

SUMMONS - CIVIL

JD-CV-1 Rev. 10-09
C.G.S. §§ 51-346, 51-347, 51-349, 51-350, 52-45a,
52-48, 52-259, P.B. Secs. 3-1 through 3-21, 8-1

STATE OF CONNECTICUT
SUPERIOR COURT

www.jud.ct.gov

See page 2 for instructions

TO: Any proper officer; BY AUTHORITY OF THE STATE OF CONNECTICUT, you are hereby commanded to make due and legal service of this Summons and attached Complaint.

- "X" if amount, legal interest or property in demand, not including interest and costs is less than \$2,500.
- "X" if amount, legal interest or property in demand, not including interest and costs is \$2,500 or more.
- "X" if claiming other relief in addition to or in lieu of money or damages.

Address of court clerk where writ and other papers shall be filed (Number, street, town and zip code) (C.G.S. §§ 51-346, 51-350)		Telephone number of clerk (with area code)	Return Date (Must be a Tuesday)
95 Washington Street, Hartford, CT, 06106		(860) 548-2700	December 22, 2015 <small>Month Day Year</small>
<input checked="" type="checkbox"/> Judicial District <input type="checkbox"/> Housing Session	<input type="checkbox"/> G.A. Number:	At (Town in which writ is returnable) (C.G.S. §§ 51-346, 51-349) Hartford	Case type code (See list on page 2) Major: T Minor: 90

For the Plaintiff(s) please enter the appearance of:

Name and address of attorney, law firm or plaintiff if self-represented (Number, street, town and zip code)		Juris number (to be entered by attorney only)
Paul Levin, Esq., Law Offices of Paul Levin, 40 Russ Street, Hartford, CT, 06106		400797
Telephone number (with area code)	Signature of Plaintiff (If self-represented)	
(860) 560-7226		

Number of Plaintiffs: 2 Number of Defendants: 4 Form JD-CV-2 attached for additional parties

Parties	Name (Last, First, Middle Initial) and Address of Each party (Number; Street; P.O. Box; Town; State; Zip; Country, if not USA)	
First Plaintiff	Name: Shawn Bell, Administrator for the Estate of Kevin Bell Address: 5 Andrew Lane, Windsor, CT 06095	P-01
Additional Plaintiff	Name: Wayatte Statham-Bell Address: 891 Garden Street, Hartford, CT 06112	P-02
First Defendant	Name: City of Hartford Address: c/o Hartford Town & City Clerk, 550 Main St., Suite 105, Hartford, CT 06103	D-50
Additional Defendant	Name: Carlos Huertas Address: 115 Montrose Street, Hartford, CT 06106	D-51
Additional Defendant	Name: James McLoughlin Address: 168 Windbrook Drive, Windsor, CT, 06095	D-52
Additional Defendant	Name: John Moree Address: 62 Montowese Street, Hartford, 06114	D-53

Notice to Each Defendant

- YOU ARE BEING SUED.** This paper is a Summons in a lawsuit. The complaint attached to these papers states the claims that each plaintiff is making against you in this lawsuit.
- To be notified of further proceedings, you or your attorney must file a form called an "Appearance" with the clerk of the above-named Court at the above Court address on or before the second day after the above Return Date. The Return Date is not a hearing date. You do not have to come to court on the Return Date unless you receive a separate notice telling you to come to court.
- If you or your attorney do not file a written "Appearance" form on time, a judgment may be entered against you by default. The "Appearance" form may be obtained at the Court address above or at www.jud.ct.gov under "Court Forms."
- If you believe that you have insurance that may cover the claim that is being made against you in this lawsuit, you should immediately contact your insurance representative. Other action you may have to take is described in the Connecticut Practice Book which may be found in a superior court law library or on-line at www.jud.ct.gov under "Court Rules."
- If you have questions about the Summons and Complaint, you should talk to an attorney quickly. The Clerk of Court is not allowed to give advice on legal questions.

Signed (Sign and "X" proper box)	<input checked="" type="checkbox"/> Commissioner of the Superior Court <input type="checkbox"/> Assistant Clerk	Name of Person Signing at Left Paul Levin	Date signed 11/12/2015
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If this Summons is signed by a Clerk: a. The signing has been done so that the Plaintiff(s) will not be denied access to the courts. b. It is the responsibility of the Plaintiff(s) to see that service is made in the manner provided by law. c. The Clerk is not permitted to give any legal advice in connection with any lawsuit. d. The Clerk signing this Summons at the request of the Plaintiff(s) is not responsible in any way for any errors or omissions in the Summons, any allegations contained in the Complaint, or the service of the Summons or Complaint.	<i>For Court Use Only</i>
	File Date

I certify I have read and understand the above:	Signed (Self-Represented Plaintiff)	Date
		11/12/2015

Name and address of person recognized to prosecute in the amount of \$250	
Jose Rojas, Esq., 40 Russ Street, Hartford, CT, 06106	

Signed (Official taking recognizance, "X" proper box)	<input checked="" type="checkbox"/> Commissioner of the Superior Court <input type="checkbox"/> Assistant Clerk	Date	Docket Number
		11/12/2015	

RETURN DATE: DECEMBER 22, 2015 : SUPERIOR COURT
SHAWN BELL, ADMINISTRATOR : J.D. OF HARTFORD
OF THE ESTATE OF KEVIN BELL :
v. : AT HARTFORD
CITY OF HARTFORD, ET AL. : NOVEMBER 12, 2015

COMPLAINT

General Allegations

1. The Plaintiff's Decedent, Kevin Bell, died intestate on October 7, 2014, a resident of the Town of Hartford, within the Hartford Probate District, and the Court appointed Shawn Bell as the administrator of the deceased's estate, and the Plaintiff is duly-qualified as such administrator and now acting as such.

2. The Defendant, City of Hartford, is a municipal corporation organized and existing under the laws of the State of Connecticut.

3. At all times relevant to this Complaint, the Defendant City of Hartford acted by and through its officials and employees, members of the Hartford Fire Department, including but not limited to the Defendants, Chief Carlos Huertas, Deputy Chief James McLaughlin, and Lieutenant John Moree.

4. At all relevant times hereto, it was the duty of the Defendant City of Hartford for the

administration, supervision, training and management of all Hartford Fire Department employees and firefighters, including Defendant Chief Carlos Huertas, Defendant Deputy Chief James McLaughlin, and Defendant Lieutenant John Moree.

5. At all relevant times hereto, it was the duty of the Defendant City of Hartford to be responsible for the training of Hartford Firefighters, including Defendant Chief Carlos Huertas, Defendant Deputy Chief James McLaughlin, and Defendant Lieutenant John Moree, on the policies and procedures of the Hartford Fire Department, including but not limited to: emergency “mayday” communications as promulgated in Department Directive No. 2.12, accounting for members, using the Self-Contained Breathing Apparatus (“SCBA”) in teams of two (2) or more as promulgated in Department Directive No. 2.43, responding to an emergency and/or hostile situation, supervision and/or command of scene as promulgated in Department Directive No. 2.25, proper tactics for fighting fire, daily testing of SCBA as promulgated in Department Directive No. 2.43, leaving emergency area with partner when the SCBA breathing alarm sounds as promulgated in Department Directive No. 2.43.

6. At all relevant time hereto, the Defendants Chief Carlos Huertas, Deputy Chief James McLaughlin and Lieutenant John Moree were agents, apparent agents, servants, and/or employees of the Defendant City of Hartford and were acting within the course and scope of their employment and/or agency and/or apparent agency with the Defendant City of Hartford.

7. On October 7, 2014, at approximately 6:38 PM, Engine Company 16 of the Hartford Fire Department responded to a fire at 598 Blue Hills Avenue, Hartford, Connecticut.

8. On said date and at said time and place, the Plaintiff's Decedent was a firefighter for Engine Company 16 and responded to the fire with other firefighters, more particularly, Defendants Lieutenant John Moree and Deputy Chief James McLaughlin.

9. On said date and at said time and place, Defendant Deputy Chief James McLaughlin was in charge and/or command of the scene.

10. On said date and at said time and place, Defendant Deputy Chief James McLaughlin ordered Engine Company 16 to fight the fire from the front of the house, and for Engine Company 14 to fight the fire from the rear pursuant to which Command the Plaintiff's Decedent was ordered to enter a burning and smoke filled building .

11. On said date and at said time and place, the Plaintiff's Decedent was equipped with his SCBA and breached the front door with Defendant Lieutenant John Moree. Thereafter, the Plaintiff's Decedent and Defendant Lieutenant John Moree entered the building and went upstairs in search for the fire.

12. On said date and at said time and place, the Plaintiff's Decedent's air pack alarm started

to go off, indicating that there was a shortage of air in the tank as reported after the fact by Defendant Lieutenant John Moree.

13. On said date and at said time and place, Defendant Lieutenant John Moree's air pack alarm also went off whereupon Defendant Lieutenant Moree exited the house without the Plaintiff's Decedent who was left behind in the same room where he and Defendant Lieutenant Moree had been paired together to ready a fire hose line for discharge.

14. On said date and at said time and place, Defendant Deputy Chief James McLaughlin was the commander of the scene per Connecticut General Statutes § 7-313e .

15. On said date and at said time and place, all firefighters at the scene were under the command, order, direction and/or instruction of Defendant Deputy Chief James McLaughlin.

16. On said date Hartford Fire Department policies required daily inspection of SCBA air packs used for survival in smoke filled environments which firefighters are commanded to enter and conduct their work.

17. On said date Hartford Fire Department policies required the prompt identification and pulling out of service and/or fixing of sub-optimal or defective equipment and air tanks that fire fighters rely on for survival in smoke filled environments which firefighters are commanded to enter and

conduct their work.

18. On said date, Hartford Fire Department policies in effect required regular face mask testing and refitting as necessary so that the SCBA air tank oxygen supply is optimally maintained as firefighters rely on same for survival when commanded to enter smoke filled environments.

19. On said date, the Hartford Fire Department, through those responsible members in command, knew that untested and/or poorly functioning oxygen tanks (air packs), sub-standard functioning of primary and secondary alarm low oxygen alert systems and ill-fitting face masks were life safety issues and the risk of injury to firefighters commanded to enter into a burning and smoke filled building with such issues present presented a substantial risk of injury or death in such circumstances.

20. On said date, the Hartford Fire Department, through those responsible members in command, knew that the Plaintiff's Decedent's engine company had such serious equipment function issues present as these conditions had been brought directly to the attention of Defendant Chief Huertas by Firefighter Nolan in the days prior to the fatal fire.

21. Firefighter Nolan's responsibilities included such manner of oversight and an email was dispatched to Defendant Chief Huertas, ostensibly intended to document his concerns. Notably, this was

outside the direct chain of command which suggests a high level of concern.

22. Notwithstanding the fact that remediation had not yet occurred, Plaintiff's Decedent and others in his engine company were commanded to enter into a burning smoke filled building without having the equipment checked, calibrated and validated for use beforehand.

23. Plaintiff's Decedent's low oxygen/passive secondary alarm system as tested by NIOSH after his death failed to meet the minimum standard for triggering its loud piercing alert sound and was significantly below the average range.

24. After Plaintiff's Decedent had entered the relatively small second floor room together with Defendant Lieutenant Moree, with whom he was paired on the fire hose line, Defendant Lieutenant Moree subsequently reported that he had lost track of Plaintiff's Decedent and was searching for him on his hands and knees but could not find him (or hear his alarm) and so left the building himself due to his tank's low oxygen level.

25. On said date, the Hartford Fire Department, through those responsible members in command, knew that poorly functioning radio equipment necessary to maintain critical communications between outside command and firefighters commanded to enter a building was necessary for survival and extraction in a live fire environment.

26. On said date, the Hartford Fire Department, through those responsible members in command, knew that the radio equipment which Plaintiff's Decedent and others in his company were issued were not adequate for maintaining critical radio transmissions, for summoning immediate help and status reports yet Plaintiff's Decedent and others were commanded to enter a burning and smoke filled environment with such poor equipment.

27. On said date, Defendant Lieutenant Moree called a "mayday" over an open transmission radio line and he subsequently reported that he had lost contact with Plaintiff's Decedent and could not locate him in the room. Defendant Lieutenant Moree's "mayday" call over the radio frequency they were using was evidently unacknowledged or ignored.

28. Notwithstanding Defendant Lieutenant Moree's "mayday" call more than eight minutes elapsed prior to a rescue team (Tactical Team) being dispatched by the scene commander into the building to search for Plaintiff's Decedent who had gone missing at the time of Defendant Lieutenant Moree's "mayday" call.

