



# What's Happening

Navy Fire and Emergency Services Newsletter

Protecting Those Who Defend America



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## Just Culture: Standardizing Fire Service Accountability

By Tory Thompson, Reprint Firehouse.com, Dec 14, 2020

Improved workplace safety, including via openness from members regarding mistakes and near-misses, results when the principles of "just culture" are pursued and applied.

Culture changes don't happen overnight and require support at the executive level. This is a leadership initiative that requires buy-in at all levels of the organization, and any undertaking such as this must start at the top.



Developing a just culture requires a multifaceted approach to managing risk. When problems or risks that are inherent in the operations of the organization are examined, it's crucial that a holistic approach be taken. If issues are looked at from just one point of view—human behavior, for instance—we can miss opportunities to make long-term, lasting improvements.

Peter Matthews/Firehouse - Just culture is an industry term used to describe a values-based accountability model that takes a look at the behaviors, systems and expectations that make up an organization. Developing a just culture requires an organization willing to look internally at its processes, beliefs and attitudes with an open mind.

### Knowledge, systems, safeguards

Many are familiar with James Reason's Swiss cheese model of system accidents, where poor outcomes are a result of an alignment of failures. To combat this alignment, just culture employs a three-pronged approach to building highly reliable outcomes.

The first prong of this approach is knowledge. In other words, what training or education can be imparted onto personnel that will lead to risk avoidance?



Supporting the Fleet, Fighter, and Family



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Simply knowing what the risks are and how to avoid or mitigate them can go a long way. Adequate knowledge relies on training, experience and situational awareness. Situational awareness is of particular interest in emergency services, because it can be affected by psychological, physiological and environmental stressors. Sleep deprivation, physical and mental wellness and substance abuse are a few that come to mind.

The second prong involves having good policies and procedures (systems) to guide employee decision-making. To have a system of accountability, there must be a standard by which to judge behavior. That simply can't be accomplished without standardized processes and procedures.

The third prong employs safeguards where possible to reinforce systems. Redundancy is utilized in many high-risk industries, including aviation. Aircraft employ redundant electrical and hydraulic systems, because the cost of failure is high in both airline liability and human life. The fire service is no different in the need to safeguard members and the citizens from harm. Employing safeguards in fire service systems adds a third layer of reliability that can lead to the outcomes we seek. According to Reason, the pursuit of safety isn't so much about preventing isolated failures, either human or technical, as it is about making the system as robust as is practicable in the face of its human and operational hazards.

At its very core, just culture recognizes that if there is one consistent attribute of human behavior, it is that humans make mistakes. Despite our best efforts, we, as human beings, simply don't always get it right. Understanding this requires organizations to begin to analyze how their personnel perform and make mistakes; what their safety and reporting culture is; and what systems and safeguards are in place to guide good decision-making.

### Human performance

Human performance, or how we approach and solve problems, is an important aspect to understand when building a just culture. To better understand how people make mistakes, it's helpful to understand the spheres of performance in relation to function complexity and operator experience. There are three main spheres that are noteworthy: skill-based performance, rule-based performance, and knowledge-based performance.

As personnel train on job functions and gain experience within an organization, certain fundamental skills become "automatic" and require little thought to perform—skill-based performance. For example, a apparatus driver, when leaving for an emergency incident, will remove wheel chocks, engage the battery switch, depress the ignition, buckle the seat belt and disengage the air brake. These are a set of steps that, once performed over a period of time, become routine and require little thought.

According to "Operators Guide to Human Factors in Aviation," in rule-based performance, a person is confronted with a situation where attention must be focused on making a decision or creating a solution. However, in this case, the

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The most dangerous for us as tactical decision-makers is the top left box: High Risk/Low Frequency

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situation is one that's known to the operator, who is able to respond rapidly with a known solution. In such situations, the person who is posed with the problem has mental cues as how to solve the problem. This also is known as recognition prime decision-making (RPDM). According to David Marx in "Patient Safety and the Just Culture: A Primer for Health Care Executives," RPDM fuses two processes - situation assessment and mental stimulation - and asserts that people use situation assessment to generate a plausible course of action. To continue the apparatus driver example, let's assume that, while responding to the incident, the driver encounters a vehicle that slows in front of the apparatus instead of pulling to the right. In an instant, the driver must revert to training and/or previous experience to slow the apparatus and maneuver to a path of safety.

In knowledge-based performance, the operator has little to no experience and must make a decision that's based solely on requisite knowledge of the system or process. These are what Gordon Graham would call "high-risk/low-frequency events." When such a situation emerges in the context of a complex system and under time pressure, the analytical capacity of human cognition might be surpassed quickly, and the chances for a successful outcome are seriously compromised, according to "Operators Guide to Human Factors in Aviation." To combat these situations, an organization's best course of action is to guard personnel against an occurrence by creating robust systems that can tolerate errors or violations, and by building in safeguards against known contributing factors.

### How we make mistakes

Understanding human behavior can be difficult. Humans are dynamic and multifaceted. However, we typically make mistakes in three predictable ways. These can be summed up as human error, at-risk behavior and reckless behavior.

Human error is a slip, lapse or mistake. In this case, the person who conducts the function or task performed an action that was different from the expected norm. Per "Operators Guide to Human Factors in Aviation," slips are actions that don't go as planned; lapses are memory failures. These types of errors typically occur at the skill-based level because of the "automatic" nature of the tasks or actions.

On the other hand, mistakes are conscious decisions that are made where the operator might have poor situational awareness or doesn't apply the correct solution, or rule, to the problem. These types of errors typically are seen under rule- and knowledge-based performance. The distinction can be made that under knowledge-based performance, the operator might be overwhelmed by information that leads to the mistake; under rule-based performance, the knowledge of the rule and its application become the critical factor.

The important factor here is to look into the root cause of why the error occurred. For instance, is there some knowledge, system or protocol that can be put in place to safeguard from future occurrences?

Many, if not most, organizations have a set of standing orders, policies or

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Firefighting is inherently risky – no need to freelance.

guidelines by which they operate. Most of this guidance is put in place by best practice, accepted standards or past experience. When people operate outside of the accepted policies and guidelines it is called “drift.” These violations are an intentional behavioral choice that increase risk, where the risk isn’t recognized or is mistakenly justified.

Employees drift for all sorts of reasons, including convenience, expediency, overconfidence and bad or overly prescriptive procedures. The real issue with at-risk behavior is that if it isn’t identified and managed through a just culture, it can lead to a normalization of deviance. Normalization of deviance occurs when a “work around,” or shortcut, to an established procedure is allowed to recur until it becomes normal practice.

Another underlying problem with normalization of deviance is that there now is a disconnect between what management believes happens on the job site and what actually goes on. According to “Applying Human Performance Improvements in an Industrial Field,” this misalignment between the two is one of the first steps in eroding an organization’s safety culture.

