

# LINE OF DUTY DEATH REPORT

REPORT F2025-07 • September 2025

## ***Volunteer Firefighter Dies and Second Injured in Privately Owned Vehicle Crash – Louisiana***

### **Executive Summary**

On July 15, 2025, a volunteer firefighter (Firefighter A) died, and another (Firefighter B) was injured during a single-vehicle crash while responding to a medical emergency. At approximately 03:35 hours, the parish public safety answering point (PSAP) received a 911 call from a motorist stopped on the side of the highway reporting trouble breathing and chest pains. Fire District 4 was dispatched for advanced life support (ALS) response. Upon activation of the pager for the dispatch, Firefighters A and B – who were married – responded in their privately owned vehicle (POV) from their home with Firefighter A driving. Dense fog and darkness created low visibility, which was compounded by rural roadway conditions that included loose surface material and no painted lines or reflectors. After traveling 0.9 miles, they approached a 90-degree righthand curve in the roadway. Firefighter A realized they had entered the curve before slowing down. Firefighter A engaged the brakes and directed the POV straight to avoid a rollover. The POV left the roadway, hit two trees, and came to a rest 97 ft from the edge of the roadway. The POV sustained severe damage (see **Photo 1**). Firefighter A was partially ejected and located by Firefighter B. She called 911 to report the crash, pulled him to a flat surface, and began cardiopulmonary resuscitation (CPR). Fire District 4 units arrived and provided medical treatment. With consultation from medical command at the local hospital, Firefighter A was pronounced deceased at the scene. Firefighter B was treated for minor injuries.



**Photo 1: POV post-incident.**  
*(Courtesy of the fire department)*

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### **Contributing Factors**

- *Weather/roadway conditions with low visibility*
- *Standard operating procedures (SOPs)*
- *Inattentive driving*
- *Self-dispatch*

### **Key Recommendations**

*Fire departments should:*

- *Ensure that initial and annual emergency vehicle operations training emphasize adjusting driving for weather and roadway conditions present.*
- *Enforce SOPs for driving and operating POVs that respond to an emergency.*
- *Ensure all firefighters are trained in and recognize the ways that physiological and psychological factors affect driving when responding to an emergency.*
- *Ensure all firefighters are trained on and aware of skill-based human performance mode errors.*
- *Ensure emergency response protocols include content that explicitly prohibits firefighters and resources from self-dispatching to an emergency scene unless formally requested.*

The National Institute for Occupational Safety and Health (NIOSH) initiated the Fire Fighter Fatality Investigation and Prevention Program to examine deaths of fire fighters in the line of duty so that fire departments, fire fighters, fire service organizations, safety experts and researchers could learn from these incidents. The primary goal of these investigations is for NIOSH to make recommendations to prevent similar occurrences. These NIOSH investigations are intended to reduce or prevent future firefighter deaths and are completely separate from the rulemaking, enforcement, and inspection activities of any other federal or state agency. Under its program, NIOSH investigators interview persons with knowledge of the incident and review available records to develop a description of the conditions and circumstances leading to the deaths in order to provide a context for the agency's recommendations. The NIOSH summary of these conditions and circumstances in its reports is not intended as a legal statement of facts. This summary, as well as the conclusions and recommendations made by NIOSH, should not be used for the purpose of litigation or the adjudication of any claim.

For further information, visit the program at [www.cdc.gov/niosh/firefighters/ffifpp/](http://www.cdc.gov/niosh/firefighters/ffifpp/) or call 1-800-CDC-INFO (1-800-232-4636).

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### **Introduction**

On July 15, 2025, a volunteer firefighter (Firefighter A) died, and another (Firefighter B) was injured. On July 21, 2025, the U.S. Fire Administration (USFA) notified the National Institute for Occupational Safety and Health (NIOSH) of this incident. On August 18, 2025, an investigator representing the NIOSH Fire Fighter Fatality Investigation and Prevention Program (FFFIPP) initiated an investigation into this incident. The NIOSH investigator conducted interviews with the fire chief. The investigator reviewed fire department SOPs, training records, witness statements, and the Louisiana State Police uniform crash report associated with the incident.

### **Fire Department**

The combination fire district in this incident has an 87 square mile jurisdiction, serves a population of 9000 residents, responds to an average of 415 calls annually, and provides emergency medical services (EMS) at the ALS level. The fire department operates four engines, one reserve engine, two service tenders, and four ALS medic units across four stations. The fire department includes 55 personnel, including 11 support staff, 29 pay-per-call volunteer firefighters, and two junior firefighters. A paid fire chief, part-time deputy chief, and a combination of part-time and volunteer station chiefs and captains oversee the fire district.