29. The Tactical Team readily located Plaintiff's Decedent once dispatched within approximately 30 seconds of elapsed time but Plaintiff's Decedent was already out of air and apparently in cardiac arrest when brought out of the building, thereafter attended to by EMTs and transported to the hospital where he was unable to be fully revived and pronounced dead.

30. On said date, Hartford Fire Department policies in effect required a minimum mandatory level of annual live fire and tactics training in order to assure that skill levels and decision making under the stress of an actual fire were demonstrably present.

31. On said date, the Hartford Fire Department, through those responsible members in command, knew that a lack of enforcing such levels of training represented a clear and present danger to all firefighters deployed and commanded to enter into active structural fires.

32. Prior to said date, the Hartford Fire Department union had repeatedly complained to the responsible members in command of the Hartford Fire Department that such live fire training was not being provided and that this presented a clear and present danger which should not be tolerated.

33. Prior to said date, the Hartford Fire Department's union President, Vincent Fusco had complained to responsible fire department members that during the 18 months immediately prior to Plaintiff's Decedent's death, though the Hartford Fire Department had allotted 16,000 hours for such essential life safety training, only 1,400 hours had actually been provided resulting in a serious shortfall of life safety training that would predictably lead to poor decision making under actual fire incident deployments.

34. On said date, the scene commander, Defendant Deputy Chief McLaughlin, had also not

received anything approaching the required recent live fire training and tactics instruction and did in consequence make a multiple number of serious command errors that contributed to chaotic behavior and decision making at the scene. Defendant Deputy Chief McLaughlin was responsible for the life and safety of subordinate fire fighters including Plaintiff's Decedent who he commanded to enter a burning and smoke filled building.

35. Upon information and belief, a member of the Tactical Team present and aware that Plaintiff's Decedent had been unaccounted for, had repeatedly requested permission from the scene commander, Defendant Deputy Chief McLaughlin, to enter the building to locate Plaintiff's Decedent leading to the squandering of precious minutes.

36. On said date and time, given the knowledge that he had already ordered the building's evacuation many minutes earlier, and the Plaintiff's Decedent was therefore left behind, Defendant Deputy Chief McLaughlin's delay in immediately sending in the Tactical Team, whose primary purpose for being on scene is precisely for such circumstances, can fairly be characterized as a conscious and intentional act which made injury or death substantially certain to occur.

37. On said date, after Defendant Lieutenant Moree reportedly lost track of Plaintiff's Decedent and was unable to locate him in the burning room on the second floor after calling a "mayday" alert that did not trigger the anticipated response for Tactical Team assistance, Defendant Lieutenant

Moree inexplicably failed to muster a prompt effort to alert fellow firefighters who had not responded to his “mayday” call in an effort to bring about the Plaintiff Decedent’s rescue.

38. On said date, under such circumstances, Defendant Lieutenant Moree’s behavior, if not actually intended to injure or kill the Plaintiff’s Decedent, may fairly be characterized as a conscious and intentional act which made injury or death substantially certain to occur.

39. The Plaintiff’s Decedent had reported to family members and fellow firefighters that some time prior to October 7, 2014 Defendant Lieutenant Moree had abandoned him in an active fire situation where they had been paired together on a fire hose line and he had confronted Defendant Lieutenant Moree about the inappropriateness of that behavior so personal animus towards Plaintiff’s Decedent or a deliberate effort to undertake the same behavior may have motivated Defendant Lieutenant Moree’s behavior at the scene of Plaintiff’s Decedent’s last firefighter effort.

40. Notice of Intent to sue was served upon the Clerk for the Town of Hartford on or about March 5, 2015 in accordance with CGS 7-465, CGS 52-557n, C.G.S 7-101a, without limitation.

**FIRST COUNT - WRONGFUL DEATH ACTION FOR INTENTIONALLY CREATING A
DANGEROUS CONDITION SUBSTANTIALLY CERTAIN TO CAUSE INJURY AS TO CITY
OF HARTFORD**

1-40. Paragraphs 1-40 of the General Allegations are hereby incorporated and hereby made Paragraphs 1-40 of this First Count as if fully set forth herein.

41. The Plaintiff, Shawn Bell, was appointed Administrator of the Estate of Kevin Bell by the Probate Court of Hartford, and acting as such Administrator brings this action for the death of Plaintiff's Decedent, Kevin Bell, pursuant to § 52-555 of the Connecticut General Statutes against the Defendant City of Hartford.

42. The death of Plaintiff's Decedent, Kevin Bell, was caused by the deliberate and/or conscious intent to create a dangerous condition substantially certain to inflict injury and/or death by the Defendant City of Hartford and/or its agents, apparent agents, servants, officers, and/or employees in one or more of the following ways, in that by:

- a) making a *conscious and deliberate decision* to not promptly service and/or fix defective equipment created a dangerous condition substantially certain to inflict

injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building utilizing such equipment (See Attachment A);

- b) making a *conscious and deliberate decision* to not administer testing and refitting of face mask created a dangerous condition substantially certain to inflict injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building utilizing such equipment (See Attachment A);
- c) making a *conscious and deliberate decision* to ignore notification that the calibration machine was inoperable and decided not to repair the calibration machine needed for the fit testing created a dangerous condition substantially certain to inflict injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building utilizing such equipment (See Attachment A);
- d) making a *conscious and deliberate decision* to not follow and/or abide by the rules, policies and procedures set forth and promulgated in the Hartford Fire Department Directives created a dangerous condition substantially certain to inflict injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building;
- e) making a *conscious and deliberate decision* to delay sending in the Tactical Team to retrieve the decedent given the knowledge of how long the decedent had been in the

building with a SCBA tank with little or no air level remaining created a dangerous condition substantially certain to inflict injury and/or death;

- f) making a *conscious and deliberate decision* to not provide adequate training on the Incident Command System, in violation of Hartford Fire Department Directive No. 2.25, created a dangerous condition substantially certain to inflict injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building without such training;
- g) making a *conscious and deliberate decision* to not provide adequate training in communicating an emergency “mayday” situation, in violation of Hartford Fire Department Directive No. 2.12, created a dangerous condition substantially certain to inflict injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building utilizing such equipment;
- h) making a *conscious and deliberate decision* to not provide training and enforcement on the requirement of remaining with designated partner when in utilization of a SCBA, in violation of Hartford Fire Department Directive No. 2.43, created a dangerous condition substantially certain to inflict injury and/or death;
- i) making a *conscious and deliberate decision* to not perform daily inspections, testing and/or assessments of SCBA, in violation of Hartford Fire Department Directive No.

2.43, created a dangerous condition substantially certain to inflict injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building;

- j) making a *conscious and deliberate decision* to not provide an Incident Safety Officer to the scene in violation of Hartford Fire Department Directive No. 2.26, created a dangerous condition substantially certain to inflict injury and/or death in the context of ordering firefighters to enter a burning, smoke filled building;
- k) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite direct knowledge that its employees, servants and/or agents, including the Plaintiff's Decedent, Kevin Bell, were utilizing inappropriate, improper, defective and unsafe SCBA's for the performance of their duties and responsibilities (See Attachment B [NIOSH]);
- l) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its direct knowledge that the mandatory daily inspections, assessment, and/or testing of SCBA were not performed (See Attachment C [Nolan email]);
- m) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its direct knowledge that all firefighters of Engine 16 needed life safety retraining in the context of ordering

engine 16 firefighters to enter a burning, smoke filled building when they lacked such life safety skills;

- n) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its knowledge that defective, inoperable, and/or faulty SCBA, would create a condition substantially certain to result in injury and/or death to its employees, including the Plaintiff's Decedent;
- o) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its knowledge that not performing daily inspections, assessments, and/or testing of SCBA would create a condition substantially certain to result in injury and/or death of its employees, including the Plaintiff's Decedent;
- p) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its knowledge that inadequate training, including but not limited to: fighting fires, leaving emergency area with partner when the SCBA breathing alarm sounds, "mayday" radio communications, having an Incident Safety Officer on scene, and the Incident Command System, would create a condition substantially certain to result in injury and/or death of its employees, including the Plaintiff's Decedent;

- q) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its knowledge that the scene commander had no scene command experience and no recent live fire command training necessary to safely direct and coordinate the activities on scene, making critical and time sensitive decisions involving life and death of the firefighters inside a burning smoke filled building;
- r) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its knowledge that the scene commander reportedly had a significant mental health condition which would logically interfere with the ability to reliably make life safety decisions under stress in a timely manner;
- s) making a *conscious and deliberate decision* to command the Plaintiff's Decedent to enter a burning and smoke filled building despite its knowledge that the radio communications equipment had been complained about and proved unreliable in transmitting and enabling critical transmissions to be clearly heard. in the context of ordering firefighters to enter a burning, smoke filled building utilizing such equipment;

- t) making a *conscious and deliberate decision* not to enforce hiring and supervision standards as respecting Defendants Lieutenant John Moree and Deputy Chief James McLaughlin in the context of the knowledge that the lives of other subordinate firefighters, including the Plaintiff's Decedent, would depend upon their actions for survival in the context of responding to structural fires within the City of Hartford.

43. Taking into account the totality of the conscious and deliberate decisions to allow an increasingly dangerous status quo and despite its knowledge of the risks involved the Defendant City of Hartford was aware that injury and/or death to its employees, including the Plaintiff's Decedent, were substantially certain to follow from its aforementioned conduct. As a result of the deliberate and/or consciously intended acts of misconduct of Defendant City of Hartford, the Plaintiff's Decedent suffered asphyxia that resulted in his untimely death.

44. The Defendant City of Hartford is vicariously liable for the actions and omissions of its scene commander, Defendant Deputy Chief McLaughlin, which were carried out in the course and scope of the scene commander's employment.

45. As a result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant City of Hartford, the Plaintiff's Decedent sustained a loss of earnings and the destruction of his earning capacity.

46. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant City of Hartford, the Plaintiff's Decedent incurred expenses for medical care and treatment, funeral and burial expenses.

47. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant City of Hartford, the Plaintiff's Decedent has been deprived of the ability to carry on and enjoy life's activities and pleasures.

48. The acts complained of were made by employees of the City of Hartford in the course and scope of their employment and the City is liable for same pursuant to Connecticut General Statute sections 52-557n., 7-465 and 7-101a.

49. Defendant Deputy Chief Commander James McClaughlin while acting as Incident Scene Commander and Defendant Hartford Fire Department Chief Carlos Huertas were of such a rank that

their actions may be deemed the alter ego of the Defendant City of Hartford in so far as the administration and activities of its Fire Department are concerned.

SECOND COUNT – LOSS OF CONSORTIUM AS TO DEFENDANT CITY OF HARTFORD

1-49. Paragraphs 1-49 of the First Count one are hereby incorporated and hereby made Paragraphs 1-49 of this Second Count as if fully set forth herein.

50. At all times relevant to the complaint, Plaintiff Wayatte Bell was the wife of Plaintiff's Decedent, Kevin Bell and resided with Plaintiff's Decedent until his death at the family home in Hartford, Connecticut.

51. As a proximate result of the willful and/or serious conduct of the Defendant City of Hartford, Plaintiff Wayatte Bell suffered the loss of the care, companionship, and consortium of her husband, Plaintiff's Decedent Kevin Bell, and will continue to suffer such losses and damages in the future.

THIRD COUNT - WRONGFUL DEATH ACTION FOR INTENTIONALLY CREATING A DANGEROUS CONDITION SUBSTANTIALLY CERTAIN TO CAUSE INJURY AS TO CHIEF CARLOS HUERTAS

1-49. Paragraphs 1-49 of the allegations in the First Count are hereby incorporated and hereby made Paragraphs 1-49 of this Third Count as if fully set forth herein.

50. The Plaintiff, Shawn Bell, was appointed Administrator of the Estate of Kevin Bell by the Probate Court of Hartford, and acting as such Administrator brings this action for the death of Plaintiff's Decedent, Kevin Bell pursuant to § 52-555 of the Connecticut General Statutes against the Defendant Chief Carlos Huertas.