At-risk behavior violations can occur in the skill-, rule- and knowledge-based spheres. Violations at the skill-based level typically are routines that the operator built into daily activities (normalization of deviance). In the rule-based sphere, violations are more situational and are based on the operator’s perceived need to cut corners or to save time to get the job done (drift). Because of the overwhelming and unpredictable nature of the knowledge-based sphere, violations might be because of a desperate or instinctive action that might lead to a catastrophic outcome.

Although rare, behavior that’s deemed reckless can have an extremely negative effect on the organization. This type of behavior is associated with a blatant disregard for risk and largely is based on intent. Inappropriate behavior or persistent negativity, which doesn’t improve with coaching or counseling, are examples of reckless behavior. According to “3 Reasons to Fire an Employee Immediately,” by John Boitnott (Inc. magazine), identifying toxic employees is an essential part of success for any business, because those employees often can have a direct effect on overall morale.

### Safety and reporting culture

Many organizations operate with, or at least generate a perception of, a punitive culture. In a punitive culture the employee believes that mistakes will be met with sanction or reprimand. The process largely is based on the outcome and not the root cause of the event or mistake. The paramount issue with a punitive culture is that it ultimately disincentivizes the employee to report mistakes. Even if this doesn’t describe your organization, chances are that there are areas where improvement can be made toward instituting a learning culture.

A learning culture involves fostering an environment in which employees are

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encouraged to prioritize safety and to self-report incidents or near-misses to the organization forward. As noted above, this change won't happen overnight and will be imperfect in its inception. There will be habits and bias that must be overcome and retrained to institute a just culture.

Functional issues must be addressed in a just culture. Philip Boyesen, in his article, "Just Culture: A Foundation for Balanced Accountability and Patient Safety," indicated that, while encouraging personnel to report mistakes, identify the potential for error and even stop work in acute situations, a just culture can't be a blame-free enterprise. To promote a culture in which members learn from their mistakes, organizations must re-evaluate how their disciplinary system fits into the equation.

Disciplining employees in response to honest mistakes does little to improve overall system safety. However, mishaps that are accompanied by intoxication or malicious behavior present an obvious and valid objection to today's call for blame-free error reporting systems, Marx noted in his book. In other words, a just culture attempts to ride the fence between a punitive and a blame-free culture.

Employees must understand that a duty is owed to the organization. These expectations clearly are laid out in the mission, values and policies of the organization. The system can tolerate a modicum of errors or drift if the employee is retrained or coached on the infraction. On the other hand, instances of repetitive or reckless behaviors might require progressive discipline, sanction or termination. The overarching intent is for organizations to be able to respond efficiently to errors, to look for trends, and to create lasting change that provides for employee and customer safety.

### Systems and safeguards

Chances are that your organization already has a host of policies and procedures that guides your employees in day-to-day operations. In essence, these are the systems that move the organization in the direction of its leader's intent. Implementing a just culture requires you to take a look at the current systems and safeguards that are in place to determine where you are lacking and where you can improve. As noted above, this only can happen if a culture in which employees feel empowered to report mistakes and near-misses is fostered. This is the foundation of a just culture.

Many are familiar with US Airways Flight 1549 and Capt. Chesley Sullenberger's forced water landing, which was dubbed, "The Miracle on the Hudson." Based on flight data recorder information, Sullenberger's aircraft was struck by birds at an altitude of 2,818 feet, which caused critical damage and a loss of power to both of the aircraft's engines. At 15:27:13, it was reported that both engines could be heard "rolling back." Six seconds later, Sullenberger was heard stating that he was starting the auxiliary power unit (backup power supply), which is a critical safeguard. Fourteen seconds after engine loss, Sullenberger was heard instructing his first officer to get out the Quick Reference Handbook for dual-engine loss. These are procedures, ([Cont. page 7](#))

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## Last Alarms

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## Last Alarms

The USFA reported 44 line of duty deaths in 2021. The following line of duty deaths were reported since we published our last issue:

**Jeffery E. Ames**  
Nelsonville, OH

**Richardo Torres Jr.** 🇺🇸  
New Haven, CT

**Charles W. Spry**  
LaGrange, NC

### 2021 Totals – 29 May 21

♥ 16 (37%) 🚗 3 (6%)

5 (11%) 20 (46%)

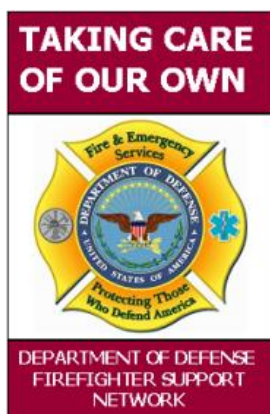
♥ Indicates medical or cardiac related death

🚗 Indicates vehicle accident related death

🇺🇸 Indicates U.S. born and bred



## TCoOO Update



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## Taking Care of Our Own

There are currently six DoD firefighters in the Taking Care of Own program.

*Taking Care of Our Own* invites all DoD F&ES personnel to donate ONE HOUR of annual leave to DoD F&ES members in need to enable them to focus on recovery rather than financial distress.

Name	Location	Point of Contact
Marshall Espinoza	Metro San Diego, CA	Breana.Sheffield@navy.mil; Diana.Maclachlan@navy.mil
Matthew Derheim	JB Elemendof-Richardson, AK	lisa.pascale.1@us.af.mil
Andrew Swick	USAG Yuma, AZ	Daniel.P.Goodwin2.civ@mail.mil
Christopher Bishop	F&ES Gulf Coast, FL	Daniel.Chiappetta@navy.mil
Philip Eubanks	F&ES Gulf Coast, FL	Michael.S.Glover@navy.mil
Mathew Rominger	USMC Mountain Warfare F&ES	Michael.I.lightfoot@usmc.mil

We provided all the service component chiefs with the proper procedures to enroll someone in the Taking Care of Our Own program. There was a trend of people using their own formats and forms which worked okay until the inevitable breach of personal identifying information (PII). We were very concerned about protecting PII when the program was stood up in 2003 and we designed standard procedures and forms to address those concerns.

Please contact your service component chief if you haven't seen this information recently.

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EVERYONE  
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or systems, that are provided to walk pilots through in-flight emergencies. In the National Transportation Safety Board aircraft accident report, the number one contributing factor to the survivability of the accident was the decision-making of the flight crewmembers and their crew resource management during the accident sequence.

The point: It isn't enough to have systems and safeguards in place in an organization. The personnel who run the day-to-day operations must know when, where and how to employ them successfully. Furthermore, when a near-miss or accident occurs, those same employees should feel compelled to report the incident in an effort to learn and grow the organization in the process. Implementing a just culture isn't simply about identifying accidents and mishaps; it's about holding employees accountable to a standard of performance and being open and transparent to a culture of safety and improvement.

### Our experience

My department's journey to implement a just culture grew out of a desire of our executive staff to make workplace safety our highest priority. As noted in the introduction, undertakings such as this are most successful when they are top-down and have executive support. Our department's assistant chief at the time instituted the motto of "Everyone Goes Home" for the department. This applied not only to fireground and incident operations but also employee well-being. Programs, such as annual physicals, health and wellness programs and cancer prevention initiatives, were spawned and grown within the organization.