### **Training, Education, and Professional Development**

The fire department requires each new firefighter to attend a standardized firefighting certification training, which includes International Fire Services Accreditation Congress certification as NFPA 1072 Hazardous Materials Responder at the awareness level. Training classes are offered in-house and online. Additional advanced classes are available, and all members are encouraged to attend. Active members are required to attend 45 hours of annual training. Apparatus drivers are required to attend a 12-hour Emergency Vehicle Operator course (EVOC) refresher each year. POV drivers are required to attend a six-hour EVOC refresher and a POV refresher course every two years.

Firefighter A had six years of total fire service with the fire district and achieved all minimum standards required. He accumulated 586 hours of training in all areas of the fire service. He had a total of 105 hours of driver training, which included fire apparatus and POV courses. Both Firefighters A and B were CPR trained. Since they did not hold EMS certifications, they were restricted on which emergency medical calls they could respond to outside of cardiac arrest with CPR in progress.

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### Apparatus, Staffing, and Communications

At 03:36 hours, the following unit was dispatched for a medical emergency (not the current incident in this report) (see Table 1):

Table 1. Unit dispatched, staffing, and arrival on scene

Apparatus	Staffing	Arrival On-Scene
Medic 410	1	03:56

At 03:53 hours, the following units were dispatched for the current incident, a POV vehicle crash (see Table 2):

Table 2. Units dispatched, staffing, and arrival on scene

Apparatus	Staffing	Arrival On-Scene
Medic 403	1	04:05
Engine 411	1	04:08
Service 432 (tender)	1	04:13
Chief 402	1	04:28
Chief 401	2	04:45

The PSAP only dispatches for the fire service in the parish. All other calls for service are routed to the appropriate dispatch center, which includes two privately-owned EMS companies with their own dispatch centers. Law enforcement is provided by the parish Sheriff's Office for unincorporated areas and by the city police department inside the city limits. The Louisiana State Police cover the whole state, primarily as a traffic enforcement and investigation unit.

### Privately Owned Vehicle (POV)

The POV involved in the incident was a 2017 F-Series (150) crew-cab pickup truck (see **Photo 2**). The vehicle was equipped with emergency lighting which was in use at the time of the incident.



**Photo 2: POV pre-incident.**  
(Courtesy of the fire department)

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### **Weather Conditions**

At 03:53 hours, on July 15, 2025, the outdoor temperature was 80°F (26°C), dewpoint was 77°F (25°C), the wind was out of the ENE at 6 mph, humidity was 90% (there was no precipitation in the last 24 hours), and conditions were cloudy [Weather Underground 2025]. There was dense fog at the time of the incident. Fog is created when there is less than a 2.5°C difference between the temperature and the dew point in conjunction with a humidity near 100% [NWS n.d.]. The weather conditions were consistent with the likelihood of fog conditions being present.

### **Investigation**

At approximately 03:35 hours, the parish PSAP received a 911 call from a motorist stopped on the side of the highway reporting trouble breathing and chest pains. Fire District 4 was dispatched at 03:36 hours for ALS response, assigning Medic 410. Firefighter A and B – who were married – were asleep at their home and heard the dispatch via pager. The incident location was under two miles from their home. After waking, they listened to the radio traffic of responding units. They heard a parish sheriff notify the PSAP that he was on scene and CPR was in progress. Based on this radio transmission and incident proximity, they decided to respond without formal activation or update from the PSAP.