51. The death of Plaintiff's Decedent was caused by the deliberate and/or conscious intent to create a dangerous condition substantially certain to inflict injury and/or death by the Defendant Chief Carlos Huertas and/or his agents, apparent agents, servants, officers, and/or employees in one or more of the following ways, in that by:

- a) making a *conscious decision* to not promptly service and/or fix defective equipment created a dangerous condition substantially certain to inflict injury and/or death (See Attachment A);
- b) making a *conscious decision* to not administer testing and refitting of face mask created a dangerous condition substantially certain to inflict injury and/or death (See Attachment A);

- c) making a *conscious decision* to ignore notification that the calibration machine was inoperable and decided not to repair the calibration machine needed for the fit testing created a dangerous condition substantially certain to inflict injury and/or death (See Attachment A);
- d) making a *conscious decision* to not follow and/or abide by the rules, policies and procedures set forth and promulgated in the Hartford Fire Department Directives created a dangerous condition substantially certain to inflict injury and/or death;
- e) making a *conscious decision* to not provide adequate training on the Incident Command System, in violation of Hartford Fire Department Directive No. 2.25, created a dangerous condition substantially certain to inflict injury and/or death;
- f) making a *conscious decision* to not provide adequate training in communicating an emergency “mayday” situation, in violation of Hartford Fire Department Directive No. 2.12, created a dangerous condition substantially certain to inflict injury and/or death;
- g) making a *conscious decision* to not provide adequate training on the requirement of remaining with designated partner when in utilization of a SCBA, in violation of Hartford Fire Department Directive No. 2.43, created a dangerous condition substantially certain to inflict injury and/or death.

52. Prior to and on October 7, 2014, the Defendant Chief Carlos Huertas had knowledge to a substantial certainty that the defective, inoperable, and/or faulty SCBA, would create a condition that could result in injury and/or death to his employees, including the Plaintiff's Decedent.

53. Prior to and on October 7, 2014, the Defendant Chief Carlos Huertas had knowledge to a substantial certainty that not performing daily inspections, assessments, and/or testing of SCBA would create a condition that could result in injury and/or death of his employees, including the Plaintiff's Decedent.

54. Prior to and on October 7, 2014, the Defendant Chief Carlos Huertas had knowledge to a substantial certainty that inadequate training, including but not limited to: fighting fires, leaving emergency area with partner when the SCBA breathing alarm sounds, "mayday" radio communications, having an Incident Safety Officer on scene, and the Incident Command System, would create a condition that could result in injury and/or death of his employees, including the Plaintiff's Decedent.

55. The Defendant Chief Carlos Huertas was aware that injury and/or death to his employees, including the Plaintiff's Decedent, were substantially certain to follow from his aforementioned conduct.

56. As a result of the deliberate and/or consciously intended acts of misconduct of Defendant Chief Carlos Huertas, the Plaintiff's Decedent suffered asphyxia that resulted in his untimely death.

57. As a result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Chief Carlos Huertas, the Plaintiff's Decedent sustained a loss of earnings and the destruction of his earning capacity.

58. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Chief Carlos Huertas, the Plaintiff's Decedent incurred expenses for medical care and treatment, funeral and burial expenses.

59. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Chief Carlos Huertas, the Plaintiff's Decedent has been deprived of the ability to carry on and enjoy life's activities and pleasures.

FOURTH COUNT – LOSS OF CONSORTIUM AS TO DEFENDANT CHIEF CARLOS HUERTAS

1-59. Paragraphs 1-59 of the Allegations of the Third Count are hereby incorporated and hereby made Paragraphs 1-59 of this Fourth Count as if fully set forth herein.

60. At all times relevant to the complaint, Plaintiff Wayatte Bell was the wife of Plaintiff's Decedent, Kevin Bell and resided with Plaintiff's Decedent until his death at the family home in Hartford, Connecticut.

61. As a proximate result of the misconduct of Defendant Chief Carlos Huertas, Plaintiff Wayatte Bell suffered the loss of the care, companionship, and consortium of her husband, Plaintiff's Decedent, Kevin Bell and will continue to suffer such losses and damages in the future.

FIFTH COUNT - WRONGFUL DEATH ACTION FOR INTENTIONALLY CREATING A DANGEROUS CONDITION SUBSTANTIALLY CERTAIN TO CAUSE INJURY AS TO DEFENDANT DEPUTY CHIEF JAMES MCLAUGHLIN

1-61. Paragraphs 1-61 of the Allegations of Count Four are hereby incorporated and hereby made Paragraphs 1-61 of this Fifth Count as if fully set forth herein.

62. The Plaintiff, Shawn Bell, was appointed Administrator of the Estate of Kevin Bell by the Probate Court of Hartford, and acting as such Administrator brings this action for the death of Plaintiff's Decedent, Kevin Bell pursuant to § 52-555 of the Connecticut General Statutes against the Defendant Deputy Chief James McLaughlin.

63. The death of Plaintiff's Decedent was caused by the deliberate and/or conscious intent to create a dangerous condition substantially certain to inflict injury and/or death by the Defendant Deputy Chief James McLaughlin and/or his agents, apparent agents, servants, officers, and/or employees in one or more of the following ways, in that by:

- a) making a *conscious and deliberate decision* to not follow and/or abide by the rules, policies and procedures set forth and promulgated in the Hartford Fire Department Directives created a dangerous condition substantially certain to inflict injury and/or death;
- b) making a *conscious and deliberate decision* to delay sending in the Tactical Team to retrieve the Plaintiff's Decedent even though it was known that Plaintiff's Decedent's air level was low or depleted and he had been left behind in the burning building for many minutes after he had ordered the building to be evacuated by all firefighters created a dangerous condition substantially certain to inflict injury and/or death;
- c) making a *conscious and deliberate decision* to not provide or obtain adequate training of the Incident Command System, in violation of Hartford Fire Department Directive No. 2.25, created a dangerous condition substantially certain to inflict injury and/or death in the event he was designated as incident commander and circumstances which he was unprepared for arose;

- d) making a *conscious and deliberate decision* to not provide adequate training in communicating, copying and responding to an emergency “mayday” situation, in violation of Hartford Fire Department Directive No. 2.12, created a dangerous condition substantially certain to inflict injury and/or death;
- e) making a *conscious and deliberate decision* to not provide adequate direction and/or instruction in combating a fire in a residential area created a dangerous condition substantially certain to inflict injury and/or death;
- f) making a *conscious and deliberate decision* to not provide adequate training and enforcement of the requirement of firefighters pairing up and remaining with their designated partner when in utilization of a SCBA, in violation of Hartford Fire Department Directive No. 2.43, created a dangerous condition substantially certain to inflict injury and/or death;
- g) making a *conscious and deliberate decision* to not perform daily inspections, testing and/or assessments of SCBA, in violation of Hartford Fire Department Directive No. 2.43, created a dangerous condition substantially certain to inflict injury and/or death;
- h) making a *conscious and deliberate decision* to not provide and/or disable the function of the Incident Safety Officer at the scene in violation of Hartford Fire Department

Directive No. 2.26, created a dangerous condition substantially certain to inflict injury and/or death;

- i) making a *conscious and deliberate decision* to not disclose to a more senior Hartford Fire Department member who arrived at the scene shortly after he assumed command that he did not have any incident command experience, had not had any recent live fire exercise leadership and command tactics training resulting in the non-assumption of such duties by the more senior and experienced member of the Hartford Fire Department which by Hartford Fire Department policies is what should have occurred in any event;
- j) making a *conscious and deliberate decision* to not disclose to his more senior Hartford Fire Department member who arrived on scene shortly after he assumed incident command that he had a mental health history which under stress might result in poor or delayed decision making impacting the safety of firefighters under his command.

64. Prior to and on October 7, 2014, the Defendant Deputy Chief James McLaughlin had knowledge to a substantial certainty that the defective, inoperable, and/or faulty SCBA, would create a condition that could result in injury and/or death to his employees, including the Plaintiff's Decedent.

65. Prior to and on October 7, 2014, the Defendant Deputy Chief James McLaughlin had knowledge to a substantial certainty that not performing daily inspections, assessments, and/or testing of SCBA would create a condition that could result in injury and/or death of his employees, including the Plaintiff's Decedent.

66. Prior to and on October 7, 2014, the Defendant Deputy Chief James McLaughlin had knowledge to a substantial certainty that inadequate training, including but not limited to: fighting fires, leaving emergency area with partner when the SCBA breathing alarm sounds, "mayday" radio communications, having an Incident Safety Officer on scene, and the Incident Command System, would create a condition that could result in injury and/or death of his employees, including the Plaintiff's Decedent.

67. The Defendant Deputy Chief James McLaughlin was aware that injury and/or death to his employees, including the Plaintiff's Decedent, were substantially certain to follow from his aforementioned conduct.

68. As a result of the deliberate and/or consciously intended acts of misconduct of Defendant Deputy Chief James McLaughlin, the Plaintiff's Decedent suffered asphyxia that resulted in his untimely death.

69. As a result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Deputy Chief James McLaughlin, the Plaintiff's Decedent sustained a loss of earnings and the destruction of his earning capacity.

70. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Deputy Chief James McLaughlin, the Plaintiff's Decedent incurred expenses for medical care and treatment, funeral and burial expenses.

71. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Deputy Chief James McLaughlin, the Plaintiff's Decedent has been deprived of the ability to carry on and enjoy life's activities and pleasures.

**SIXTH COUNT – LOSS OF CONSORTIUM AS TO DEFENDANT DEPUTY CHIEF JAMES
MCLAUGHLIN**

1-71. Paragraphs 1-71 of the Allegations of the Fifth Count are hereby incorporated and hereby made Paragraphs 1-71 of this Sixth Count as if fully set forth herein.

72. At all times relevant to the complaint, Plaintiff Wayatte Bell was the wife of Plaintiff's Decedent, Kevin Bell and resided with Plaintiff's Decedent until his death at the family home in Hartford, Connecticut.

73. As a proximate result of the misconduct of Defendant Deputy Chief James McLaughlin, Plaintiff Wayatte Bell suffered the loss of the care, companionship, and consortium of her husband, Plaintiff's Decedent, Kevin Bell and will continue to suffer such losses and damages in the future.

SEVENTH COUNT - WRONGFUL DEATH ACTION FOR INTENTIONALLY CREATING A DANGEROUS CONDITION SUBSTANTIALLY CERTAIN TO CAUSE INJURY AS TO DEFENDANT LIEUTENANT JOHN MOREE

1-40. Paragraphs 1-40 of the General Allegations are hereby incorporated and hereby made Paragraphs 1-40 of this Seventh Count as if fully set forth herein.

41. The Plaintiff, Shawn Bell, was appointed Administrator of the Estate of Kevin Bell by the Probate Court of Hartford, and acting as such Administrator brings this action for the death of Plaintiff's Decedent, Kevin Bell pursuant to § 52-555 of the Connecticut General Statutes against the Defendant Lieutenant John Moree.

42. The death of Plaintiff's Decedent was caused by the deliberate and/or conscious intent to create a dangerous condition substantially certain to inflict injury and/or death by the Defendant Lieutenant John Moree and/or his agents, apparent agents, servants, officers, and/or employees in one or more of the following ways, in that by:

- a) making a *conscious decision* to abandon his partner, Plaintiff's Decedent, while in the burning structure and make an inadequate effort to locate him before exiting the room;
- b) making a *conscious decision* to refrain from repeating his faintly transmitted "Mayday" call after not having his transmission acknowledged and instead leaving Plaintiff's Decedent inside the burning structure;
- c) making a *conscious decision* to delay communicating to the scene commander that he could not find Plaintiff's Decedent or notifying the Tactical Team or other nearby

firefighters immediately upon his exiting of the structure that the Plaintiff's Decedent was still inside and low on oxygen;

- d) making a *conscious decision* to not follow and/or abide by the rules, policies and procedures set forth and promulgated in the Hartford Fire Department Directives created a dangerous condition substantially certain to inflict injury and/or death;
- e) making a *conscious decision* to not effectively communicate an emergency "mayday" situation, in violation of Hartford Fire Department Directive No. 2.12, created a dangerous condition substantially certain to inflict injury and/or death;
- f) making a *conscious decision* to not remain with designated partner when in utilization of a SCBA, in violation of Hartford Fire Department Directive No. 2.43, created a dangerous condition substantially certain to inflict injury and/or death.

43. As a result of the deliberate and/or consciously intended acts of misconduct Defendant Lieutenant John Moree, the Plaintiff's Decedent suffered asphyxia leading to cardiac arrest that resulted in his untimely death.

44. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Lieutenant John Moree, the Plaintiff's Decedent sustained a loss of earnings and the destruction of his earning capacity.

45. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Lieutenant John Moree, the Plaintiff's Decedent incurred expenses for medical care and treatment, funeral and burial expenses.

46. As a further result of the aforesaid deliberate and/or consciously intended acts of misconduct of Defendant Lieutenant John Moree, the Plaintiff's Decedent has been deprived of the ability to carry on and enjoy life's activities and pleasures.

EIGHTH COUNT – LOSS OF CONSORTIUM AS TO DEFENDANT LIEUTENANT JOHN MOREE

1-46. Paragraphs 1-46 of the Allegations of the Seventh Count are hereby incorporated and hereby made Paragraphs 1-46 of this Eighth Count as if fully set forth herein.