Just culture was another initiative that was aimed at improving how the department looks at and interacts with overall department mission and goals. To assist with implementation, the organization utilized a third-party firm that develops tools that operationalize all the tenants of just culture into a useable and reproducible program. Since the department implemented the just culture model a little more than three years ago, the department has seen several benefits and improvements over time. Some of these benefits include a standardized approach to investigation and decision-making, a reduction in bias, improved data on accidents and injuries and an eroding of the punitive culture perception that was held by many of the department's employees.

### Standardization and bias reduction

The standardized approach to investigation and decision-making is crucial to the success of the program. Employee confidence in the program is bolstered based on the knowledge that all investigations are handled in the same manner and with the same process. Standardization also reduces bias in the investigation process. Like the people who are involved in the incidents, investigators also are prone to bias. According to "Applying Human Performance Improvements in an Industrial Field," biases are preconceived notions and understanding that you bring with you when you try to understand events in real time or those that are reviewed in hindsight.

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### About the Author:

#### Tory Thompson

Tory Thompson joined the fire service in 1998. He began his career with the Pflugerville, TX, Fire Department, and over the past 20 years, he rose through the ranks. Currently, he is assigned as a captain and the safety officer. Regarding the latter, Thompson's responsibilities include implementation of health and safety initiatives, accident/injury investigations and emergency-incident management. He graduated from the Austin Community College (ACC) Fire Academy in 1998. Since then, Thompson earned an associate degree in fire protection technology from ACC, a bachelor's degree in applied arts and sciences from Texas State University and a master's of public affairs degree from University of Texas at Rio Grande Valley. He has extensive experience in leadership and management, including new officer development. Thompson developed multiple programs for his fire district, including a five-week recruit academy, an ALS education program, and a comprehensive risk and hazard mitigation program.

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Two types of bias that investigators are prone to are hindsight and outcome bias. Hindsight bias simply is the preconception that your findings in an incident should have been apparent to those who were experiencing the event in real time. Outcome bias places value judgments on an event that's based on the perceived gravity of the outcome alone. The problem is that, despite our best efforts to remain objective, humans have a natural proclivity to observe that, when reviewing events prior to a bad outcome, they clearly could "see it coming." We are calibrated poorly because of hindsight bias and greatly overestimate what our ability would have been to see the negative outcome and its severity before it arrives ("Applying Human Performance Improvements in an Industrial Field"). Having a standardized approach to investigation through applied tools and processes allows the investigator to remove at least some of the bias that's inherent in our nature.

### Big data

The need for data in today's world is paramount in running a successful organization. The ability to serve your community adequately, to take advantage of emerging technologies, and to ensure that employees work safely and effectively all hinge on the ability to collect and interpret data. Prior to my department's implementation of just culture, it was impossible to quantify how many accidents, injuries or near-misses went unreported. Reasons for this include a complacent attitude toward risk and safety and a culture that was perceived as punitive and reactive. Since the department implemented a just culture, it has seen an uptick in reported incidents. This isn't to say that the department is at 100 percent compliance and doesn't have room to improve. However, the department is able to collect data on its accident reports and identify trends to determine how best to modify systems and train employees to mitigate risk.

Data really is the key to closing the loop within the just culture framework. Without follow-through, no system can have much of an effect on an organization.

### Building trust

Building trust within an organization is difficult, particularly when you talk about relationships between staff and line members. I do believe that many of the department's employees believed that they operated under a punitive culture prior to the introduction of just culture. I don't believe that this was department leadership's intent nor that their actions indicated such a culture. However, unfortunately, perception is reality.

Building trust requires consistency and follow-through. The department has been committed to implementing and consistently applying the just culture framework. Although this is a slow process, we believe that it is one that is worth doing. As employees gain confidence and understanding in the process, their comfort level in reporting improves. Information and lessons learned are shared through quarterly meetings in which safety officers discuss previous



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## Back in the Day



Tom Shand

incidents and how to prevent future occurrences while keeping names anonymous. Over time, something that at first seemed foreign now is commonplace.

A just culture is an evolving process that never will end, but by weaving it into the fabric of the organization, you can ensure that it continues to benefit your employees and your community as a whole.

## Back in the Day

By Tom Shand

During World War II virtually all production of municipal fire apparatus was halted with the fire apparatus industry devoting their manufacturing efforts to support the troops in various ways. Several builders including American LaFrance, Mack, Maxim, and Seagrave produced hundreds of structural and airfield apparatus for all branches

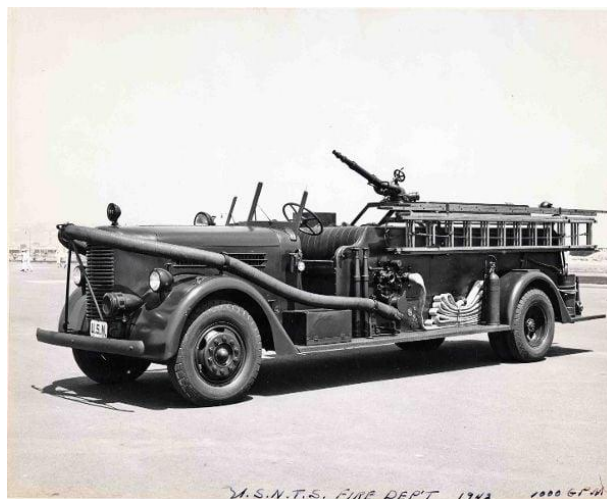


Photo from the collection of Ted Heinbuch

of the military. Several manufactures designed completely new vehicles to meet the needs of the Department of Defense including small four wheel drive pumpers that could go virtually anywhere as well as trailer pumps which could be towed with a regular automobile for use in auxiliary firefighting to protect the home front. Guidelines issued by the Office of Production Management requested that fire apparatus builders refrain from building quints, service ladder trucks, rescue and salvage units for domestic use. Any pumper built could not be larger than 500 gpm and the use of chrome, aluminum, cadmium and tin for external components was prohibited.

The Peter Pirsch Company, located in Kenosha, Wisconsin began operations during 1900 producing hand and horse-drawn hose and chemical wagons along with hook and ladder trucks. The distinctive Pirsch truss style ground ladder quickly gained popularity, resulting in their first large order for ten, city service ladder trucks for the New York City Fire Department.

During 1931 Pirsch introduced the first fully powered aerial ladder using a hydro-mechanical hoist with an 85 foot two section wooden ladder that was delivered to Spokane, Washington. In 1942 the Norfolk Naval Base placed into service a similar 85 foot tractor drawn ladder. One aluminum and steel aerial ladders gained favor, Peter Pirsch supplied a number of their aluminum lattice aerials to departments across the county including the District of Columbia, Baltimore, Chicago and Memphis.