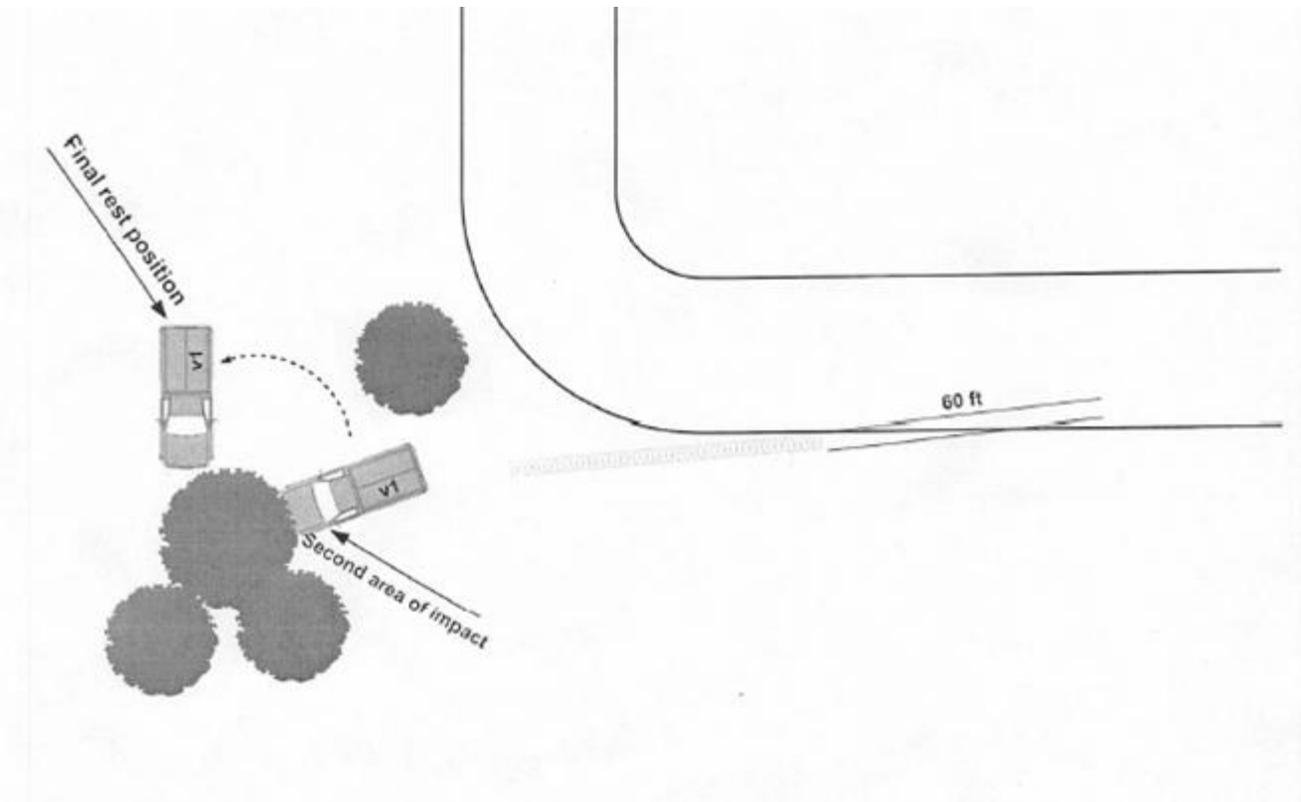
Firefighters A and B responded in their POV with Firefighter A driving. Firefighter B used her mobile phone application to read dispatch notes and send a notification that they were responding to the scene. Dense fog and darkness created low visibility, which was compounded by rural roadway conditions that included loose surface material and no painted lines or reflectors. After traveling 0.9 miles, they approached a 90-degree righthand curve in the roadway (**see Photo 3**). The posted speed limit on the roadway was 35 mph, changing to a posted speed limit of 15 mph to navigate the curve.



**Photo 3: Roadway approaching the righthand curve.**  
*(Courtesy of Google Maps)*

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Firefighter A realized they had entered the curve before slowing down and preparing to negotiate the turn. Firefighter A engaged the brakes and directed the POV straight to avoid a rollover. The POV left the roadway, striking one tree on the passenger side, approximately 69 ft from the edge of the roadway. The POV continued, striking a second tree on the driver's side and causing the POV to spin counterclockwise. It came to a rest 97 ft from the edge of the roadway. Braking created a 60 ft skid mark on the roadway (see **Diagram 1**).



**Diagram 1: Roadway approaching the righthand curve.**  
(Courtesy of the Louisiana State Police)

The POV sustained severe damage (see **Photo 4**). The impact with the second tree tore both driver's side doors off and caused the tree to fall onto the POV.

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Firefighter A was partially ejected from the POV (see **Photo 5**). Firefighter B was dazed by the impact and airbag deployment. Once she regained her senses, she called 911 to report the crash, which was received by the parish PSAP at 03:51 hours. She located Firefighter A, who was unresponsive and in cardiac arrest. Firefighter B pulled him from the vehicle to perform CPR. The parish PSAP dispatched Fire District 4 for a vehicle accident with injuries at 03:53 hours with Medic 403, Service 432, Chief 401, and Chief 402 responding. Upon arrival, Medic 403 provided care until the arrival of EMS. They called medical command at the local hospital for consultation. Based on relayed information, treatment was terminated. Firefighter A was pronounced deceased at the scene and transported by a funeral home. Firefighter B was treated for minor injuries.