47. At all times relevant to the complaint, Plaintiff Wayatte Bell was the wife of Plaintiff's Decedent, Kevin Bell and resided with Plaintiff's Decedent until his death at the family home in Hartford, Connecticut.

48. As a proximate result of the misconduct of Defendant Lieutenant John Moree, Plaintiff Wayatte Bell suffered the loss of the care, companionship, and consortium of her husband, Plaintiff's Decedent and will continue to suffer such losses and damages in the future.

NINTH COUNT – NEGLIGENCE AS TO CITY OF HARTFORD

1-40. Paragraphs 1-40 of the General Allegations are hereby incorporated and hereby made Paragraphs 1-40 of this Ninth Count as if fully set forth herein.

41. Well prior to the official release of the cause of death by the medical examiner's findings as to the Plaintiff Decedent's cause of death, toxicology results from Plaintiff's Decedent's blood were delivered to high ranking members of the Hartford Fire Department and based upon information and belief this included the Defendants Chief Carlos Huertas and scene commander Defendant Deputy Chief John McLaughlin. At or around this time, scandalous rumors began to circulate that the Plaintiff's Decedent had "cocaine in his blood" and "suffered a heart attack" with an implication that it was the Plaintiff Decedent's level of fitness for duty which contributed to his death.

42. Said rumors were of a nature and variety that they were partially based upon distorted private information shared with the Hartford Fire Department and either encouraged or allowed to circulate for many months prior to the release of official information.

43. Said rumors were circulated throughout the community, other fire house stations throughout the State of Connecticut and were heard by Plaintiff Decedent's family members including the Plaintiff Shawn Bell and the Plaintiff Wayatte Bell and were extremely hurtful and of course were untrue.

44. The responsible members of the Hartford Fire Department were also aware of same and who in the Hartford Fire Department were the sources of said scandalous rumors and yet no private or public effort to stop the defamatory information from continuing to circulate was undertaken.

45. In the meantime, the official Board of Inquiry that had been constituted in accordance with Hartford Fire Department policy to explore the circumstances leading to the death of a firefighter in the line of duty was upon information and belief deliberately denied information that had been requested by the Board of Inquiry and in fact advised to stand down but not "tell the public" that this was going to occur.

46. A member of the Board of Inquiry refused to obey what was viewed as an unlawful command and to mislead the public by participating in such a charade.

47. Instead of rapidly enabling the Board of Inquiry to fulfill its function, senior members of the Hartford Fire Department who knew that the Plaintiff's Decedent did not have cocaine in his blood system or suffer a heart attack due to his level of fitness chose to obstruct the investigation.

48. Both the encouragement and/or allowance of scandalous information concerning the death of a firefighter occurring from personal misbehavior and conditioning, the failure to take steps to address such hurtful information now circulating in the community and the decision to obstruct its own Board of Inquiry stem from high level Hartford Fire Department members in a position to act and yet failed to do so.

49. Both the encouragement and/or allowance of scandalous information concerning the death of a firefighter occurring from personal misbehavior and conditioning, the failure to take steps to address such hurtful information now circulating in the community and the decision to obstruct its own Board of Inquiry are consistent with the apparent goal of taking the focus off the embarrassing failures of command structure, equipment maintenance irregularities and the lack of State of Connecticut mandated training provided to their firefighters and instead allow the “blame” to impliedly fall upon the Plaintiff’s Decedent as per the scandalous rumors continuing to circulate.

50. The City of Hartford is liable for the acts and omissions of its Hartford Fire Department members who had a duty to secure private information about the Plaintiff Decedent’s toxicology and medical examiner findings communicated to them and failed to do so in a competent manner.

51. The City of Hartford is liable for the acts and omissions of its Hartford Fire Department members who had a duty to address and take actions to stop the scandalous rumors circulating based upon certain factual distortions of the Plaintiff Decedent’s toxicology and medical examiner findings communicated to them.

52. The City of Hartford is liable for the acts and omissions of its Hartford Fire Department members who had a duty not to allow and encourage the scandalous untrue information circulating both within and outside the department and the public domain based upon certain factual distortions of the Plaintiff Decedent's toxicology and medical examiner findings communicated to them.

53. The City of Hartford is liable for the acts and omissions of its Hartford Fire Department members who had a duty to not delay and obstruct the work of its own Board of Inquiry while at the same time taking active steps meant to deceive the public and instead allow the scandalous untrue information about the Plaintiff's Decedent to be the only information coming out of the Hartford Fire Department about the fateful events leading to the unnecessary death of one of its members.

54. The City of Hartford is liable for the acts and omissions of its Hartford Fire Department members who had a duty to have in place and/or observe communication and privacy policies about members of its department and the role that any personal conduct, blood chemistry or personal health /cause of death information.

55. The City of Hartford is liable to the wife of the Plaintiff's Decedent, Plaintiff Wayatte Bell, for the tremendous emotional and mental trauma that such has had on her, particularly when she had not yet had time to begin to complete the grieving process.

56. The City of Hartford is liable to the Estate of the Plaintiff Decedent for the trampling of his reputation and honor as a firefighter which cannot fully be recovered despite the Board of Inquiry and every other report thus far released many months after the fateful event directing all criticism on the

actions and failures of the Hartford Fire Department for the various reasons recounted within the body of this Complaint.

57. The responsible members of the Hartford Fire Department who committed these acts owed a duty to both individuals affected and the general public to not engage in that behavior.

58. The responsible members of the Hartford Fire department who committed these acts were violating ministerial duties to hold personnel related information, including medical information, from those without authorization to receive it.

59. The responsible members of the Hartford Fire department who committed these acts were committing what may be considered proprietary acts meant to help defend and/or shield their Department from Civil liability for the death of the Plaintiff's Decedent.

60. The actions and omissions complained of were made by employees of the City of Hartford in the course and scope of their employment and the City is liable for same pursuant to Connecticut General Statute sections 52-557n., 7-465 and 7-101a.

TENTH COUNT – DEFAMATION AS TO CITY OF HARTFORD

1-60. Paragraphs 1-60 of the Allegations of the Ninth Count are hereby incorporated and hereby made Paragraphs 1-60 of this Tenth Count as if fully set forth herein.

61. At all relevant time hereto, Defendant City of Hartford, through its agents and employees, knowingly made false statements to members of its own Hartford Fire Department who repeated them to

others outside the Hartford Fire Department stating that the Plaintiff's Decedent was under the influence of cocaine at the time of death and was physically unfit in some way relating to the health of his heart.

62. Said Medical Examiner Report details that cocaine was not in the Plaintiff's Decedent's system at the time of death and that the Plaintiff's Decedent died from asphyxia due to a lack of oxygen leading to cardiac arrest.

63. Said actions of Defendant City of Hartford constitutes Defamation of Character in that Defendant City of Hartford made statements which it knew to be false, malicious and injurious to the Plaintiff's Decedent's reputation.

64. Defendant City of Hartford published the aforementioned statements with actual malice in that neither (a) knew the statements were false, or (b) acted with reckless disregard for the truth of such statements.

65. Because of the publication of such statements, as previously set forth, the Plaintiff's Decedent has suffered injuries and damages.

66. Because of the publication of such statements, as previously set forth, the Plaintiff Wayatte Bell has been defamed as the memory of her late husband in the community is intricately bound up with her own.

ELEVENTH COUNT – FALSE LIGHT AS TO DEFENDANT CITY OF HARTFORD

1-66. Paragraphs 1-66 of the Tenth Count are hereby incorporated and hereby made Paragraphs 1-66 of this Eleventh Count as if fully set forth herein.

67. Said statements are highly offensive to a reasonable person.

68. The Defendant City of Hartford knew or should have known, or acted in reckless disregard, as to the falsity of the publicized statements and the false light in which the Plaintiff's Decedent would be placed.

69. Because of the publication of such statements, as previously set forth, the Plaintiff's Decedent has suffered injuries and damages

70. Because of the publication of such statements, as previously set forth, the Plaintiff Wayatte Bell has suffered injuries and damages.

TWELTH COUNT – NEGLIGENT INFLECTION OF EMOTIONAL DISTRESS AS TO DEFENDANT CITY OF HARTFORD

1-70. Paragraphs 1-70 of the Eleventh Count are hereby incorporated and hereby made Paragraphs 1-70 of this Twelfth Count as if fully set forth herein.

71. The Defendant City of Hartford engaged in conduct that it should have realized involved an unreasonable risk of causing emotional distress and that distress, if it were caused, might result in illness or bodily injury.

72. Said conduct caused emotional distress to the Plaintiff Wayette Bell.

THIRTEENTH COUNT – BREACH OF FIDUCIARY DUTY AS TO DEFENDANT CITY OF HARTFORD

1-70. Paragraphs 1-70 of the Eleventh Count are hereby incorporated and hereby made Paragraphs 1-70 of this Thirteenth Count as if fully set forth herein.

71. In regards to the reputational interests of the Plaintiff's Decedent concerning his conduct, fitness for duty and cause of death in the line of duty the Defendant City of Hartford was in a position of a unique degree of trust and confidence to a level of duty which Connecticut law should recognize as a fiduciary.

72. The Plaintiff's Decedent was unable to protect his own reputational interests and the Defendant City of Hartford had a high degree of control over the subject matter complained of.

73. Members of the Hartford Fire Department such as the Plaintiff's Decedent reasonably expect that should their death occur in the line of duty that the Defendant City of Hartford would administer its policies and behavior in a manner reflecting the superior knowledge, skill and expertise that commanding officers and members involved in the post event inquiry and communications about same would possess and exercise on behalf of a fallen member of the Hartford Fire Department who entrusted his personal safety and professional reputation as a firefighter to the Defendant City of Hartford.

74. For the afore referenced reasons the conduct of the Defendant City of Hartford, through its responsible members has breached the fiduciary duty which was owed to the Plaintiff's Decedent and the Plaintiff's Decedent has suffered damages.

FOURTEENTH COUNT – INDEMNIFICATION - CITY OF HARTFORD

1-49. Paragraphs 1-49 of the First Count are hereby incorporated and hereby made Paragraphs 1-49 of this Fourteenth Count as if fully set forth herein.

50-51. Paragraphs 48-49 of the Second Count are hereby incorporated and hereby made Paragraphs 50-51 of this Fourteenth Count as if fully set forth herein.

52-110. Paragraphs 1-59 of the Third Count are hereby incorporated and hereby made Paragraphs 52-110 of this Fourteenth Count as if fully set forth herein.

111-178. Paragraphs 1-69 of the Fifth Count are hereby incorporated and hereby made Paragraphs 111- 178 of this Fourteenth Count as if fully set forth herein.

179-180. Paragraphs 58-59 of the Sixth Count are hereby made Paragraphs 179-180 of this Fourteenth Count.

181-226. Paragraphs 1-46 of the Seventh Count are hereby made paragraphs 181-226 of this Fourteenth Count.

227-228. Paragraphs 47-48 of the Eighth Count are hereby made Paragraphs 227-228 of this Fourteenth Count.

229. The Plaintiff's injuries and damages were the direct and proximate result of the acts and deliberate failures to act, by their officers, agent and employees, acting within the course and scope of their official duties and the City of Hartford owes a duty to indemnify them pursuant to Connecticut General Statutes Section 7-101a and 7-465.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiffs prays for the following relief:

1. Money damages.
2. Punitive damages relative to Counts One, Two, Seven, Eight, Nine and Thirteen including attorney's fees, cost and interest.
3. Such other relief as to law or equity pertain.

PLAINTIFFS,

By 

Paul S. Levin, Esq.
Law Offices of Paul S. Levin
40 Russ Street
Hartford, CT 06106
Tel. (860) 560-7226
Juris No. 400797

By 

Jeff Ment, Esq.
Rome McGuigan P.C.
One State Street
Hartford, CT 06103
Tel. (860) 493-3522
Juris No. 027726

STATEMENT OF AMOUNT IN DEMAND

The amount in demand, exclusive of interest and costs, exceeds the sum of Fifteen Thousand (\$15,000.00) Dollars.

PLAINTIFFS,

By 

Paul S. Levin, Esq.
Law Offices of Paul S. Levin
40 Russ Street
Hartford, CT 06106
Tel. (860) 560-7226
Juris No. 400797

By 

Jeff Ment, Esq.
Rome McGuigan P.C.
One State Street
Hartford, CT 06103
Tel. (860) 493-3522
Juris No. 027726

EXHIBIT A

From: msmith@hartford.gov
Sent: Monday, March 16, 2015 2:47 PM
To: FierR001@hartford.gov
Subject: Fwd:

Sent from my iPhone

Begin forwarded message:

From: "Madden, Daniel J." <MADDD001@hartford.gov>
Date: March 16, 2015 at 2:03:39 PM EDT
To: "Smith, Michael E." <msmith@hartford.gov>

This email is in response to your comments you made to me on 3/11/2015 in the lunch room at 12:50 in the afternoon.