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## *Back in the Day (Cont.)*

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[Courtesy from Wikipedia](#)

To support the war effort, Peter Pirsch supplied a number of commercial and custom chassis fire apparatus to the U.S. Navy. Among the more unique devices produced were seventy two, portable 65 foot wheeled aerial ladders for servicing Navy blimps. While many of the U.S. Navy pumpers were Pirsch model 20G, equipped with 750 gpm pumps, several of the larger model 41, 1000 gpm pumpers were produced for installations at Kodiak, Alaska, Pearl Harbor along with serial number 1282 which was delivered to the Naval Training Station at San Diego, California.

These pumpers were somewhat austere in appearance with no chrome or bright work. The San Diego pumper was outfitted with a squirrel tail suction hose, similar to what was utilized for many years by fire departments in Louisville and Memphis. The extent of modern day vehicle features included a windshield, with an open cab and no doors. Equipment carried included wooden ground ladders, 2.50 inch smooth bore play pipes along with a two inlet deck gun mounted above the fire pump. The model 41 pumper was powered by a Waukesha 779 cubic inch gasoline motor producing 240 horsepower and was equipped with a 150 gallon water tank.

Due to the ongoing war effort, fire apparatus of this era were outfitted with minimal warning devices. As noted in the photo, the San Diego engine had a single forward facing red flashing light on the cowl, along with a mechanical siren and large searchlight on the officer's side of the cab.

After the war there was an unrepresented demand for new fire apparatus as many departments had not acquired any new apparatus for almost a decade. The fire apparatus industry ramped up production and once again began to develop new vehicle designs to meet the needs of the fire service. The introduction of cab-forward apparatus and longer aerial devices with 100 foot capabilities were not too far in the future. Back in the Day, new apparatus had unique looks which could easily differentiate each manufacturer's designs.

## *ICS Training*



# FEMA

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## *Incident Command Instructor Training*

Recognizing the need to expand the need for additional FEMA Incident Command System (ICS) Intermediate and Advanced (ICS 300 & 400) courses, N36T has launched ICS Train-the-Trainer (K449 TtT) courses. These TtT courses are being held in conjunction with FEMA and graduates acquire both CNIC and FEMA ICS Instructor status. This was made possible by an agreement between CNIC and FEMA designating the N36T as the Authority Having Jurisdiction (AHJ) for ICS instructor training for the Navy. The initial TtT class was held over five days in February. This class was held entirely virtually via MS TEAMS. 14 students from two Regions completed the course.

The next ICS TtT course is planned for September 2021. Individuals interested in obtaining information about enrolling into an ICS 300 or 400 class and/or information regarding the pre-requisites for the ICS TtT course can contact [cnic\\_n36t\\_sotg.fct@navy.mil](mailto:cnic_n36t_sotg.fct@navy.mil).

## SA Matters!

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## The Art of Speaking Up

By Rich Gasaway



Recently I received a phone call from a captain in Colorado. He wanted to bounce a few ideas off me about training ideas I inspired during my recent Training for Failure program they hosted. One of the topics we addressed was teaching firefighters how to speak up when they have concerns. Teaching how to do this is especially important for new firefighters. Here's why.

### Recruit Firefighter Expectations

Many recruit training programs are highly regimented and recruits are taught to shut up and do as they are told. They spend weeks, sometimes months, learning how to take orders and execute those orders without question. Instructors can be intimidating – sometimes on purpose and sometimes not.

Recruits have a lot to learn and oftentimes there's not much time for debate, discussion or opinions about what is being taught. The programs are highly regimented and recruits are there to learn. If this describes your training program, there's nothing wrong with that. Environments like this teach recruits to be seen but not heard.

### Post Recruit Firefighter Expectations

When recruit firefighters complete their training and receive their station assignment, it is highly probable that the respect for authority and the seen-but-not-heard expectations ingrained in them during their recruit training is likely to continue.

Most company officers and command officers I have spoken to have told me, without question, if they were making a mistake that would cause a subordinate firefighter to get hurt or killed they would want the subordinate to speak up and express their concerns in hopes of preventing a catastrophe.

However, it's highly likely that firefighters will not speak up – out of fear or respect.

A few years ago I had an opportunity to give two presentations to wildland firefighters. The first day's presentation was for the bosses. The second day's presentation was for hand crews (front line firefighting crews). When I was with the bosses we talked about a wild land fatality incident where front line personnel did not



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## **SA Matters!** **(Cont.)**

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speak up, even though they knew things were going bad. We dissected that event and talked about organizational culture, fear of retribution and the importance of creating an environment where front line firefighters would be willing to speak up if they thought mistakes were being made.

The bosses assured me that they have worked hard to create an open culture and strongly encourage hand crew personnel to speak up if they see or sense something is going wrong. They referred me to the wild land fire “Ten Standard Firefighting Orders” and the “Eighteen Watch Out Situations”, (a.k.a. as the “10s and 18s”). Several in attendance held up their field guides. Since they seemed to have a handle in this important cultural concept, we quickly moved on to the next lesson.

However, on the second day, when I had the hand crews in the room, the story was quite different. Along with the hand crews, there were also some crew bosses present so I asked them to step out of the room for a few minutes so I could talk just to the hand crews. Once the room was clear of all bosses, I asked the hand crews to raise their hands if they would be comfortable speaking up if they saw or sensed something was going wrong in the field. Out of 50+ in the room, three raised their hands and one of them qualified his vote by saying it depended on which crew boss it was.

### **Speaking up is a skill**

Knowing when and how to speak up if there is a concern... is a skill. As a skill, it can be taught. But is it? The curiosity about this led me to the next question for the students. Raise your hands if you’ve ever participated in a training session where you actually practiced speaking up to a boss.

Several of the attendees had admitted to receiving instruction about how and when to speak up. But, sadly, not one student in the room had ever practiced the skill. It’s much easier to TALK ABOUT speaking up than it is to ACTUALLY speak up.

This brings me back to my discussion with the Captain that prompted this post. Like the bosses of the wild land crews he also admitted to having many discussions where he encouraged his firefighters to speak up. But, by his admission, they’d never actually practiced it.



I recommended the captain teach his crew how to disagree with him and then have them practice the skill. It’s important that during the practice, the firefighter avoid talking in the third-person voice (e.g., “I would tell the captain that I disagree with his decision because...”). There is no ownership in the action when presented in the third-person voice. Rather, the firefighter would look the captain in the eye and say something like:

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## ***SA Matters!*** ***(Cont.)***

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“Captain Jones, I have a concern about what we are doing here and I want to tell you why before we engage. Then the firefighter would express his concern in the first-person voice, talking directly to the captain as if it were a real conversation on a real fireground.