**Photo 4: POV damage with second tree.**  
*(Courtesy of the fire department)*

### Contributing Factors

Occupational injuries and fatalities are often the result of one or more contributing factors or key events in a larger sequence of events that ultimately result in injuries or fatalities. The NIOSH investigator identified the following items as key contributing factors in this incident:

- Weather/roadway conditions with low visibility
- SOPs
- Inattentive driving
- Self-dispatch

### Cause of Crash

According to the Louisiana State Police uniform crash report, the cause of the crash was inattentive driving. The report noted that Firefighter A was partially ejected from the POV. It was unknown if Firefighter A was restrained at the time of the



**Photo 5: Final resting position of POV.**  
*(Courtesy of the fire department)*

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incident due to the severe vehicle damage. Firefighter B was properly restrained and received minor injuries. The report noted the presence of a 15 mph right turn diamond-shaped warning sign located approximately 0.1 mile from the crash scene. The uniform crash report did not include an estimation or calculation of speed for the POV.

### **Recommendations**

***Recommendation #1: Fire departments should ensure that initial and annual emergency vehicle operations training emphasize adjusting driving for weather and roadway conditions present.***

In this incident, the weather conditions included dense fog, and the roadway did not contain any painted markings or reflectors. This created low visibility for Firefighter A.

In 2022, vehicle crashes were the second leading cause of firefighter fatalities, with a total of 17 firefighters dying from crashes involving fire apparatus and POVs [USFA 2022]. Since 1998, NIOSH has investigated over 100 incidents of firefighter deaths and serious injuries involving vehicle crashes. NIOSH has suggested in many previous traumatic investigations that fire departments can implement a comprehensive driver training program to train firefighters on the safe operation of emergency vehicles, including POVs. Emergency vehicle operations training includes [IFSTA 2015; NFPA 1451 2018]:

- Lectures and hands-on skills assessments to introduce and reinforce competencies associated with emergency vehicle driving.
- Teaching proper driving techniques that include the mental and physical aspects of driving.
- Discussions to ensure firefighters are aware of the effects of adrenaline on driving when responding to an emergency.
- Understanding requirements for mandatory seat belt use.

NFPA 1451 [2018] encourages fire departments to provide their personnel, including junior firefighters, with training on unique hazards they may encounter when responding to calls for service in POVs or unconventional means of transportation. Fire departments can develop training from available resources or requisition existing training. Emergency vehicle operations trainings are available through fire academies and private fire training organizations. NFPA 1451 [2018] encourages fire departments to monitor the effectiveness of trainings in reducing vehicle crashes, as well as deaths and serious injuries. Fire departments can also develop SOPs using the information learned from training.

Specific to this incident, the state of Louisiana regards a POV belonging to members of an organized volunteer fire department or fire district as an “authorized emergency vehicle” when designated by the fire chief. This designation permits a driver of an authorized emergency vehicle to exercise certain privileges, such as exceeding the maximum speed limit or proceeding past a stop sign when responding to a call for service. These privileges do not relieve the driver from the duty to drive with proper consideration for the safety of all persons [Louisiana 2024a; Louisiana 2024b].

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***Recommendation #2: Fire departments should enforce SOPs for driving and operating POVs that respond to an emergency.***

In this incident, the fire district had SOPs that included driving and operating POVs that respond to an emergency.

Volunteer firefighters often use POVs for emergency scene response as a deployment model, either to the station or directly to the emergency scene. As a result, many incidents of volunteer firefighter driving deaths and serious injuries have involved POVs rather than fire department apparatus [IAFC and NVFC 2015; IFSTA 2015]. These incidents often involve driver error, excessive speed, lack of seat belt use, rollovers, inclement weather, and crashes at intersections [VFIS 2018]. NIOSH has investigated several firefighter fatalities involving POVs driven to an emergency. For each, investigation reports emphasized the benefits of fire departments developing and enforcing SOPs for the use of POVs to reduce injuries and fatalities [NIOSH 2000; NIOSH 2001; NIOSH 2002; NIOSH 2003; NIOSH 2004]. NFPA 1451 [2018] further encourages fire departments to establish written SOPs that address both emergency response and non-emergency activities related to driving and operating POVs. Aspects of safe vehicle operation and arrivals include [NIOSH 2004; IAFC and NVFC 2015; VFIS 2018]:

- Complying with all applicable state and local laws, such as a motor vehicle code.
- Considering use and exercise of special privileges, such as emergency lights and sirens.
- Driving at speeds appropriate for conditions, including inclement weather.
- Using seat belts for drivers and occupants.
- Staging assignments at an emergency scene.
- Performing [vehicle safety checks](#).
- Listing requirements for driver's training.

