked the stairwell roof access to ensure it was open.
22. BC6 continued to supervise mixed companies as they performed search & rescue on Divisions 6-11. Numerous occupants were trapped on Division 11 with smoke conditions increasing. An attempt to utilize the elevators at this time failed and it was clear that the elevators would remain out of service. BC6 moved all of the trapped occupants on Division 11 to a large balcony area in the penthouse. SAFD Aerial Platform 32 (AP32) used their apparatus to evacuate occupants, two at a time, from the 11th floor penthouse balcony.
23. A 3rd alarm was requested.
24. Throughout the incident, companies from all agencies were rotated into the existing Division/Group assignments and continued to rescue and remove occupants.
25. A thorough secondary search was conducted systematically throughout the building.
26. SAFD Public Information Officer (PIO) coordinated information between the media and Unified Command. Castle Hills officials were briefed and held a news conference with information about the incident as well as where a shelter would be established.
27. Churchill High School was designated as a temporary shelter and VIA buses were made available to transport displaced residents to the shelter.
28. Castle Hills officials, assisted by the Red Cross, the South Texas Regional Advisory Council (STRAC), the San Antonio Office of Emergency Management (SAOEM) and the Bexar County Office of Emergency Management (BCOEM), established and maintained the temporary sheltering operations at Churchill High School.
29. Displaced residents were placed with family members or in local hotels. Over the next week or so, Castle Hills FD, SAFD EMS, STRAC, Red Cross and other medical staff evaluated residents at hotels and worked to deliver needed medications and follow up medical care.
30. Baptist Children & Family Services (BCFS) assisted over the following week by providing extended case management for displaced residents. Among other services, they assisted residents with obtaining new identification documents as well as transporting them to polling locations to vote.

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What worked well

1. Castle Hills Captain DeHart requested additional resources early. This action resulted in timely arrival of non-CHFD resources to the scene to assist.
2. Apparatus placement was good. Staging procedures were followed and most personnel were very disciplined. This allowed adequate scene access for fire and EMS units. Personnel were familiar with the maneuverability and limitations of their apparatus as some were utilized to their maximum capacity. Looping the 5-inch supply line out onto Blanco Road was necessary given the location of the fire hydrant.
3. Unified Command and interoperable communications were established.
4. Divisions were assigned to the 2nd alarm Battalion Chiefs to supervise which led to better coordination for assignments and accountability. Communication and organization improved thereafter.
5. Many Groups and Divisions were comprised of personnel from different agencies. They all worked well together without major issue.
6. Throughout the incident, Command received numerous high priority radio transmissions. Inevitably, there were some miscommunications. BC4 was assigned to assist Command and also to monitor radio transmissions and fireground assignments. This was critical to help eliminate miscommunications.
7. The Ambulance Bus (AMBUS) was requested early by CHFD and arrived on scene in a timely fashion.
8. Key assignments were made such as Lobby Control, Medical Branch and Attack Group Supervisor.
9. FSC-ICT assumed Occupant Services in the lobby and BC8-ICT assumed Water Supply. Occupant Services was a monumental task both during and after the fire. SAFD Chaplain John Longoria assisted FSC-ICT at the scene. Castle Hills Public Works removed and cared for a number of pets until they could be reunited with their owners.

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10. Engine 19 requested that a large number of SCBA bottles be brought to the lobby early in the incident. This kept SCBA bottle replenishment from becoming an issue. AC39 provided refilled SCBA bottles in a timely manner as well.
11. Temporary shelter and reception operations were set up at Churchill High School where VIA buses transported displaced Wedgewood residents immediately after the fire. STRAC, SAOEM, BCOEM, City of Castle Hills, and Red Cross, worked on plans for food, shelter arrangements, medications, and identification of the missing and fatalities. SAFD personnel assisted with some medical needs and check-in until relieved by Acadian and CHFD personnel. Long-term case management was provided by BCFS.