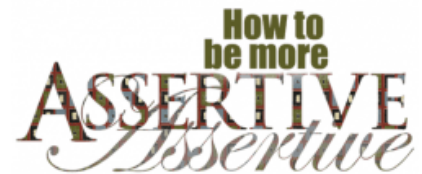
Expect there to be some stumbling and stammering at first because many firefighters are going to be uncomfortable voicing their concerns. The captain could, preemptively, demonstrate how he would want to be addressed under such conditions by role-playing as the firefighter. This will help the firefighters find the words – and the courage – to speak up.

Then, once the courage has been mustered in the classroom, it is time to take the skill set to the next level and create training scenarios where the captain makes a bad decision and/or gives inappropriate orders on purpose. Of course, it goes without saying, these scenarios should never create actual danger for the firefighters. Then, in the moment, the firefighter practices their newly acquired skill set of disagreeing with respect.

### **The Five Step Assertive Statement Process**

I have previously written about this concept, so I will only cover it in summary fashion here and include a link to the article.

The Five Step Assertive Statement Process comes directly from the Crew Resource Management program developed in aviation. For the process to be most effective, a department should develop a policy and train all firefighters on when, why and how to use the process. The steps of the process include:



1. Addressing the person you have a concern with formally.
2. Using a standard phrase to indicate you have a concern. (In aviation, it is simply “I have a concern.”)
3. State the concern.
4. Recommend an alternative action.
5. Gain approval or consensus of the decision maker.

### **Rich Gasaway’s Advice**

It is likely that in most organizations the bosses would want subordinates to speak up if there was a concern about safety or concerns about decision making. Sadly, however, in some organizations, the culture is not supportive of subordinates taking exception to the decisions of superiors. So, the subordinates say nothing and let the incident degrade into a catastrophe. This leads to outcomes that are both tragic and avoidable.

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## ***SA Matters! (Cont.)***

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### ***Photo Op***

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I recommend developing a policy that stipulates the terms and conditions that authorize a subordinate to speak up and express a concern without fear of retribution. In fact, the policy should go as far as to explicitly state the employee will be protected from retribution.

But a policy is not enough. Subordinates need to practice the script, in the first-person voice, to gain comfort with how to utter the words and how to overcome the inherent fear of defying an authority figure.

Honestly, some bosses will also need to practice receiving this kind of feedback. Because, let's face it, some bosses are equally uncomfortable receiving the feedback that indicates they are making a mistake.

### **The Pigs are Eating Lemons**

A couple of years ago I had the opportunity to speak to the recruit class of the Buckley Fire Department (Washington). Chief Predmore was in attendance and he took my message seriously. Having firefighters who would not speak up if they had a concern was, in his words, unacceptable. So he engaged his firefighters in a discussion about how to speak up and what they might say if they had a concern. Step 2 of the Assertive Statement Process is to use a phrase that indicates there is a concern. In Buckley, they got creative. They wanted a phrase that would be so unusual that the commander would have to listen up. They chose "The Pigs are Eating Lemons!" It may not work for everyone... but it works well for Buckley.

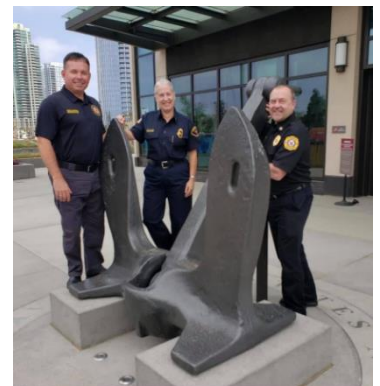
### **Action Items**

1. Assess your department's culture to determine if line personnel feel free to speak up when there are concerns for safety.
2. Assess your department's culture to determine if supervisors are open to critical feedback.
3. Consider developing a policy to address how and when to employ an assertive statement process.
4. Provide training for all personnel on how to give and receive critical feedback.
5. Create training scenarios where personnel practice the skill expressing concerns for safety.

## ***A Break for Fire Prevention***

Left to Right  
Hans Christian, CNRSE  
Jan Lozoya, CNRSW  
Burke Ferrin, CNRNW

Photo in front of the new  
CNRSW Region Headquarters



## USNS Diehl

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## Crew of USNS Walter S. Diehl Trains with Philadelphia, Navy Region Mid-Atlantic Firefighters

By Captain Frank McCleaster, Navy Region Mid-Atlantic Fire & Emergency Services

Navy Region Mid-Atlantic F&ES Station 17 at the Philadelphia Navy Yard was contacted in late 2020 by Philadelphia Ship Works, advising that the USNS Diehl (T-AO-193), a Henry J. Kaiser-class fleet replenishment oiler operated for the Navy by the Military Sealift Command, was in dry dock 3 for repairs. Captain Andrew Chen, the Diehl's master, invited the fire department for walk-throughs and training. Training Officer Justin Deemer and Supervisory Captains Frank McCleaster and Peter Marcinonis coordinated and executed the training.

The City of Philadelphia Fire Department was also invited to the training. With the current issue of COVID 19 always on the forefront of safe operations, procedures were established and strictly adhered to for mandatory temperature checks, use of masks, safety glasses and good personal hygiene for Navy and city training participants. Interaction with the Diehl's crew also facilitated effective pre-planning. The Diehl was in "cold iron" status with no fixed suppression systems or fire pumps operable due to the nature of the ship repairs being done. The ship was completely dependent on water supply from the dry dock and emergency services. Crews also identified the risks of confined spaces and hazardous material operations based on the specific work being conducted on the ship. This information was discussed with the Philadelphia Fire Department's Special Operations section chiefs to coordinate participation by city rescue, squad and Haz-Mat personnel. A total of 24 training sessions over a 4 week period were planned and conducted in February and March 2021.



On the bridge wing of USNS Walter S. Diehl. City of Philadelphia and Navy Region Mid-Atlantic firefighters, and Licensed Deck Officers Captain Andrew Chen, Second Officer Brad Musselman, Second Officer Brian Bosch and Third Officer Bjorn Briggs. (International Organization of Masters, Mates & Pilots photo)

The training sessions covered shipboard firefighting, technical rescue, hazardous materials and incident command. All of the training included tours and planning of high hazard areas that present challenges during an emergency response.

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## ***USNS Diehl (Cont.)***

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City and Navy crews enjoyed a combination of vessel familiarization and targeted sessions to observe and discuss firefighting operations including the engine room, paint storage and hazardous materials storage, hot work areas, and fuel transfer and pump rooms. Crews also reviewed technical rescue and patient extraction considerations such as fuel, lube oil and ballast tanks; and baffled chain fall spaces, all of which present difficult access and rigging issues. Marine Incident Command issues, vessel plans, and fire department utilization of ship's engineered systems (fire barriers, HVAC and exhaust systems, fixed fire mains) to aid in firefighting tactics and strategy were also discussed.

The training was very successful and valuable for the city, Navy and ship personnel. The interaction also opened dialogue and planning for future training for ship operations and other types of emergency responses in the vicinity of the Navy Yard.

After a 15-year forward deployment in San Diego, the Diehl shifted its homeport recently to Naval Station Norfolk. Eighty-nine civil service mariners operate the vessel. The licensed deck officers are represented by the Masters, Mates, & Pilots Federal Employees Membership Group.

