NYC Firefighter Daniel F. Pujdak

[Name of the Writer]

[Name of the Institution]

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On the date of June 21, 2007, a young man, 23 years old male career firefighter (the victim) died on falling from the top of a four-story apartment building fire. At the time when firefighters came on the situation, very light fire and smoke were seen from a window of the fourth floor. In the scene, the victor (23 years old male) climbed on the truck ladder on the top bulkhead and was trying/attempting to the low himself to the main top/roof when the man fell. The top of the building is seen that hung on the back of the victim shifted causing the man (victim) to misplace and lose his stability and balance and fall down to the ground. Firefighters had been on the situation or scene for not more than 3 minutes after the time when the victim falls down from the building. After the scene, the victim (23 years old man) has been shifted to the hospital (metropolitan hospital) where the young man yielded to his bad injuries.

The major contributing and adding factors to this critical incident include majorly 1) the judgment of the firefighter decision regarding making a risky and amazed move from the top partition to the main top or roof of the building, 2) the placement and settlement of the ladder against the top partition instead of the main top or roof which further led to the extra risks and dangers for the career firefighter (the victim), 3) while the third and one of the crucial factors in the scene and situation occurred is the dangerous task of climbing a ladder while loaded with huge amount of equipment and many tools, (Eliason, 2011) 4) the method or way through which the saw has been carried that allowed the shifting saw to put the firefighter (the victim) out of his balance and stability. In this incident/scene, the department has kept around 11,500 career firefighter involved. Those career firefighters serve a population that is amounted for more than 8 million in the area of round about 322 square miles by length (CDC, 2019).

Below are actions which have been concluded by the NIOSH to reduce and minimize the danger of the same happenings. Based on the conclusion of NIOSH, the fire departments need to;

* Make known all of the firefighters to the hugeness and importance of taking care of cautions while working at the elevation.
* Keep the place and location of aerial ladders completely considered so that the firefighters can be prevented from climbing and falling down from elevation during the fire ground activities and operations.
* Keep the usage of portable scissor ladders considered for facilitating and supporting access to any midair ladder to the top (CDC, 2019).
* Make sure that the each of the firefighters converse and communicate every critical and potential danger with each other and makes sure that the entire teams or group is properly maintained and fully organized during the operations at the roof (Kunadharaju, Smith, & DeJoy, 2011).
* Completely judge the manner and way by which the equipment is yoked, attached and carried by every firefighter to save the loss of stability and balance while operating.
* Keep the considered the decrease in the number of equipment which every firefighter needs to carry with him or herself when climbing on the top of the building.

Beyond above, it has been advised that the producers of saws (fire service saws) need to;

1. Consider the design principles of ergonomics for decreasing the weight of the aeration saws (CDC, 2019).
2. Keep the developing and rising the improved carrying slings considered all the time.

**References**

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