1- You asked why you did not receive an email why that the fit testing machine is broken.
 - Last summer the wick that is soaked in alcohol became detached from the holder and has to be taken out manually to be stored rather than with the attached handle. The unit is still functional but Steve did contact the company and they said they do not have parts available any longer and were unsure if they would be able to repair until looked at. The annual calibration was coming up soon. They sent us a notice for a discount if we upgraded to a new unit.

2- you asked why we haven't been doing fit testing.
 In the fall when we were try to get ready to start fit testing we did not have enough spare mask to handle anticipated replacements due to lack of parts. 10/2/2014 You had also stated when confronted about parts that we were going to getting all new AV3000 face masks and that everyone would need to be redone anyway and to hold off.

3- You stated that Steves daily log hasn't been done and implied that he hasn't been doing anything.

- Steve has been writing down his daily log and entering in computer as time permits. You came to me in January with the concern that he hasn't been entering them in Firehouse and I immediately went to him and requested that he start filling out current week and working backwards in the Firehouse database in an effort to keep up to date.

4- You stated that if Steve hasn't been doing fit test and air pack repairs, the threat was made that the Scott room would be closed down and repairs and fit testing would be contracted to Shipmans Fire Equipment. Steve would then be put back on the shop floor doing maintenance as the other mechanics.

- Steve has been performing repairs to air packs and masks as needed and performing repairs and road work at fire houses at my direction. He also performs repairs to apparatus as needed when company's stop at shop with inquiries. Steve has been keeping air packs functional by borrowing parts from out of service packs and and spare air packs.
 Steve had requested \$40,000 for air pack and mask parts in July, in October the department received a \$900,000 grant for breathing apparatus. Steve then asked if we could get around \$5000 to make needed repairs for time being and again on 2-2-2015 you were asked for minimum amount.

There has been a total lack of communication between you and Steve in regards to Scott room needs especially in light of last October's events. When there is no communication with one or more members of this division and you spend large amounts of time with other division members working with them is viewed as work place harassment and intimidation by the training classes we all took from city attorneys on City of Hartford personal policies

There are other issues that we have been waiting to be addressed. The NIOSH report that came out citing bottle hydrotesting and service life. Steve has been warning of the amount of bottles coming out of service for many years with you and with past Assistant Chiefs Milner, Freeman, and Acting assistants Shapiro and Waller. Steve has also tried to establish a minimum needed amount of bottles for the Hartford Fire Dept. and has tried to work with you and Health and safety to determine that number. We have not seen an agreement to this and Steve has determined that 412 fills all the spots we currently have. We currently have an unacceptable number now that need to be removed from service per manufacturer recommendations. I am fully aware that it is extremely difficult to rectify this due to budgetary matters and political budget cuts. We are currently trying to keep past due bottles out of normal circulation and reserve for drastic situations.

On 3/9/2015 Department Directive # DD 2.221 came out in regards to apparatus checks and procedures. Upon my return to work on 3/10/2015 nothing was said in regards to that coming out and you seemed to distance yourself from me in a more than usual fashion as well as the outburst on 3/11/2015 in front of all EMD members. I then learned on 3/15/2015 that PO Gauvreau had sent a letter to Chief Huertas requesting that the department look into updating its daily apparatus drivers check list to one that I had suggested to him. I did NOT condone this, it was offered to him to look up on his own from the Connecticut Fire Equipment Mechanics Association and use at his discretion to help him with own daily checks. I also told him he had to continue with the current drivers checklist and not bypass it. This check list that he obtained was with the house captains permission and help in an effort to have better communication between drivers and officers and better accountability of truck and equipment.

There have been multiple requests to me over the last year about carwash slips and apparently there have been multiple changes that I was never informed of. The only time you talked to me of the issue was when we were changing from using slips to the facility having a list of approved users. I have received several requests for slips as of late and am unaware of what our policy is.

This budget year it appears to me that we have reached an epidemic amount of vendors that have been calling on us about past due invoices and putting us on COD, these include NAPA, Fleetpride GCR Firestone tire and Shipmans Fire Equipment. Chips auto electric and International Radiator have also only allowed us to pick up repairs after they have been paid for and not allowing us to put on account. Again I understand that we have put under budget restraints and I am trying to work within means.

There is also the matter of Ladder 6 aerial test that sat out of service for 3+ months without appointment due to 3 past due invoices. I had tried to schedule a testing date before we took it apart and you then told me I'll take care of it. It has become a running joke among the shop members "I'll Take Care Of It" these include Scott parts, snowblower parts and car parts that we need to use P-card for. (ie a vacuum solenoid for Dist 2 car on 1/6/2015 that Dave worked on, Ariens snow blower bearing for Lloyd)

On March 26 2014 Ladder 4, car 40 came in for fuel leak and it was determined excessive rusting has led to leak and the possibility that there may be a crack under the weld as advised by John Taylor from Sutphen that the Fuel Beam should be replaced and he then put together a parts quote for us that I handed to you. I have asked for status updates on in the past but not as of lately.

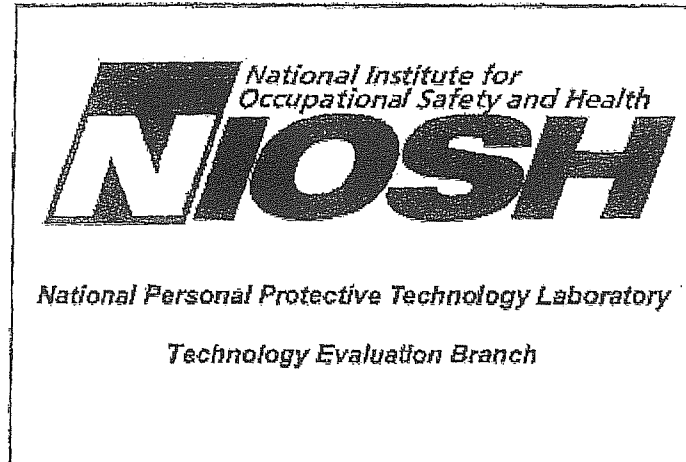
This letter is in response to asking why you were not notified by email about fit testing machine being broken, so I felt compelled to notify you of these others issues that are of equal importance to the operation of this division.

Respecttily,

Dan Madden
Supervisor Hartford Fire Dept. EMD
38 Jennings rd
Hartford Ct. 06120
Office 860-757-4592
Cell 860-761-4280
Fax 860-722-8224

wearethepopleofhartford.com

EXHIBIT B



Status Investigation Report of Two
Self-Contained Breathing Apparatus
Submitted by the
NIOSH Division of Safety Research for the Hartford
Connecticut Fire Department
Hartford, CT

NIOSH Task Number 19908

December 4, 2014

Disclaimer

The purpose of Respirator Status Investigations is to determine the conformance of each respirator to the NIOSH approval requirements found in Title 42, *Code of Federal Regulations*, Part 84. A number of performance tests are selected from the complete list of Part 84 requirements and each respirator is tested in its "as received" condition to determine its conformance to those performance requirements. Each respirator is also inspected to determine its conformance to the quality assurance documentation on file at NIOSH.

In order to gain additional information about its overall performance, each respirator may also be subjected to other recognized test parameters, such as National Fire Protection Association (NFPA) consensus standards. While the test results give an indication of the respirator's conformance to the NFPA approval requirements, NIOSH does not actively correlate the test results from its NFPA test equipment with those of certification organizations which list NFPA-compliant products. Thus, the NFPA test results are provided for information purposes only.

Selected tests are conducted only after it has been determined that each respirator is in a condition that is safe to be pressurized, handled, and tested. Respirators whose condition has deteriorated to the point where the health and safety of NIOSH personnel and/or property is at risk will not be tested.

Investigator Information

The SCBA performance tests were conducted by Mike Commodore, Engineering Technician, and Jay Parker, Acting Laboratory Manager. The SCBA inspections were performed and this report was written by Jay Tarley, Physical Scientist. The investigators are part of the Policy and Standards Development branch, National Personal Protective Technology Laboratory, National Institute for Occupational Safety and Health, located in Bruceston, Pennsylvania.

**Status Investigation Report of a
Self-Contained Breathing Apparatus
Submitted By the
NIOSH Division of Safety Research for the Hartford, Connecticut Fire
Department**

NIOSH Task Number 19908

Background

As part of the *National Institute for Occupational Safety and Health (NIOSH) Fire Fighter Fatality Investigation and Prevention Program*, the National Personal Protective Technology Laboratory (NPPTL) agreed to examine and evaluate two SCBA units identified as Scott Health and Safety model AirPak 4.5, 4500 psi, 30-minute, self-contained breathing apparatus (SCBA).

This SCBA status investigation was assigned NIOSH Task Number 19908. The NIOSH Division of Safety Research (NIOSH/DSR) and the Hartford Fire Department were advised that NIOSH NPPTL would provide a written report of the inspections and any applicable test results.

The SCBA units, contained within a plastic shipping container, were delivered to the NIOSH facility in Morgantown, WV on October, 28, 2014. The units were taken to the lower floor of lab room 1513 for secured storage. The SCBA units were then transported to Pittsburgh for inspection on November 18, 2014 and were taken to building 20 and stored under lock until the time of the evaluations on November 21, 2014.

SCBA Inspection

Both units were initially removed from their packaging in the Communications Classroom, Room 116 (Building 40) and inspected on November 18, 2014 by Tom Pouchot, General Engineer, and Jay Tarley, Physical Scientist, NPPTL. The two SCBAs were identified as the Hartford Fire Department SCBA Unit #1 and Unit #2. These SCBA units were extensively examined, component by component, in the condition received to determine the conformance of each unit to the NIOSH-approved configuration. The units were identified as the Scott Health and Safety Company model AirPak 4.5, 30 minute, 4500 psi units, NIOSH approval numbers TC-13F-0076 and TC-13F-0076CBRN. The visual inspection process was documented photographically.

Also on November 25, 2014 the SCBA data logger was downloaded by personnel from Scott Health and Safety with NIOSH personnel present. Once all the inspections were completed the SCBA unit was repackaged and placed back in building 20 under lock.

The complete SCBA inspection is summarized in Appendix I. The condition of each major component of the SCBA that were photographed with a digital camera is contained in Appendix III.

NIOSH/DSR for Hartford, Connecticut Fire Department – Status Investigation Report – Page 2

It was judged that both SCBA units could not be safely pressurized and tested in the condition received. The fire department supplied new air cylinders and a facepiece for the evaluation. Unit #1 and Unit #2 were tested on November 21, 2014 with two representatives from the Hartford Fire Department and a representative from NIOSH/DSR present.

SCBA Testing

The purpose of the testing was to determine the conformance of each SCBA to the approval performance requirements of Title 42, *Code of Federal Regulations*, Part 84 (42 CFR 84). Further testing was conducted to provide an indication of the conformance of each SCBA to the National Fire Protection Association (NFPA) Air Flow Performance requirements of NFPA 1981, *Standard on Open-Circuit Self-Contained Breathing Apparatus for the Fire Service*, 1997 Edition.

NIOSH SCBA Certification Tests (in accordance with the performance requirements of 42 CFR 84):

1. Positive Pressure Test [§ 84.70(a)(2)(ii)]
2. Rated Service Time Test (duration) [§ 84.95]
3. Static Pressure Test [§ 84.91(d)]
4. Gas Flow Test [§ 84.93]
5. Exhalation Resistance Test [§ 84.91(c)]
6. Remaining Service Life Indicator Test (low-air alarm) [§ 84.83(f)]

National Fire Protection Association (NFPA) Tests (in accordance with NFPA 1981, 1997 Edition):

7. Air Flow Performance Test [Chapter 5, 5-1.1]

Unit #1 and Unit #2 both needed a replacement air cylinder and facepiece to be tested. These units were tested on November 21, 2014. A representative of the Hartford Fire Department and NIOSH/DSR were present for all the testing.

Appendix II contains the complete NIOSH test report for the SCBA. **Tables ONE, TWO, THREE and FOUR** summarize the NIOSH and NFPA test results.