Editor's Note: Another article describing this training was also published in The Master Mate and Pilot, Vol. 57, No.1 Spring 2021, International Organization of Masters, Mates & Pilots, available at [www.bridgedeck.org](http://www.bridgedeck.org)

## ***CNRMA Achievements***

### ***Navy Region Mid-Atlantic Recognizes Career Achievements***

By Navy Region Mid-Atlantic Fire & Emergency Services Staff

Congratulations to Navy Region Mid-Atlantic Fire & Emergency Services personnel on recent career achievements:



**District Chief Anthony Sickell,  
Navy Region Mid-Atlantic Fire &  
Emergency Services, District 1  
(NAVSTA Norfolk and NSA  
Hampton Roads)**

District Chief Anthony Sickell graduated from Old Dominion University's Graduate Certificate in Public Sector Leadership in March, 2021. Offered by ODU's Strome College of Business, the 12-month certificate program is a unique opportunity provided to broaden the experience and increase leadership capability for high potential civilian leaders below the executive level (GS13-15). The program offers graduate level courses in cyber security, finance, change management, and the Navy's U.S. Fleet Forces Command manages the Navy's cohort each year. Chief Sickell is the third Navy Region Mid-Atlantic F&ES employee to complete the program, which has offered the specialized Navy cohort opportunity since fall of 2015.

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## Achievement (Cont.)

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From left to right, Captain Jason Schneider (Commanding Officer, Naval Weapons Station Yorktown); Battalion Chief George Beodeker having his new badge pinned on by Beodeker children Nora, Colton, and Owen; and Mrs. Katie Beodeker holding Sophie.

investigators, assumes Battalion Chief-Operations duties at Fire District 1. Congratulations, Chiefs Beodeker, Dougherty, and Woods.

Assistant Chief Shannon Pawlowski graduated from the Graduate School USA Executive Leader Program (ELP), in May 2021. The program is tailored to the Federal environment with skills, experience and exposure to management and leadership challenges for GS-11 to GS-13 level personnel with high management potential. Chief Pawlowski completed a 90-day developmental assignment at U.S. Fleet Forces Command's N45 Branch, and participated in mentorship with SES Lisa Jox, (Director, Human Resources Operations, Office of Civilian Human Resources) at the Washington Navy Yard. Shannon is Navy Region Mid-Atlantic's Training Program Manager.

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Supervisory Captains George Beodeker (NSA Hampton Roads), Brad Dougherty (NAVSTA Norfolk), and Dana Woods (NAS Oceana) assumed the rank of Battalion Chief in April 2021 after a competitive department-wide promotion process. Chief Dougherty assumes the duties of Training Officer in Fire District 1 (NAVSTA Norfolk and NSA Hampton Roads). Chief Beodeker, the department's PPE & Bunker Gear Program Manager, assumes Battalion Chief-Operations duties in District 2's Virginia Peninsula operating area (NWS Yorktown and Cheatham Annex). Chief Woods, one of the department's fire



Left Photo- From left to right, Captain Patrick Dziekan (acting CNRMA Chief of Staff), MCPO Asa T. Worcester (CNRMA Command Master Chief), Assistant Chief Shannon Pawlowski, and Mrs. Julie A. Heller (CNRMA Executive Director) at CNRMA Fire headquarters on May 14, 2021

*Congratulations*

## Corpus Fire Chief Retires

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## Corpus Christi Fire Chief Retires



Fire Chief Ruben Perez

Born and raised in Ozona, Texas, Ruben Perez entered the U.S. Navy in November 1983 and received an honorable discharge as a Petty Officer Third Class in March 1989.

He entered the Department of Defense Fire & Emergency Services at Naval Air Station Corpus Christi in May 1989 as a GS-0081-03. While at NAS Corpus Christi he completed all Fire Fighter entry-level training and was promoted to GS-0081-04 on May 1990.

In September 1990 he transferred to the Naval Station Ingleside Fire & Emergency Services Department. While at Naval Station Ingleside he held the positions of Engineer, Captain, and Assistant Fire Chief. While at Naval Station Ingleside, he was the Program Manager for the Fire Fighter Certification System, Physical Fitness, Emergency Medical Services and Special Rescue Operations. He earned an Associates degree in Applied Fire Science Degree from Del Mar College in May 1996. He also became a certified instructor as an Emergency Vehicle Operator's Course, Hazardous Materials Awareness, Operations, Technician and Incident Commander level, Emergency Operations Center, Fire Service Peer Fitness (American Council on Exercise), Nuclear Biological Chemical Technician and Emergency Medical Technician.

In September of 2001, he was selected as Fire Chief and reported onboard Naval Air Station Kingsville Fire & Emergency Services Department. In May of 2004, he was assigned as Fire Chief of Naval Air Station Corpus Christi and simultaneously continued to be the Fire Chief for NAS Kingsville. By March of 2005 he was Fire Chief for three of the installations, NAS Corpus Christi, NAS Kingsville, and NS Ingleside. During the timeframe he managed seven separate district areas consisting of 149 fire fighters, 11 dispatchers, and 16 military fire fighters for a total of 176 personnel staffing 16 Engine Companies. He was a key player in the standup of the Fire & Emergency Services of Navy Region South which included NAS Corpus Christi, NAS Kingsville, NS Ingleside, NAS/JRB Ft Worth, and NAS/JRB New Orleans. During this tenure NS Ingleside was selected as Department of Navy's Small Fire Department of the Year and NAS Corpus was selected as CNRSE Large Fire Department of the Year. Furthermore, he was assigned in 2005 to NAS/JRB New Orleans managing sixty fire fighters from six different Navy Regions during Hurricane Katrina/Rita Recovery Phases in which they were responsible for sixty-six rescues Jean Lafitte, Louisiana and another eighty personnel from a shelter at the Worley Middle School in Westwego, Louisiana. He successfully managed the GS-05 to GS-07 upgrades of over one-hundred Firefighters, implemented cross-

## Corpus Fire Chief Retires

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staffing operations to reduce labor cost and converted all 40-hour Firefighters to 72-hour Firefighters. He assisted with the seamless transfer of Command Navy Region South Fire & Emergency Services onto Command Navy Region Southeast Fire & Emergency Services during this tenure. Once Navy Region South was merged onto Navy Region Southeast in 2006/2007 he returned back as Fire Chief of NAS Kingsville. In 2010, He was recognized as the Navy's Fire Chief of the Year and NAS Kingsville was recognized as the 2009 Department of the Navy Medium Fire Department of the Year. During this tenure his department teamed up with the Department of Homeland Security and was credited with the removal of \$2.3M in illegal drugs from U.S. Highways.

He was selected as Fire Chief for NAS Corpus Christi in October of 2017. He lead NAS Corpus Christi Fire & Emergency Services achieve their 2nd Accreditation from the Center for Public Safety Excellence in 2020, one only 12 in the United States Navy, hired the first female firefighters since the 1940s, hired seventeen local hires via Direct Hire Authority, developed the Deputy Fire Chief position and successfully promoted nineteen internal promotions.