Fire departments may identify new SOP dissemination tactics to increase awareness and compliance. For example, they can review SOPs during initial orientation and include content in annual emergency vehicle operations training.

***Recommendation #3a: Fire departments should ensure all firefighters are trained in and recognize the ways that physiological and psychological factors affect driving when responding to an emergency.***

When driving to an emergency, firefighters are exposed to several risks before arriving on scene. Besides physical risks, such as collisions with other vehicles, firefighters may experience higher levels of psychological stress due to the pressure to respond quickly while driving to an unknown, potentially very dangerous situation. Some of these psychological impacts may be hard to self-detect due to the initial adrenaline rush of responding to an emergency.

An adrenaline rush is a surge of the hormone epinephrine into the bloodstream. As a biological defense mechanism, this allows individuals to actively respond to stress. This surge generally causes a faster or irregular heartbeat and feelings of overexcitement or anxiety which may cause atypical behaviors [Wong et al. 2008]. Driving with high epinephrine levels may cause individuals to take more risks or become

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more aggressive, which can result in careless or inattentive driving [USFA 2014; Hsiao et al. 2018]. Aggressive driving behaviors, such as speeding, have been observed in emergency vehicle drivers who were involved in vehicle crashes [Hsiao et al. 2018]. Specifically, inattention impacted the ability to recognize changes in roadway conditions or actions of other drivers, such as failing to yield. Inattention is often furthered when overconfidence is present in experienced emergency vehicle drivers [Hsiao et al. 2018].

***Recommendation #3b: Fire departments should ensure all firefighters are trained on and aware of skill-based human performance mode errors.***

Firefighter A was a commercial truck driver who drove regularly and received routine emergency vehicle operator training through the fire department for both fire apparatus and POV.

Skill-based human performance mode involves using highly practiced or routine actions, like driving, in familiar situations where there is little conscious monitoring. Experience, training, and practice contribute to this performance. Highly practiced or routine actions are less dependent on external conditions [NFPA 70E 2024]. When skills are learned or practiced to the point of being automatic, they can be performed “without thought” or allocation of attention resources. In a typical day, many actions are controlled in this unconscious manner [DOE 2009a].

Gaps in skill-based human performance mode can contribute to [NFPA 70E 2024]:

- **Inattention**: Primarily execution errors that involve oversights triggered by not recognizing changes in task requirements or related work conditions.
- **Perceived reduction in risk**: When familiarity with a task increases, the individual’s perception of associated risk is less likely to match the actual risk(s), creating inattentive blindness and insensitivity to the presence of hazards.

Individuals can be so focused on a skill-based task that important information in the workplace is not detected [DOE 2009a]. For example, driving was a highly practiced action for Firefighter A, both in emergency and non-emergency situations. When responding to the call on a roadway he drove often, he may have driven in an unconscious manner. This may have delayed identification of needed changes in task requirements and adjustments in speed to prepare for a turn until he was past the point of correction on the roadway. Firefighter B shared that “he did not realize he was already in the curve until it was too late” for corrective action.

Firefighters train and practice many fireground tasks in skill-based mode. As such, fire departments may develop training to ensure firefighters are aware of skill-based human performance mode errors, such as inattention. This training can include how to recognize errors and tools for helping firefighters maintain positive control of a work situation. Various tools, such as self-checking and maintaining a questioning attitude, attempt to improve an individual’s insightfulness and ability to detect unsafe conditions while performing in skill-based mode [DOE 2009b].

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***Recommendation #4: Fire departments should ensure emergency response protocols include content that explicitly prohibits firefighters and resources from self-dispatching to an emergency scene unless formally requested.***

Firefighters A and B were CPR-trained. Per the fire district's unwritten protocols, their training did not qualify them to respond to the initial dispatch for chest pain and difficulty breathing. Upon hearing a radio transmission that CPR was in progress along with the proximity of the incident, they decided to respond without formal activation or update from the PSAP.