Summary and Conclusions

Two SCBA units were submitted to NIOSH/NPPTL by the NIOSH/DSR for the Hartford Connecticut Fire Department for evaluation. The SCBA units were delivered to NIOSH on October 28, 2014 and extensively inspected on November, 18, 2014. Both units were identified as a Scott Health and Safety model AirPak 4.5, 4500 psi, 30-minute, SCBA (NIOSH approval numbers, TC-13F-0076, Unit #1 and TC-13F-0076CBRN, Unit #2). Scott Health and Safety performed a downloading of the Unit #2 data logger on November 25, 2014. The units suffered very slight amounts of damage but exhibited other signs of wear and tear and the units were slightly covered with general dirt. The cylinder valves, as received, on Unit #1 and Unit #2 were in the closed position. The cylinder gauges showed no pressure. The cylinder valve hand-wheels

could be turned on both units. The regulator and facepiece mating and sealing area on both units were relatively clean. The units had only slight scratches on the lenses. Visibility through the facepiece lenses of Units #1 and #2 were good to fair with the lenses having slight scratches. The facepiece head harness webbing on both units were in fair condition and were slightly dirty with some fraying at the connection points. The NFPA approval label on Unit #1 and Unit #2 were present and readable after some dirt was wiped away. The personal alert safety system (PASS) on both units functioned.

The air cylinder on the Unit #1 had a manufactured date of 01/04. Under the applicable DOT exemption, the air cylinder is required to be hydro tested every 5 years. For the air cylinder on Unit #1, a retest date before the last day of 01/09 is required. The retest label was readable on Unit #1 with a retest date of 4/13; therefore, the cylinder was within the hydro certification when last used. The cylinder on Unit #1 was in fair to good condition with surface scratches and gouge repairs present on the outer coating. There was no air remaining in the cylinder. Although the cylinder was within the hydro testing requirements, it was determined that it may not be safe to pressurize. Another cylinder and facepiece was requested from the Hartford fire department. The SCBA Unit #1 was tested as it was received as no other maintenance or repair work was performed on the unit at any time.

The air cylinder on the Unit #2 had a manufactured date of 01/04. Under the applicable DOT exemption, the air cylinder is required to be hydro tested every 5 years. For the air cylinder on Unit #2, a retest date before the last day of 01/09 is required. The retest label was not present on Unit #2 and could not be pressurized safely. The cylinder on Unit #2 was in fair to good condition with surface scratches and gouge repairs present on the outer coating. There was no air remaining in the cylinder. Another cylinder and facepiece was requested from the Hartford fire department. The SCBA Unit #2 was tested as it was received as no other maintenance or repair work was performed on the unit at any time.

SCBA Unit #1 did meet the requirements of the NIOSH Positive Pressure Test, as the unit did maintain a positive pressure for the 30 minute minimum duration of the unit. Unit #1 failed the remaining service life indicator test. The secondary bell failed to operate within the parameters. The unit passed all of the other NIOSH tests.

SCBA Unit #2 did not meet the requirements of the NIOSH Positive Pressure Test, as the unit did not maintain positive pressure throughout the 30 minute minimum duration of the unit. The unit passed all of the other NIOSH tests.

In light of the information obtained during this investigation, NIOSH has proposed no further action on its part at this time. The SCBA units were returned to storage pending return to the Hartford, Connecticut Fire Department.

If these units are to be placed back in service, the SCBAs must be repaired, tested, cleaned and any damaged components replaced and inspected by a qualified service technician, including such testing and other maintenance activities as prescribed by the schedule from the SCBA manufacturer. Typically a flow test is required on at least an annual basis.

Appendix I

SCBA Inspection Report



National Personal Protective Technology Laboratory / Policy and Standards Development Branch

Respirator Field Problem
Incoming Inspection Report Summary – Unit #1

Task Number: TN-19908	Requestor: NIOSH/DSR for the Hartford Fire Department
Date Received: October 28, 2014	
Date Inspected: November 18, 2014	Description: Fatality
Manufacturer: Scott Health and Safety	Inspected by: Tom Pouchot, Jay Tarley
Approval Number: TC-13F-076	SCBA Type: Open Circuit, Pressure-Demand

The SCBA was received in a plastic shipping box (refer to Figures 1 – 3 in Appendix III). A shipping label was the only markings on the outside of the shipping box. The SCBA was placed inside a paper bag located inside the box.

Contact Agency: NIOSH/DSR for the Hartford, Connecticut Fire Department.

As received:

- Cylinder Gauge no pressure showing
- By-Pass in the half-way position
- Donning Switch Off, Regulator Active
- Mask mounter regulator (MMR) locked into Facepiece
- Cylinder Valve closed, no air remaining in cylinder

Components and Observations – Unit #1

NOTE: All references to "right" or "left" are from the user's perspective.

I. Facepiece (Refer to Figures 4 - 9 in Appendix III):

Facepiece assembly; P/N None Large Model: AV2000 Lot: unknown
 Facepiece Seal P/N: 10009779
 MFG date: 4th quarter 2004
 Nosecup P/N: 31001256 MFG Date: 2nd quarter 1998 Other markings: unknown
 Head Harness: 804177-01 replaces 802240-01

- Overall condition is fair
- Lot number label present.
- Lens is good with some slight scratches present, the visibility is fair.

NIOSH/DSR for the Hartford, CT Fire Department -- SCBA Inspection Report -- Page 1

- Hairnet dirty.
- Hairnet Straps twisted, straps move freely hold in place, held securely to facepiece, slightly dirty.
- Attachment points for straps are frayed.
- The facepiece seal "rubber" portion is okay.
- Regulator interface area is in good condition and clean.
- Nose cup slightly dislodged from left voicemitter.
- Voicemitters dented

2. Mask Mounter Regulator (Refer to Figures 10 - 14 in Appendix III):

EZ-Flo Regulator

Front Label: AirPak Plus, VibraAlert with City of Hartford sticker

Regulator assembly P/N: damaged

Other markings: 027

S/N:

MFG Date:

- Overall condition, is good to fair with some dirt
- Donning switch is in good condition. Switch is off, regulator active. Has cut in it.
- Secured to low pressure line
- By Pass in the Half on.
- By pass knob slightly dirty
- Inside Flange has some scratches.
- Sealing area mostly clean and in decent shape
- Regulator can be attached and removed.
- Locking assembly does function.

3. Low Pressure Regulator Hose (Refer to Figures 15 and 16 in Appendix III):

Scott partial part number: None present

- Overall condition is good to fair
- Secured at all attachments points.
- Quick disconnect in fair to good condition and functions.
- Line runs through the shoulder strap to the reducer.

4. 4.5 Pressure Reducer Assembly (Refer to Figures 17 and 18 in Appendix III):

P/N: S02220-03

Marking:

S/N: ND010200145881

MFG Date:

- SCOTT marking is present
- Overall condition is fair to good but dirty.
- All airline connections are secure.

- NIOSH label present, and readable TC-13F-0076 for the unit
- Cylinder latch , marking, E-16 10009126

9. Bell alarm (Refer to Figure 31 in Appendix III):

- Dirty w/ 2 screws present through cover

10. Straps and Buckles (Refer to Figures 32 - 33 in Appendix III):

- Overall strap condition is fair to good but dirty.
- Both Shoulder straps attached at the top of the backframe
- Hose lines and wires pass through shoulder straps.
- All adjustable buckles move and hold in place.
- Waist area buckle latches and releases
- Lumbar strap in fair condition with some dirt and fraying at attachment points on either side of the pad.

11. Compressed Air Cylinder and Cylinder Valve Assembly (Refer to Figures 34 - 38 in Appendix III):

Some DOT and other information:

DOT-E-10915-4500

TC-SU-5134-310

OK81706

Scott logo visible Scott Part number: 10009673 Luxfer REE 78

L34N-18 434033 Manufacture date: 1/04 30 Minute, 4500 PSIG

Valve assembly part number label present but not readable

- Overall condition is fair to good as there are some surface scratches and dirt present
- Gauge is readable.
- Threads ok -some corrosion
- As received cylinder valve fully closed with no air remaining.
- Can open and close valve—no paint on hand wheel valve
- Rubber bumper at base on cylinder valve is in good to fair condition, some warping.
- Rehydro label present: 02 14 281-590-4311
- Marking on neck 50R49924
- P/N for assembly/cylinder not readable
- Cylinder has been repaired for gouges up by cylinder valve assembly

NOTE: This cylinder has a 5 year rehydro testing requirement. The air cylinder on the Unit #1 had a manufactured date of 01/04. For the air cylinder on Unit #1, a retest date before the last day of 01/09 is required. The retest label was readable on Unit #1 with a retest date of 4/13; therefore, the cylinder was within the hydro certification when last used. The cylinder on Unit #1 was in fair to good condition with surface scratches and gouge repairs present on the outer coating. There was

no air was remaining in the cylinder. Although the cylinder was within the hydro testing requirements, it was determined that it may not be safe to pressurize.

12 Auxiliary Hose (Refer to Figures 39 and 40 in Appendix III):

P/N; not visible

- Fitting connection is clean
- Attached to mounting block
- Attaches to intermediate side of pressure reducer

Respirator Field Problem
Incoming Inspection Report Summary – Unit #2

Task Number: TN-19908	Requestor: NIOSH/DSR for the Hartford Fire Department
Date Received: October 28, 2014	
Date Inspected: November 18, 2014	Description: Near miss
Manufacturer: Scott Health and Safety	Inspected by: Tom Pouchot, Jay Tarley
Approval Number: TC-13F-0076CBRN	SCBA Type: Open Circuit, Pressure-Demand

The SCBA was received in a plastic shipping box (refer to Figures 1 – 2 in Appendix IV). A shipping label was the only markings on the outside of the shipping box. The SCBA was placed inside a paper bag inside the box.

Contact Agency: NIOSH/DSR for the Hartford, Connecticut Fire Department.

As received:

- Cylinder Gauge no pressure showing
- By-Pass in the half-way position
- Donning Switch Off, Regulator Active
- Mask mounted Regulator (MMR) locked into Facepiece
- Cylinder Valve closed, no air remaining in cylinder

Components and Observations – Unit #2

NOTE: All references to “right” or “left” are from the user’s perspective.

I. Facepiece (Refer to Figures 3 - 8 in Appendix IV):

Facepiece assembly; P/N Not visible Large Model: AV2000 Lot: unknown
 Facepiece Seal P/N: 10009779
 MFG date: 4th quarter 2004
 Nosecup P/N: UKN MFG Date: 1st quarter 2008 Other markings: 7

- Overall condition is fair but dirty
- Lot number label present.
- Lens is dirty with some slight scratches present, the visibility is good. Some dirt present near the regulator connection, right side.
- Hairnet dirty.
- Hairnet Straps twisted, straps move freely hold in place, held securely to facepiece, dirty. Some fraying

- Attachment points for straps are frayed.
- The facepiece seal "rubber" portion is okay.
- Regulator interface area is in decent condition and clean.
- A very slight amount of dirt is present inside nose cup, dirt is black in color.
- Voicemitters dented

2. Mask Mounted Regulator (Refer to Figures 9 - 11 in Appendix IV):

EZ-Flo Regulator with HUD.

Front Label: AirPak Plus CBRN, VibraAlert
with City Label

Regulator assembly P/N:

Other markings:

S/N:

MFG Date:

- Overall condition, is fair with some dirt and slightly damaged
- Donning switch is in good condition. Switch is on, regulator not active.
- Secured to low pressure line
- By Pass in the Half on.
- By pass knob slightly dirty
- Inside Flange has some scratches.
- Some dirt inside regulator. White powder.
- Sealing area mostly clean with sealing gasket slightly damaged at bottom.
- Regulator can be attached and removed.
- Locking assembly does function.

3. Low Pressure Regulator Hose (Refer to Figures 12 - 14 in Appendix IV):

Scott part number: None present

- Overall condition is good to fair
- Secured at all attachments points.
- Quick disconnect electrical connector clean and in good shape.
- Line runs through the shoulder strap to the reducer.

4. 4.5 Pressure Reducer Assembly (Refer to Figures 15 and 16 in Appendix IV):

P/N: 2004430-01

Marking:

S/N: 1591115006103ND010200145881

MFG Date: 04/14/11

- SCOTT marking is present
- Overall condition is fair to good but dirty.
- All airline connections are secure—no labels or P/N

5. High Pressure Hose and Cylinder Attachment (Refer to Figures 17 - 19 in Appendix IV):

Cylinder Attachment P/N: not visible

other marking: none

- Overall condition is good.
- Cylinder attachments threads are somewhat clean with some corrosion, threads on and off, "O" ring in place.