Fire Chief Perez's personal awards include the Good Conduct Award, Sea Service, Battle "E", Civilian of Quarter, Civilian of the Year (2-awards), Navy Fire Chief of Year, CNRSE Fire Chief of the Year, Senior Civilian of the Year, Navy Civilian Meritorious Award and various other service awards. During his tenure he has served under ten different Installation Commanding Officers. Under his management, the F&ES personnel have been responsible for three lifesaving awards including two Mutual Aid Firefighters saved from a fire, responded to over 10,000 emergency responses, over 1,000 mutual aid responses and supported over 3.7 million flight operations. He has served as the Incident Commander for ten Air Shows at NAS Kingsville and NAS Corpus Christi with an estimated attendance of 1.1 million spectators.

He is involved with the Knights of Columbus, actively involved with Catholic Church, youth football (7 years), and youth baseball leagues (16 years) in the Portland Community, 2012 Baseball All-Star coach for team that reached Super Regional Tournament. He is a member of Nueces County Fire Chief's Association, South Texas Fire Chief's Association and the Coastal Bend of Governments. He is the father of three children, Brandon, Brianna, and Blake.

## Honor and Remember

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### Honor and Remember



**To Publicly Honor and Remember Every American Fallen Service Member and Recognize the Enduring Sacrifice of Every Family**

# Kingsville A/C Retires

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# Kingsville Assistant Fire Chief Training, Vernon Easley Retires

Assistant Chief Vernon Easley, the Assistant Chief of Training for the NAS Kingsville Fire Department, retired after 28 years as a military and civilian firefighter.

His fellow firefighters honored him and CAPT Thomas Korsmo, NASK Commanding Officer, presented him with a flag flown over NASK and a retirement certificate. CAPT Korsmo also presented Erin (wife) with a Certificate of Appreciation for her support.



Vernon and Erin Easley exit under the traditional firefighter's pike pole salute. Photos provided by Kingsville Public Affairs

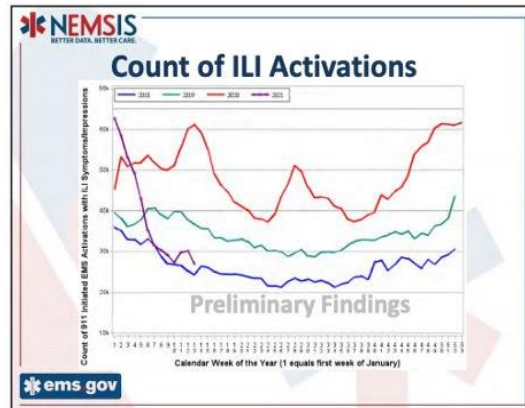
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## EMS Data

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## Twenty Years of National EMS Data

By [https://www.ems.gov/newsletter/spring2021/twenty\\_years\\_of\\_national\\_ems\\_data.html](https://www.ems.gov/newsletter/spring2021/twenty_years_of_national_ems_data.html)



Already this year, more than 5 million EMS incidents have been recorded in the National EMS Database—many of them just minutes after EMS clinicians submitted the patient care report. Thanks to participation from 50 states and territories, that means data from the majority of EMS responses in the country now helps inform decision-making by EMS leaders at all levels, including state and federal officials.

“It’s been incredible to watch the National EMS Information System and National EMS Database grow since its creation just two decades ago,” said Jon Krohmer, MD, director of the Office of EMS at the National Highway Traffic Safety Administration, which oversees NEMSIS.

“We now get frequent requests for EMS data from our colleagues throughout the federal government—at the Centers for Disease Control and Prevention, for example, or leaders of the COVID-19 response or the fight against the opioid epidemic—not just because they want to see what EMS is doing, but because we have one of the most complete healthcare datasets in the country, making it a great tool for seeing the big picture of the health of the entire nation,” Krohmer said.

### EMS Data Shed Light on COVID

Since the beginning of the pandemic, for example, the team at the NEMSIS Technical Assistance Center (TAC) has worked tirelessly to provide NHTSA and its federal partners, state officials and researchers with relevant and nearly real-time information. Weekly reports showing the impact of COVID-19 on trends across the country have been shared with officials and are also available to the public at [NEMSIS.org](https://www.nemsis.org).

Those reports were especially useful at showing the increase in calls for flu-like symptoms at the onset of COVID and during subsequent spikes in hospitalizations and deaths, as well as the simultaneous decrease in overall calls as people stayed home and avoided seeking healthcare.

“Those two charts alone can better tell the story of the impact of COVID on EMS clinicians and systems than anything else,” Krohmer said. “The simultaneous risk to clinicians’ health and risk to EMS systems’ financial health is summed up by those peaks and valleys.”



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## ***EMS Data (Cont.)***

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Researchers pored through the data as well, publishing several articles in a number of peer-reviewed journals. In July, researchers from the University of Buffalo and the Oregon Health and Science University teamed up with experts at the NEMSIS TAC to publish a preliminary report on the impact of COVID-19 on EMS in the United States. What made that research all the more remarkable is that the article used NEMSIS data from up to and including May 24, 2020—just weeks before the publication date.

“While many healthcare research articles rely on data from years before, having that near-real-time information can be critical, especially during rapidly changing scenarios like the pandemic,” said Clay Mann, PhD, the principle investigator for the NEMSIS TAC and a co-author of the article.

The NEMSIS TAC maintains a list of publications using national EMS data on its website, where you can also find information on how to request datasets for your own research projects.

### **NEMSIS Supports Innovative ET3 Model**

The launch of the Center for Medicare and Medicaid Innovation’s Emergency Triage, Treat, and Transport (ET3) Model earlier this year marked a pivotal milestone for EMS—and for EMS data.

The team at the NEMSIS TAC and NHTSA have been collaborating with the ET3 team, state officials, software vendors and local agencies to support their needs as they embark on a five-year evaluation of a payment model that will provide greater flexibility to EMS by allowing them to bill for treatment in place and transport to alternative destinations, such as urgent care clinics. (The next phase, which will include medical phone triage lines, has not gone live yet.)

In January, 184 public and private ambulance providers and suppliers representing 36 states agreed to participate in the ET3 Model. Data collection, reporting and analysis will be an important piece of the program and evaluating whether the model successfully meets its goals of reducing healthcare costs and improving care options.

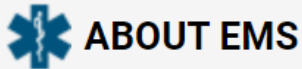
Because of the NEMSIS standard, these EMS agencies and their software vendors were already using a consistent data format that will allow the Centers for Medicare and Medicaid Services to easily collect, aggregate and analyze the information submitted by the participating agencies. As of March 15, 2021, ET3 has received about 250,000 electronic patient care reports from 27 participants.