Areas of needed improvement

1. The initial request for mutual aid did not indicate that the occupancy was a high-rise structure. This delayed sending the most appropriate resources.
2. Different radio channels were in use during the early stages of scene development. Although channels were patched together relatively early in order to facilitate interoperable communications, in the future it should be taken into consideration by all surrounding fire departments to put all high-rise incidents on a mutual aid channel similar to how grass/brush fires are currently dispatched. This would allow interoperable communications sooner.
3. A continuous water supply line (connected to a hydrant) must be established by the first two engines on scene as per the SAFD High-Rise Initial Operations SOG. It can never be assumed to be in place by later arriving resources unless the supply is readily visible. A second continuous water supply line should also be considered by the Incident Commander.
4. All Medic Officers (MOFs) and the Medic Shift Commander (MSC) should have been sent as early as possible to this incident. This was a Mass Casualty Incident (MCI) and needed a strong medical presence at the Incident Command Post (ICP). Acadian Ambulance Services contracts with Castle Hills for EMS service. An Acadian supervisor/medic was assigned to the Medical Branch early in the incident and was present in the ICP. At some point the Acadian supervisor/medic departed the ICP without notice and did not return. SAFD Medical Officer 3 (MOF3) was then assigned to assume the Medical Branch to manage patient care, triage and transport. All emergency response agencies must understand their role and responsibilities at

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an interagency emergency scene as per National Incident Management System (NIMS) parameters.

5. Fireground Group/Division designations were not consistently used after units were given assignments. With all of the various agencies that were involved in this incident, it would have proven very useful to stick to Group/Division designations (i.e. Division 3 Attack) for identification and clarity on expectation of assignments rather than individual unit designations (i.e. E31 or L17).
6. Scene accountability was not easily achieved due to the lack of adherence to Group/Division assignment designations. Units that needed to alter their assigned course of action were, for the most part, not able to break through on Mutual Aid 8. This resulted in some units engaging in freelancing.
7. Span of control expanded quickly as the scene developed and was not effectively reduced until BCs arrived with the 2nd alarm. Units continuously transmitted directly to Command. Command was flooded with continuous high priority transmissions and was not able to easily manage the extreme demand of all the incoming transmissions. It should be noted that Company Officers were assigned as Division Supervisors but had to remain with their companies while rescuing and removing victims. This meant that they were unable to spend time supervising the Divisions they were assigned. Those Division assignments were passed from one Officer to another too often for each Officer to maintain good situational awareness of their assigned geographical area. This led to duplication of effort as some rooms were searched three or more times. The arrival and assignment of BCs as Division Supervisors rectified this problem.
8. The SAFD High Rise Standard Operating Guideline (SOG) establishes Staging two floors below the fire floor. In this case, Staging was on the first floor, co-located with Lobby. The Lobby Control Manager, E28 Captain, also became responsible for Staging. A separate Officer should have been assigned to manage the Staging Area.
9. Additional resources (i.e., 2nd and 3rd alarm companies) should have been requested earlier in the incident. SAFD units were first dispatched at 0632 hours, 2nd alarm companies were dispatched at 0717 hours, and 3rd alarm units were dispatched at 0805 hours.