6. Console Assembly PASS (Refer to Figures 20 - 21 in Appendix IV):

Console P/N: S/N: Mfg date:

- Overall condition is good but slightly dirty
- Lines good shape—pressure/electrical
- Gauge lens is readable.
- Protective casing slightly dirty
- Rubber attachment strap present, attached to the PASS console but not shoulder strap.
- PASS did function
- SEI Label attached NFPA 1982, 1998 edition.
- Console assembly 805191-01
- Sensor assembly 805193-01
- Pressure switch 805177-01
- PASS control cable and pressure gauge line securely attached to console.
- Has Hartford police evidence tag

7. PASS Control Module (Refer to Figures 21 - 23 in Appendix IV):

PAK ALERT SE7 PASS DEVICE (30 Sec)

Part Number: 200451-01-11 200451-02-12 with PAK TRACKER

Mfg date: Not present

- Overall condition is good with some dirt present
- Held securely to backframe
- Wire connection connected to PASS device
- Wire held secure to backframe and runs to console assembly
- Label on back cover, HUD US Patent number 5,097,826

8. Backframe Assembly (Refer to Figures 24 - 29 in Appendix IV):

P/N: 2002275-011 Other markings: A4Q08

SEI Label attached: NFPA 1981: 2007 ed.

- All labels covered with dirt
- Overall fair to good condition, no bends/cracks in wire frame, but some dirt
- Shoulder straps were attached to the frame

- Cylinder strap and latch are dirty but functional
- Cylinder strap latch is in fair condition dirty but functional.
- BBRN label present
- NIOSH label present and readable, TC-13F-0076CBRN for the unit.
- Cylinder bracket marking, TAC
- Bottom frame marked with 3313

9. Straps and Buckles (Refer to Figures 30 - 31 in Appendix IV):

- Overall strap condition is fair to good but dirty.
- Both Shoulder straps attached at the top of the backframe
- Hose lines and wires pass through shoulder straps.
- All adjustable buckles move and hold in place.
- Waist area buckle latches and releases
- Lumbar strap in fair condition with some dirt.
- Police tag attached

10. Compressed Air Cylinder and Cylinder Valve Assembly (Refer to Figures 32 - 36 in Appendix IV):

Some DOT and other information:

DOT-E-10915-4500

TC-SU-5134-310

OK81706

Scott logo visible Scott Part number: 10009671 Luxfer REE 78

L45M-18 Manufacture date: 1/04 30 Minute, 4500 PSIG

Valve assembly part number label present but not readable

- Overall condition is fair to good as there are some surface scratches and dirt present
- Gauge is readable.
- Threads ok -some corrosion
- As received cylinder valve fully closed with no air remaining.
- Can open and close valve—no paint on hand wheel valve
- Rubber bumper at base on cylinder valve is in good to fair condition, but has some damage.
- Evidence of a sticker present that had been removed.
- Cylinder valve number not visible.
- Painted top of cylinder red
- P/N for assembly/cylinder not readable
- Cylinder has been repaired for gouges up by cylinder valve assembly

NOTE: This cylinder has a 5 year rehydro testing requirement. The air cylinder on the Unit #2 had a manufactured date of 01/04. For the air cylinder on Unit #2, a retest date before the last day of 01/09 is required. A rehydro label was not present; therefore, the cylinder could not be safely pressurized.

11. RIC Fitting: (Refer to Figures 37, 38 in Appendix IV):

P/N: not visible

- Overall condition is good with cover
- Fitting is clean
- Cover is in good condition.

RIC fitting relief valve good

12. Auxiliary Hose (Refer to Figures 39 and 40 in Appendix IV):

P/N: not visible

- Fitting connection is clean
- Attached to mounting block
- Attaches to intermediate side of pressure reducer



National Personal Protective Technology Laboratory / Policy and Standards Branch

SCBA Test Report

Task Number: TN-19908
 Manufacturer: Scott Health and Safety
 NIOSH Approval Number: Unit #1: TC-13F-0076 and Unit #2: TC-13F-0076CBRN
 Tests Performed by: Mike Commodore and Jay Parker
 Report written by: Jay Tarley
 Date of Report: December 4, 2014

I. Background

On October 28, 2014, two SCBA units from the Hartford Connecticut Fire Department were delivered to the NIOSH facility in Morgantown, West Virginia. The units were taken to the lower floor of lab room 1513 for secured storage. The SCBA units were then transported to Pittsburgh for inspection on November 18, 2014. Both units were initially removed from their packaging in the Communications Classroom, Room 116 (Building 40) and initially and extensively inspected on November 18, 2014. Unit #1 was manufactured by Scott Health and Safety Company under NIOSH approval number TC-13F-0076 and was an NFPA 1981:1997 ed. Unit #1 was determined to need a new cylinder and facepiece to safely pressurize and test. Unit #2 was manufactured by Scott Health and Safety Company under NIOSH approval number TC-13F-0076CBRN and was an NFPA 1981:2007 ed. Unit #2 was determined to need a new cylinder and facepiece to safely pressurize and test.

A series of performance tests were conducted on Unit #1 and Unit #2 on November 21, 2014. In addition, the SCBA data logger for Unit #2 was downloaded by Scott Health and Safety with NIOSH personnel present on November 25, 2014.

II. Test Outlines

A. POSITIVE PRESSURE TEST – NIOSH Test Procedure No. 120 42 CFR Part 84 Reference: Subpart H, § 84.70 (a)(2)(ii)

Requirement:

The pressure inside the facepiece in relation to the immediate environment is positive during both inhalation and exhalation.

NIOSH/DSR for Hartford Fire Department – SCBA Test Report – Page 1

Procedure:**Unit #1 and Unit #2:**

A breathing machine with a 622 kg.-m./min. cam operating at 24 RPM with a 40-liter per minute flow rate (115 liters per minute peak flow) is connected to an anthropometric head for cycling. A pressure tap in the head is connected to a transducer which in turn is connected to a strip chart recorder for determining the pressure in the facepiece. The facepiece and cylinder were replaced on both units prior to the testing.

Results – Both units were tested on November 21, 2014, the SCBA Unit #1 did meet the test requirement. Unit #2 did not meet the test requirements.

Unit 1:

The inhalation breathing resistance did not become negative during the test. The PASS unit, secondary alarm and the donning switch functioned properly. The facepiece and cylinder were replaced prior to the testing.

Unit 2:

The unit supplied air to the breathing machine for 34.30 minutes; however, the inhalation portion of the breathing curve fell below the requirement throughout the test. The PASS unit, the HUD alarm and the donning switch functioned properly.

Unit #1	
Inhalation Breathing Resistance: (inches of water column)	0.20
Pass / Fail	PASS

Unit #2	
Inhalation Breathing Resistance: (inches of water column)	-0.10
Pass / Fail	FAIL

B. RATED SERVICE TIME TEST – NIOSH Test Procedure No. 121

42 CFR Part 84 Reference: Subpart F, § 84.53 (a) and Subpart H, § 84.95 (a) and (b)

Requirement:

Service time will be measured while the apparatus is operated by a breathing machine as described in § 84.88. The open-circuit apparatus will be classified according to the length of time it supplies air or oxygen to the breathing machine. Classifications are listed in § 84.53.

Procedure:

A breathing machine with a 622 kg.-m./min. cam operating at 24 RPM with a 40 liters per minute flow rate is connected to an anthropometric head for cycling. A pressure tap in the

head is connected to a transducer which in turn is connected to a strip chart recorder for determining the pressure in the facepiece. The breathing machine is run until the inhalation portion of the breathing curve falls below the minimum requirement.

Results - Tested on November 21, 2014 the SCBA Unit #1 met the test requirement and Unit #2 did not meet the test requirement. Unit #2 did not meet the test requirement due to positive pressure not being maintained inside the facepiece during the inhalation cycle of the breathing machine throughout the test.

Test Notes: The measured service time (adjusted to correspond with the recorded breathing cycles) was more than the rated service time of 30 minutes for Unit #1. The PASS unit and secondary alarm functioned during the test. The SCBA did not go negative on inhalation but maintained positive pressure in the facepiece at the same level.

The measured service time (adjusted to correspond with the recorded breathing cycles) was more than the rated service time of 30 minutes for Unit #2. The HUD and PASS functioned during the test. The SCBA did go negative on inhalation which did not meet the test requirement.

Unit #1		
Measured Service Time:	Minutes	Seconds
	33	10
Pass / Fail	PASS	

Unit #2		
Measured Service Time:	Minutes	Seconds
	34	30
Pass / Fail	Fail	

C. STATIC PRESSURE TEST – NIOSH Test Procedure No. 122
42 CFR Part 84 Reference: Subpart H, § 84.91 (d)

Requirement:

The static pressure (at zero flow) in the facepiece shall not exceed 38 mm, (1.5 inches) water-column height.

Procedure:

The facepiece is fitted to an anthropometric head for testing. A pressure tap in the head is connected to a calibrated manometer. Full cylinder pressure is applied to the unit at zero flow and a reading from the manometer is recorded.

Results – Tested on November 21, 2014, the SCBA Unit #1 and Unit #2 both met the test requirement.

Unit #1	
Facepiece Static Pressure:(inches of water column)	1.15
Pass / Fail	Pass

Unit #2	
Facepiece Static Pressure:(inches of water column)	1.30
Pass / Fail	Pass

D. GAS FLOW TEST – NIOSH Test Procedure No. 123
42 CFR Part 84 Reference: Subpart H, § 84.93 (b) and (c)

Requirement:

The flow from the apparatus shall be greater than 200 liters per minute when the pressure in the facepiece of demand apparatus is lowered by 51 mm. (2 inches) water column height when full container pressure is applied. Where pressure demand apparatus are tested, the flow will be measured at zero gage pressure in the facepiece.

Procedure:

A pressure tap in the anthropometric head is connected to a manometer for determining when the pressure inside the facepiece is at zero. A mass flow meter is connected in line between the anthropometric head and an adjustable vacuum source to measure flow. The SCBA cylinder is replaced by a test stand which is adjusted initially to full cylinder pressure. The vacuum source is adjusted during the test to maintain the desired pressure inside the facepiece. Once the proper facepiece pressure has stabilized, a flow reading is recorded. The procedure is then repeated with the test stand adjusted to 500 psig.

Results – Tested on November 21, 2014, the SCBA Unit #1 and Unit #2 both met the test requirement.

	Unit #1	Pass/Fail
Applied pressure	Air Flow (liters per minute)	
4500 psig	475.73	Pass
500 psig	280.34	Pass

	Unit #2	Pass/Fail
Applied Air Flow (liters per pressure minute)		
4500 psig	438.96	Pass
500 psig	280.34	Pass

E. EXHALATION RESISTANCE TEST – NIOSH Test Procedure No. 122
42 CFR Part 84 Reference: Subpart H, § 84.91 (c)

Requirement:

The exhalation resistance of pressure-demand apparatus shall not exceed the static pressure in the facepiece by more than 51 mm. (2 inches) water-column height.

Procedure:

The facepiece is mounted on an anthropometric head form. A probe in the head form is connected to a slant manometer for measuring exhalation breathing resistance. The air flow through the apparatus is adjusted to a rate of 85 liters per minute and the exhalation resistance is recorded.

Results – Tested on November 21, 2014, the SCBA Unit #1 and Unit #2 both met the test requirement.

	Unit #1
Exhalation Breathing Resistance: (inches of water column)	2.03
Static Pressure: (inches of water column)	1.15
Difference: (inches of water column)	0.88
Pass / Fail	Pass
	Unit #2
Exhalation Breathing Resistance: (inches of water column)	2.07
Static Pressure: (inches of water column)	1.30
Difference: (inches of water column)	0.77
Pass / Fail	Pass

F. REMAINING SERVICE LIFE INDICATOR TEST – NIOSH Test Procedure No. 124
42 CFR Part 84 Reference: Subpart H, § 84.83 (f) and Subpart G, § 84.63 (c)

Requirement:

Each remaining service life indicator or warning device shall give an alarm when the remaining service life of the apparatus is reduced within a range of 20 to 25 percent of its rated service time or pressure.

This requirement is modified under § 84.63(c) as follows: *For apparatus which do not have a method of manually turning off remote gage in the event of a gage or gage line failure the remaining service life indicator is required to be set at 25% ± 2% of the rated service time or pressure.*

Procedure:

A calibrated gauge is connected in line between the air supply and the first-stage regulator. The unit is then allowed to gradually bleed down. When the low-air alarm is activated, the pressure on the gauge is recorded. This procedure is repeated six times. The average of the six readings is calculated and recorded.

Results – Tested on November 21, 2014. As these SCBA models do not have a remote gauge shutoff, the test requirement is 25% ± 2%.

Testing Notes:

Unit #1: This SCBA unit contained two alarms—a Secondary Bell and a vibra-alert type alarm. The Secondary bell and Vibra alarm for Unit #1 did function. Required range is between 1035 and 1215 psig. The Secondary bell functioned at an average of 1026 psig, which did not meet the test requirements.

