



## NUCLEAR VERDICT: FIREFIGHTER LODD \$31.5 MILLION VERDICT



On December 4, 2021, Lieutenant Garrett Edward Ramos lost his life at a 'routine' residential single-family ranch-style dwelling. According to court testimony, the event is as follows:

At 2304 the residents of the home called 911 and reported a fire in the attached garage. The Rock Falls (RFFD) and mutual-aid Sterling Fire Departments (SFD) were initially dispatched.

RFFD Chief was first to arrive at 2314, established command, and reported a 'fully involved attached garage with extension to the house'. The Chief met with the homeowners and verified no one was in the house. The Chief did "an incomplete 360-degree evaluation of the structure".

Engines and firefighters began arriving at 2318 and were assigned various roles and suppression activities. Hoses were stretched to the front and back porches. At 2321, an interior attack was initiated by Lt. Ramos and Captain Kobbeman. Ceilings were pulled down, revealing that the fire had completely extended into the attic. At 2239, Ramos and Kobbeman were relieved and exited to exchange their SCBA air cylinders.

At 2341, photographs show the roof assembly already compromised. Shortly after Ramos and Kobbeman reenter and are assigned to pull ceilings in different bedrooms. At 2354, Kobbeman leaves the building to give an update. While speaking with the Division C Chief, his low air alarm sounds, and he leaves for another cylinder exchange. At the same time, Ramos is joined by mutual-aid firefighters who assist with overhaul.

A hole in the floor is reported on the radio at 0001. A muffled mayday was first heard at 0004, which is when it is assumed that Lt. Ramos fell through the hole and into the basement. IC cleared the radio and asked for the firefighter calling mayday to repeat themselves. There was no response. A partial PAR was initiated by the Operations Chief.

A second mayday was heard at 006. Operations Chief requested a second PAR. One sector reported they had PAR, but other sectors did not respond, nor was there a follow-up by the Operations Chief. At 0017, following the PAR, operations were resumed.

At 0037, firefighters realized Lt. Ramos had not been seen and could not find him. A RIT team was assigned to enter the basement to look for Lt. Ramos. After two unsuccessful attempts at removal, Lt. Ramos was removed.

The jury's \$31.5 million verdict was based solely on negligence. With the widow's consent, Attorney Michael Gallagher did not seek punitive damages. Nor did they name the Department Chief, who was also the Incident Commander, personally.

Lexipol sponsored a roundtable discussion of the lessons that fire departments and fire officers should learn from the verdict. The attorney for the widow, Michael Gallagher, expert witness, Chief (ret.) Gary Ludwig, and moderator Deputy Chief Billy Goldfeder were the panelists.

They discussed six key mistakes that led to the jury's verdict.

- Failure to properly perform a 360-degree assessment and discover the basement
  - Command did not ask the homeowner if a basement was present. 50-75% of homes in the area have basements.
  - Command did not establish a stationary Command Post.
- Failure to appoint a Safety Officer in a timely manner
  - A Safety Officer was not appointed until more than 50 minutes after the arrival of IC and the first arriving units, and about 3 minutes after the Mayday call.
- Failure to change from an interior to exterior approach when structural compromise was evident
  - Timeline
    - 11:14 – first crews arrive on scene
    - 11:21 – attached garage roof collapses
    - 11:41 – a section of the home's truss roof collapses
    - 11:56 – floor collapse observed by crews and reported
    - 12:04 – Lt. Ramos calls mayday
- Failure to timely call for a PAR in response to multiple mayday calls
  - In violation of the Fire Department's Standard Operating Guideline, PARs were not called for when certain specific events occurred on the fireground, such as roof and floor collapse.
  - There was about a 4-minute delay in Command calling for a PAR after hearing Lt. Ramos' mayday call.
- Failure to properly perform a PAR when Lt. Ramos was unaccounted for.
  - The company officer reported everyone was accounted for when Lt. Ramos was not present.
- Failure to adequately train for Mayday and PAR response
  - Command staff acknowledged the PAR and Mayday training were inadequate. The Department trained on Mayday and PAR SOG 5 times in 20 years.

The presenters offer six incident command lessons that should be learned by incident commanders:

1. Know your Department's Mayday and PARS policies. Ensure policies align with NFPA and OSHA standards. Train on them frequently. Include mutual aid partners.
2. Appoint a Safety Officer early in the incident.
3. Check for a basement.
4. Ensure PARs are thorough and complete
5. Identify and locate the Mayday caller before terminating the Mayday response
6. Understand how the actions of leaders affect the department's liability
7. If you are not trained as an Incident Commander, get trained now. Learn to read smoke and fire, building construction and failure modes, decision-making models, and more.

All fire departments should honor Lt. Garrett Ramos by taking these lessons to heart and starting tomorrow to tighten policies and training. For more information on the event, see the resources below.

[Illinois OSHA report](#)

[Illinois DOL Ridge Incident Poster](#)

[Illinois NIOSH Report](#)

[Chief \(ret.\) Gary Ludwig's expert witness report](#)