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Lessons learned

1. This incident vividly demonstrates how crucial it is that all fire departments put into practice what the National Incident Management System (NIMS) has established for emergency incident management. The intent of NIMS was tailor-made for incidents of this very nature. The use of common terminology allows personnel from different agencies to work together to achieve the most positive outcome possible.
2. The incoming request for mutual aid to SAFD from CHFD failed to specify that the incident was a high-rise incident. FSC Mikel stated that he was informed that Castle Hills had a "big fire at a senior assisted living facility with multiple entrapments," but was not given any information about the building being a high-rise structure. This resulted in only a 4-2 compliment of SAFD resources initially being dispatched to assist. We need to identify target hazards, both within and outside San Antonio city limits, where the possibility exists for SAFD units to be requested for mutual aid by other fire departments and agencies.
3. The layout of the building was incredibly challenging. The decision on how to divide this building into easily identified Divisions was an enormous challenge. At the end of each of the three wings was a stairwell. With 11 floors, four stairwells and three wings, the possibilities of how these areas could have been divided is an excellent subject for future tabletop exercises.
4. The stairwells were openly vented to the exterior by various vents located at each floor level. This design prevented units from successfully pressurizing the stairwell with PPVs. With a pre-plan in hand, we would have been able to see that only the center stairwell could have been protected by pressurization. No pre-plan was available. All high-rise and extremely dangerous structures should be pre-planned, including those in the jurisdiction of adjacent agencies. The pre-plans should be readily available to all agencies that could respond.
5. With the number of occupants involved, it was very difficult to identify some of the victims and account for all the residents of the building. It was several days before the identities and whereabouts of all the Wedgwood residents were known.
6. Effective span of control was quickly exceeded during the initial stages of the incident. This led to some simple miscommunications (i.e., referred to the wrong unit or the wrong floor). These miscommunications were eliminated when a second Battalion Chief, (BC4), was assigned to assist Unified Command with monitoring

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radio transmissions. It is imperative that Command has another Chief Officer in the Incident Command Post to help monitor each channel that has been assigned.

7. It is important to call for greater resources as early as possible with an incident and structure of this magnitude. The 2nd alarm and 3rd alarm should have been requested sooner in this incident. Once 2nd alarm SAFD companies arrived, the incident organization and communications rapidly improved.
8. Base was established in the Target store parking lot nearby. It deserves mention that this area was incorrectly referred to as "Staging" instead of Base during this incident. For a high-rise incident, Staging should be located two (2) floors below the fire floor which turned out to be in the lobby for this incident. Smoke was present on nearly every floor of this building. Staging will need to be established in the lobby or another non-IDLH environment if the normal staging area (i.e., two floors below the fire floor) is filled with smoke.
9. A very long and detailed list of information was entered by SAFD Dispatchers on the Data 911 system. This information, along with the time stamps attached to each entry, provides a reliable timeline of key events for the duration of this incident. However, it is not realistic to expect the Incident Commander, or other responders, to be able to keep up with this massive influx of information during the incident. Information entered on the Data 911 Computer Aided Dispatch (CAD) notes should include: the IC's communication plan (i.e., MA8 - Ops, MA9 - Medical, MA10 - Logistics, MA11 - Rescue); building orientation (i.e., Alpha side-BC8's Vehicle, Bravo side- Swimming Pool/Park area); and basic fire info (i.e., 11-story building with confirmed fire in 302). If the Data 911 notes are more concise, then responders and Command can more easily find critical information further into the incident.
10. On mutual aid incidents, the SAFD needs to be able to see units from other responding fire departments/jurisdictions on our Data 911 system. Currently we do not have this capability.
11. Occupant Services was a monumental task at this incident and continued for more than a week after the incident. EMS personnel, SAOEM, STRAC, SAFD Medical Control and Red Cross continued to evaluate displaced residents and provide follow-up care until more permanent case management for the residents was in place by BCFS. FSC-ICT, with the assistance from SAFD Chaplain John Longoria, did an outstanding job of managing Occupant Services during the initial stages of the incident when additional resources were unavailable. Castle Hills Public Works removed numerous pets from the building and cared for them until they could be reunited with their displaced owners.