Unit #2: This SCBA unit contained two alarms—a Heads-Up Display (HUD) - light alarm and a vibra-alert type alarm. The HUD light alarm and Vibra alarm for Unit #2 did function. Required range is between 1035 and 1215 psig.

Run #	Unit #1 Vibra Alarm Point (psig)	Unit #1 Secondary Bell Point (psig)
1.	1140	1030
2.	1145	1030
3.	1140	1030
4.	1140	1030
5.	1135	1020
6.	1135	1015
Avg.	1139	1026
Pass / Fail	Pass	Fail

Run #	Unit #2 Vibra Alarm Point (psig)	Unit #2 HUD Alarm Point (psig)
1.	1040	1160
2.	1040	1130
3.	1035	1130
4.	1035	1130
5.	1030	1130
6.	1030	1130
Avg.	1035	1135
Pass / Fail	Pass	Pass

G. NFPA AIR FLOW PERFORMANCE TEST

NFPA 1981 (1997 Edition) Reference: Chapter 5, Performance Requirements, Sec. 5-1.1

Requirement:

SCBA shall be tested for air flow performance as specified in Section 6-1, Air Flow Performance Test, and the SCBA facepiece pressure shall not be less than 0.0 in. (0.0 mm) water column and nor greater than 3½ in. (89 mm) water column above ambient pressure from the time the test begins until the time the test is concluded.

Procedure:

The required equipment specified in the NFPA standards were used to conduct the tests on both of these units. A pressure tap in the head is connected to a transducer which in turn is connected to a flatbed chart recorder for determining the pressure in the facepiece.

Results – SCBA Unit#1 and Unit#2 were both tested on November 21, 2014. Both units passed this test. The NFPA facepiece pressure tests were performed initially on the units and the units passed.

Test Notes – Unit #1: The secondary alarm and PASS unit functioned normally. The facepiece and cylinder were replaced prior to testing. Unit #2: The HUD alarm and PASS unit functioned normally. The facepiece and cylinder were replaced prior to testing.

Unit #1	
Maximum Facepiece Pressure: (inches of water column)	2.35
Minimum Facepiece Pressure: (inches of water column)	0.45
Pass / Fail	Pass

Unit #2	
Maximum Facepiece Pressure: (inches of water column)	2.55
Minimum Facepiece Pressure: (inches of water column)	0.45
Pass / Fail	Pass

III. Disposition:

Following testing, the SCBA units were returned to the packages in which the units were shipped to NIOSH and placed in storage pending a final disposition.

The results of all tests are summarized in Tables One, Two, Three and Four which follow.

TABLE ONE – Summary of NIOSH Test Results – Unit #1

Task Number: 19908
Manufacturer: Scott Health and Safety
NIOSH Approval Number: TC-13F-0076
Tests Performed By: Mike Commodore, Jay Parker
Dates of Tests: November 21, 2014

TEST / 42 CFR PART 84 REFERENCE	STANDARD	UNIT #	RESULT	PASS	FAIL
A. POSITIVE PRESSURE TEST Reference: Subpart H, § 84.70 (a)(2)(ii) ≥ 0.00 INWC		#1	0.20 INWC	X	
B. RATED SERVICE TIME TEST Reference: Subpart F, § 84.53 (a), Subpart H, § 84.95 (a) and (b) ≥ 30 min.		#1	33 min 10 s	X	
C. STATIC PRESSURE TEST Reference: Subpart H, § 84.91 (d) ≤ 1.50 INWC		#1	1.15 INWC	X	
D. GAS FLOW TEST (at Full Cylinder Pressure) Reference: Subpart H, § 84.93 (b) and (c) ≥ 200 lpm		#1	475.73 LPM	X	
D. GAS FLOW TEST (at 500 psig) Reference: Subpart H, § 84.93 (b) and (c) ≥ 200 lpm		#1	280.34 LPM	X	
E. EXHALATION RESISTANCE TEST Reference: Subpart H, § 84.91 (c) Difference ≤ 2.00 INWC		#1	0.88 INWC	X	
F. REMAINING SERVICE LIFE INDICATOR TEST (vibrating alarm) Reference: Subpart H, § 84.83 (f) and Subpart G, § 84.63 (c) Between 1035 and 1215 psig		#1	1139 PSIG	X	
F. REMAINING SERVICE LIFE INDICATOR TEST (secondary alarm) Reference: Subpart H, § 84.83 (f) and Subpart G, § 84.63 (c) Between 1035 and 1215 psig		#1	1026 PSIG		X

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NOTE: The Positive Pressure Test and Rated Service Life Test are run simultaneously.

TABLE TWO – Summary of NFPA Test Results – Unit #1

TEST / REFERENCE	STANDARD	UNIT #	RESULT	PASS	FAIL
G. NFPA AIR FLOW PERFORMANCE Reference: NFPA 1981 (1997 Edition), Section 5-1.1	≤ 3.50 INWC Exhalation Resistance	#1	2.85 INWC	X	
G. NFPA AIR FLOW PERFORMANCE Reference: NFPA 1981 (1997 Edition), Section 5-1.1	≥ 0.00 INWC Inhalation Resistance	#1	0.65 INWC	X	

TABLE THREE – Summary of NIOSH Test Results – Unit #2

Task Number: 19908
 Manufacturer: Scott Health and Safety
 NIOSH Approval Number: TC-13F-0076CBRN
 Tests Performed By: Mike Commodore, Jay Parker
 Dates of Tests: November 21, 2014

TEST / 42 CFR PART 84 REFERENCE	STANDARD	UNIT #	RESULT	PASS	FAIL
A. POSITIVE PRESSURE TEST Reference: Subpart H, § 84.70 (a)(2)(ii) ≥ 0.00 INWC		#2	-0.10 INWC		X
B. RATED SERVICE TIME TEST Reference: Subpart F, § 84.53 (a), Subpart H, § 84.95 (a) and (b) ≥ 30 min.		#2	34 min 30 s		X
C. STATIC PRESSURE TEST Reference: Subpart H, § 84.91 (d) ≤ 1.50 INWC		#2	1.30 INWC	X	
D. GAS FLOW TEST (at Full Cylinder Pressure) Reference: Subpart H, § 84.93 (b) and (c) ≥ 200 lpm		#2	438.96 LPM	X	
D. GAS FLOW TEST (at 500 psig) Reference: Subpart H, § 84.93 (b) and (c) ≥ 200 lpm		#2	280.34 LPM	X	

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E. EXHALATION RESISTANCE TEST Reference: Subpart H, § 84.91 (c) Difference ≤ 2.00 INWC	#2	0.77 INWC	X	
F. REMAINING SERVICE LIFE INDICATOR TEST (vibrating alarm) Reference: Subpart H, § 84.83 (f) and Subpart G, § 84.63 (c) Between 1035 and 1215 psig	#2	1035 PSIG	X	
F. REMAINING SERVICE LIFE INDICATOR TEST (light alarm HUD) Reference: Subpart H, § 84.83 (f) and Subpart G, § 84.63 (c) Between 1035 and 1215 psig	#2	1135 PSIG	X	

TABLE FOUR – Summary of NFPA Test Results – Unit #2

Task Number: 19908
 Manufacturer: Scott Health and Safety
 NIOSH Approval Number: TC-13F-0076CBRN
 Tests Performed By: Mike Commodore, Jay Parker
 Dates of Tests: November 21, 2014

TEST / REFERENCE	STANDARD	UNIT #	RESULT	PASS	FAIL
G. NFPA AIR FLOW PERFORMANCE Reference: NFPA 1981 (1997 Edition), Section 5-1.1	≤ 3.50 INWC Exhalation Resistance	#2	2.55 INWC	X	
G. NFPA AIR FLOW PERFORMANCE Reference: NFPA 1981 (1997 Edition), Section 5-1.1	≥ 0.00 INWC Inhalation Resistance	#2	0.45 INWC	X	

NOTE: The Positive Pressure Test and Rated Service Life Test are run simultaneously.

Also, SCBA Unit #2 was equipped with data logging device that measures several performance parameters during a predetermined time period. This data was down loaded from SCBA Unit #2 by Scott Health and Safety personnel and witnessed by members of NIOSH on November 25, 2014. The data is included for informational purposes only.

UNIT #2
DATA LOGGER
INFORMATION

Time	Date	Off To Sensing	Sensing To Off	Pre Alarm To Alarm	Manual Alarm	Alarm Reset	Low Battery	Sensing To Pre Alarm	Clock Reset Pending	Clock Reset	Power On Reset	SEMS Idle/Down	SEMS Link UP	EVAC	EVAC ACK
18:12:02	10/7/14	-	X	-	-	-	-	-	-	-	-	-	-	-	-
18:11:30	10/7/14	-	-	-	-	X	-	-	-	-	-	-	-	-	-
18:01:08	10/7/14	-	-	X	-	-	-	-	-	-	-	-	-	-	-
18:00:56	10/7/14	-	-	-	-	-	-	X	-	-	-	-	-	-	-
18:00:38	10/7/14	-	-	-	-	X	-	-	-	-	-	-	-	-	-
17:59:12	10/7/14	-	-	X	-	-	-	-	-	-	-	-	-	-	-
17:59:00	10/7/14	-	-	-	-	-	-	X	-	-	-	-	-	-	-
17:58:40	10/7/14	-	-	-	-	X	-	-	-	-	-	-	-	-	-
17:57:36	10/7/14	-	-	X	-	-	-	-	-	-	-	-	-	-	-
17:57:24	10/7/14	-	-	-	-	-	-	X	-	-	-	-	-	-	-
17:56:40	10/7/14	-	-	-	-	-	-	X	-	-	-	-	-	-	-
17:46:30	10/7/14	X	-	-	-	-	-	-	-	-	-	-	-	-	-

EXHIBIT C

Kevin Brookman

From: twaffer@hartford.gov
Sent: Monday, October 06, 2014 1:28 AM
To: HuerC001@hartford.gov
Subject: Re: Fwd:

I will handle this and give you a report ASAP.

Sent from my iPhone

On Oct 5, 2014, at 8:52 AM, "Huertas, Carlos M." <HuerC001@hartford.gov> wrote:

Terry,

Please handle and ensure immediate measures are taken to correct this egregious behavior. The mere fact that the driver on the opposite shifts states all the equipment was check is not acceptable. It must be documented for accountability purposes and safety concerns.

I require Fire Services from both shifts explaining what in the "Sam Hill" is going on.

Make those involve with not adhering to proper procedures aware they are subject to discipline up to termination if I discover blatant disregrards to safety!

Respectfully submitted,

Carlos M. Huertas
Fire Chief
Hartford Fire Department
Emergency Management Director
Hartford Public Safety Complex
253 High Street
Hartford, Connecticut 06103

Office: (860)-757-4500
Fax: (860)-722-8205
Cell: (860) 761-4277
HuerC001@hartford.gov

"Be impeccable with your word; Don't take anything personally; Don't make assumptions; Always do Your Best", Don Miguel Ruiz

Begin forwarded message:

From: "Nolan, John F." <NolaJ001@hartford.gov>
Date: October 5, 2014 at 8:32:44 AM EDT
To: Fire Service <FireService@hartfordschools.org>
Cc: "Dalton, Thomas D." <DALTT001@hartford.gov>

Department of Fire Service
Quarters of Engine Co. 16

October 5, 2014

Carlos M. Huertas
Chief of Department

Sir, This fire service is to inform you of an ongoing problem at Engine 16. I have repeatedly spoken to Lt. Simon about the Company members on his shift regarding daily apparatus checks and house work not being completed on his shift. I have informed Captain Dalton of this problem and he has spoken to Lt. Simon on numerous occasions. Often times Captain Dalton came in on his off time to do this. Last tour I came in to find out that the machine shop had dropped off our apparatus after having a PM performed. When my driver relieved Acting PO, F.F. James Eaton, he told PO Gauvreau that he had checked out the apparatus thoroughly and it was all set. P.O. Gauvreau pulled the apparatus out on the ramp and began his checks. He found it was 25 gallons low on fuel, generator empty of fuel, gas can empty. The pump was not primed even though F.F. Eaton said he flowed water. The relief valve was set below 100, 2 empty Scott bottles. Just 2 tours before this the EMS bags on the apparatus were not stocked and had no BVM which we needed for a medical call. House work has not been performed any where near satisfactory, if at all. I strongly recommend that both Lt. Simon and F.F. Eaton be sent for retraining. Life safety cannot be taken lightly. Thank you for your attention to this matter.

Respectfully Submitted,

Lt. John Nolan #624
Engine 16 Tour C