“This is another example of the power of NEMSIS in facilitating data sharing and integration,” Mann said. “The data standard, now used nearly universally across the country, has transformed EMS data into a powerful healthcare, research and evaluation tool. We’re excited for the

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## EMS Data (Cont.)

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## Pay Raise



Erich Wagner

Erich Wagner is a staff correspondent covering pay, benefits and other federal workforce issues. He joined Government Executive in the spring of 2017 after extensive experience writing about state and local issues in Maryland and Virginia, most recently as editor-in-chief of the Alexandria Times. He holds a bachelor's degree in journalism from the University of Maryland

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ET3 Model and other data-sharing partnerships on the horizon.”

Upcoming NEMSIS Training, Meetings

Interested in learning more about NEMSIS and EMS data? The Technical Assistance Center is planning two meetings later this year, both virtual due to COVID-19.

On July 13, 2021, they'll be hosting the Boot Camp for State Data Managers: Transitioning to v3.5. And on August 3-5, the annual meeting will feature a number of workshops, speakers and opportunities to get your questions answered about the continued implementation of Version 3 and future updates. Details, including agendas and registration information, will be posted here when they are available.

***Biden Proposes 2.7% Raise for Feds in 2022, Restoring Pay Parity - Although it is unclear how plan breaks out between locality pay and across-the-board increases, the topline number matches the president's proposed pay raise for members of the military.***

By Erich Wagner

President Biden on Friday formally proposed an average 2.7% pay increase for federal civilian employees in 2022 as part of his fiscal 2022 budget proposal.

The figure marks a stark improvement over the 1.0% across-the-board increase feds received in 2021 after former President Trump pushed for a pay freeze in the final days of spending negotiations last year. But it falls short of a proposal by some Democratic lawmakers to provide feds with a 3.2% average pay raise next year, as well as the average 3.1% pay increase approved for 2020.

“The administration is committed to empowering, rebuilding and protecting the federal workforce, which is why the budget provides for a 2.7% percent pay increase for the federal civilian workforce,” the White House stated in budget documents.

It was unclear Friday how Biden’s proposal would be divided up between an across-the-board boost to basic pay and increases in locality pay. In recent years, pay raise provisions have included a 0.5% average increase in locality pay, although it was frozen at 2020 levels this year. The Office of Management and Budget did not respond to a request for comment on the split between basic and locality pay.

The proposal also marks a return to the principle of pay parity between the civilian and military workforce, as service members would also receive a 2.7% pay raise in 2022. The Trump administration often proposed pay freezes on the civilian side, while consistently pushing for military pay raises.

## Pay Raise (Cont.)

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Government  
Executive

In a statement, National Treasury Employees Union National President Tony Reardon described Biden's pay raise proposal as a "solid start," although he continues to support the 3.2% pay increase proposal.

"NTEU is working in Congress to pass the Federal Adjustment of Income Rates Act, which would provide federal employees a 3.2% average pay increase next year," Reardon said. "This legislation has broad support and provides a 2.2% average across the board increase and a 1% adjustment to locality pay, which is essential for employees who live in high-cost areas of the country. We look forward to working with the administration and lawmakers to meaningfully recognize the contributions of the federal workforce, a bedrock of our democracy."

Everett Kelley, national president of the American Federation of Government Employees, said that while the nation's largest federal employee union appreciates many of the federal workforce investments across Biden's budget proposal, a 2.7% pay raise is not sufficient to properly compensate workers.

"While we are supportive that the long tradition of military-civilian pay raise parity has been honored in the President's proposal, 2.7% is simply not nearly enough to compensate for the losses in buying power of federal wages and salaries over the past decade," Kelley said. "On average, federal workers are underpaid by 23% compared to those doing the same jobs in the private sector and state and local government. We ask Congress to support the modest 3.2% increase included in the FAIR Act."

## Combs Cartoon



## Super Expectations



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**TSP Update**

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**TSP Funds Snapshot**  
As of Friday, May 28, 2021

Fund	Price	%	YTD
G Fund	\$16.60	0.02%	0.53%
F Fund	\$20.73	0.12%	-2.22%
C Fund	\$62.96	0.09%	12.61%
S Fund	\$82.81	0.10%	11.60%
I Fund	\$39.13	0.70%	10.58%
L Income	\$22.92	0.09%	2.88%
L 2025	\$11.79	0.16%	5.61%
L 2030	\$41.52	0.20%	7.07%
L 2035	\$12.46	0.21%	7.71%
L 2040	\$47.12	0.23%	8.36%
L 2045	\$12.90	0.25%	8.91%
L 2050	\$28.26	0.26%	9.49%
L 2055	\$13.86	0.30%	11.70%
L 2060	\$13.86	0.30%	11.70%
L 2065	\$13.86	0.30%	11.69%

[TSP Data Center](#)

**“Rebuild Rehab”**

**Firefighter Safety Stand Down – Focus on Rehab**



June 20-26

Firefighting puts intense strain on firefighters, both physically and mentally. It is critical that firefighters receive a comprehensive rehab program after fire incidents.



The Safety Stand Down campaign encourages departments to suspend nonemergency activities for a week to conduct safety training focused on physical and psychological rehab, which are critical to mitigating the physiological and mental impacts of firefighting. Departments should revisit rehab procedures to ensure that post-incident protocol covers all areas of health and safety, including cardiac, nutrition, exposure, psychological, hydration and heat stress.

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**Learn More:** <https://www.safetystanddown.org/>

## Navy F&ES POCs

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## Navy Fire & Emergency Services (N30)

Commander, Navy Installations Command  
716 Sicard Street, SE, Suite 305  
Washington Navy Yard, DC 20374-5140

[http://www.cnic.navy.mil/om/operating\\_forces\\_support/fire\\_and\\_emergency\\_services.html](http://www.cnic.navy.mil/om/operating_forces_support/fire_and_emergency_services.html)

DSN 288

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Senior EMS Systems Specialist Gary Easley gary.easley@navy.mil 202-433-6517	Senior Fire Protection Specialist Dan Gaumont dan.gaumont@navy.mil 202-685-0882	Management & Program Analyst Derrick Coleman derrick.coleman@navy.mil 202-433-9084	
EMS Systems Specialist Adam Farb adam.farb@navy.mil 202-685-0712	Senior Fire Protection Specialist Eric Rhode eric.rhode@navy.mil 202-433-0256	Management & Program Analyst Valerie Douglas valerie.douglas@navy.mil 202-433-4782	
	Senior Fire Protection Specialist VACANT	Program Analyst VACANT	

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\* Denotes member of Navy F&ES Hall of Fame. If you know of someone we missed, please e-mail the editor.

## Navy F&ES Legacy

## Distribution

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To receive this newsletter automatically, e-mail [gene.rausch@navy.mil](mailto:gene.rausch@navy.mil) to be added to the *What's Happening* distribution list.



# HELP WANTED!

Navy civilian firefighters needed, visit [USAJobs.gov](http://USAJobs.gov) for details.  
Search for 0081-series