Self-dispatching, or adding oneself to an emergency without formal request or authorization, undermines the integrity of established response protocols [Furey 2016]. Through pre-incident planning and community risk reduction, fire departments develop and establish specific protocols that dictate what resources will respond based upon emergency type and location. PSAPs use these established protocols to dispatch the appropriate resources upon receipt of emergency calls for service [IFSTA 2019; NFPA 1225 2022].

Self-dispatching can create additional safety issues at the emergency scene. In incidents like the one described in this report, where the PSAP and incident commander are unaware of the responding self-dispatching units, their involvement in a crash is not immediately recognizable as no one is expecting non-dispatched responders to show up at the scene. This can delay providing non-dispatched responders with assistance such as emergency medical care. Additionally, self-dispatching units may be unable to communicate with or receive updates from the PSAP or incident commander if non-dispatched responders do not have communications equipment such as portable radios. This can create confusion on arrival to the scene where the self-dispatching units are unaware of the incident action plan, assignments, or critical safety information [DHS 2002; Furey 2016].

Undermining the established response protocols can create significant safety issues at the emergency scene. Specifically, the uncoordinated and uncontrolled arrival of resources disrupts accountability and the overall incident management system. The incident commander managing the emergency may be unaware of the arrival of unrequested resources at the emergency scene. This creates a lack of accountability for personnel safety and freelancing, which potentially may interfere with assigned units performing work [DHS 2002; Furey 2016]. Additionally, the arrival of self-dispatching units may interfere with staging by blocking roadways or creating traffic jams that prevent dispatched firefighters operating at the scene from receiving the tools or equipment they need [IAFC 2002; NIOSH 2014]. The arrival of self-dispatching units can also present security concerns due to the appearance of unrecognized and non-credentialed POVs and individuals at the scene [DHS 2002].

Finally, self-dispatching may create liability or compensation (workers' compensation, collective bargaining agreements, and benefit laws) concerns for both the fire department and firefighters when there is a death or serious injury [Varone 2022]. Specifically, self-dispatching may raise concerns with applying liability or compensation since the firefighter was not formally requested or authorized to be engaged in response or "job-related" work. This includes the use of POV and the coverage of fire department or private insurance if there is a crash or other incident involving a firefighter in a POV [IAFC and NVFC 2015].

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### **Investigator Information**

This incident was investigated and the report was authored by Louis (Rick) Lago, Investigator, with the Fire Fighter Fatality Investigation and Prevention Program, Surveillance and Field Investigations Branch, Division of Safety Research, NIOSH located in Morgantown, WV. David Lewis, Maryland State Director, of the National Volunteer Fire Council provided an expert review of the investigation report. A subject matter expert review was provided by Jerome (Jerry) DiGennaro of the Pennsylvania State Fire Academy.

### **Additional Information**

#### **Volunteer Firemen’s Insurance Services (VFIS)**

VFIS provides resources and continuing education to fire department, EMS agencies, communications centers, and other emergency service organizations that meet their unique needs with safety-forward solutions. These resources and trainings can be accessed at <https://education.vfis.com/>.

#### **National Volunteer Fire Council (NVFC)**

The NVFC is the leading nonprofit membership association representing the interests of the volunteer fire, EMS, and rescue services. The NVFC serves as the voice of the volunteer in the national arena and provides critical resources, programs, education, and advocacy for first responders across the nation. Access resources and training relating to vehicle and roadway response from the NVFC and their partners at [www.nvfc.org/vehicle-response](http://www.nvfc.org/vehicle-response).

### **Disclaimer**

The information in this report is based upon dispatch records, audio recordings, witness statements, and other information that was made available to the National Institute for Occupational Safety and Health (NIOSH). Information gathered from witnesses may be affected by recall bias. The facts, contributing factors, and recommendations contained in this report are based on the totality of the information gathered during the investigation process. This report was prepared after the event occurred, includes information from appropriate subject matter experts, and is not intended to place blame on those involved in the incident. Mention of any company or product does not constitute endorsement by NIOSH, Centers for Disease Control and Prevention (CDC). In addition, citations to websites external to NIOSH do not constitute NIOSH endorsement of the sponsoring organizations or their programs or products. Furthermore, NIOSH is not responsible for the content of these websites. All web addresses referenced in this document were accessible as of the publication date.