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12. Consideration should be given to regional or multi-jurisdictional responses for high-hazard occupancies in the greater San Antonio area. The response plan should include joint training for the agencies involved, shared pre-planning, automatic aid responses, and multi-agency post-incident analyses.
13. The SAFD High-Rise Initial Operations SOG calls for the use of Engineers in Base to be assigned to the Stairwell Support Group. In this incident, the Engineers were used as part of their 4-man company as additional manpower. There were few Engineers left in Base to assign to the Ground Support Unit. The lesson to be learned is that there may not be available Engineers in Base to assign to a Group or Division. Command should take this into consideration when determining the number of resources needed. Additional resources should be requested to assign as the Ground Support Unit.
14. Senior citizens represent approximately 13% of our population but account for 30% of fire deaths. This represents a drastically disproportionate statistic. In the state of Texas, over the past ten years (2004 - 2014), there have been 114 fire deaths in multi-family residences where no sprinklers were present. Not one fire death has occurred in multi-family residences where working sprinkler systems were present. Occupants with limited mobility and delayed egress characteristics create extra challenges for firefighters. These challenges and risks to occupants are even greater in high-rises that lack a sprinkler system. Fire Department pre-incident planning is essential for emergency response agencies in order to implement an informed action plan.
15. San Antonio has approximately 200 high-rises. About 91 were built before the 1982 sprinkler requirement. Approximately 36 of those built before 1982 are residential occupancies (i.e., apartments, condos, hotels). The City of San Antonio will be exploring how to make high-rise buildings safer to include the possibility of a sprinkler system retrofit code requirement. Stakeholder groups are being formed to explore the feasibility of this measure.

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Safety

According to the B-Shift Safety Captain Victor Garza, there was no A-shift Safety Captain on duty at the time this incident began. Safety Captain Garza arrived on scene at approximately 0912 hrs. Safety Captain Garza reported to the Incident Command Post to ensure accountability, to note the current Incident Action Plan, and to address any ongoing safety concerns. B-shift Safety Captain Observations:

1. Command was in a safe, visible, and suitable location.
2. To the best of my knowledge there was no Incident Safety Officer (ISO) assignment made prior to my arrival.
3. Due to the complexity of this incident, (i.e. high-rise building, multiple entities and mutual aid), accountability was an ongoing issue and was addressed appropriately using the BCs as Division Supervisors.
4. There was a Rapid Intervention Team (RIT) in place.
5. Formal Rehab was established.
6. After doing some air monitoring, the carbon monoxide (CO) levels were high (108) at and near the 3rd floor center stairwell mainly due to gasoline powered PPV's that were pressurizing the stairwell. The 3rd floor itself averaged about 40 ppm. This was reported to Unified Command and personnel were advised to keep their SCBA donned.
7. I asked the manager and maintenance personnel on scene about any asbestos issues within the building. They stated that testing had been done for asbestos prior to modifications and repairs in the past which did not reveal any asbestos. I do not know the extent or time frame of modifications or repairs.
8. We received reports of asbestos in the building several weeks after the fire.

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Conclusion

On the morning of the incident, it was reported that five residents were killed and eighteen were injured. A few days after the incident, the sixth victim had perished. One of the fatalities had occurred in the room of origin and the others were reported to have been caused by smoke inhalation throughout the building. The cause of the fire was still under investigation at the time of this writing.

The Wedgewood incident has caused us to take a closer look at our own city and similar occupancies we have in San Antonio. There are many things we can do as public safety professionals to reduce the impact of fires in these types of occupancies. Code requirement updates, timely inspection, and proper enforcement can make buildings safer. Fire safety training and education for our citizens can better prepare them for emergencies. Fire companies can continue to identify target hazards in their districts and properly pre-plan for fire events. By capitalizing on the benefits of proper building identification, inspection, education, training, and planning, we can continue to provide the professional service our citizens both expect and deserve.

The firefighters who responded to the Wedgewood incident all deserve to be commended for the heroism that was demonstrated on this fateful morning. They all demonstrated an exceptional level of bravery and professionalism throughout the duration of this incident. Of course it is easy to point out all the things that could have been done differently looking back, but the truth of the matter is that no firefighters were injured or killed and their actions that day saved countless lives. This experience has taught us many valuable lessons operationally, but above all else, we performed our job safely and courageously.