Gabriel House Fire After Action Report

Date of Incident: July 13, 2025

Prepared by the Fall River Fire Department
Office of the Fire Chief
October 2025

All photographs in this report are courtesy of Retired Fall River Firefighter Kenneth Leger.

Scope

The scope of this report is limited to the operational response of the Fall River Fire Department during the Gabriel House fire. Specifically, it covers:

- Dispatch, staffing, and resource deployment.
- Building construction and occupancy factors affecting fire spread and occupant survivability.
- Operational challenges faced by FRFD personnel during fire suppression and rescue efforts.
- Command and control, communications, and accountability practices.
- Lessons learned from the incident and recommendations for improvement based on NFPA standards, NIOSH firefighter fatality investigations and other sources.

This report does not address insurance issues, property loss evaluations, or post-fire civil or criminal investigations.

Methodology

The findings and recommendations in this report are based on:

- Review of FRFD dispatch and response records, including alarm assignments and staffing levels.
- Incident command reports and radio traffic recordings.
- Firsthand accounts and debriefings with FRFD personnel who operated at the fire.
- Building construction information, including inspection records and observations of fire investigators.
- Review of nationally recognized standards, including NFPA 72, 99, 101, 1225, 1550, 1620, 1700, 1710, and 1932.
- Review of NIOSH Firefighter Fatality Investigation and Prevention Program reports for lessons applicable to this incident.

This methodology ensures that the recommendations provided are evidence-based, rooted in national standards, and directly applicable to improving FRFD's operational readiness.

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I. Executive Summary

The Gabriel House fire on the night of July 13, 2025, escalated rapidly from a routine alarm to one of the most tragic incidents in Fall River Fire Department (FRFD) history. Firefighters, police officers, and EMTs/paramedics responded with bravery and professionalism under extreme conditions, carrying out rapid fire suppression, coordinated ladder and interior rescues, and medical care for numerous residents, many of whom had mobility limitations or cognitive impairments. Although 10 lives were lost that night, 53 residents were rescued from the building by either being carried down ladders (27) or down hallways and stairs (26). Without the decisive actions of the FRFD, the Fall River Police Department (FRPD) and Fall River EMS (FREMS), the loss of life would have been far greater. Without the dedication of the Special Services Unit (SSU), first responders would not have received the rehabilitation required on such a labor-intensive scene and physical injuries to first responders would have been a far greater number than the 10 total reported.

CREWS RESCUING AN RESIDENT FROM A SECOND FLOOR WINDOW

This incident stands as a testament to the strength of coordination and teamwork among the city's public safety departments.

The building presented unique challenges: it is Type V construction (City of Boston, 2024) and fully sprinkled, with no hallway fire doors or smoke-compartmentalization. Rooms were equipped with window AC units with

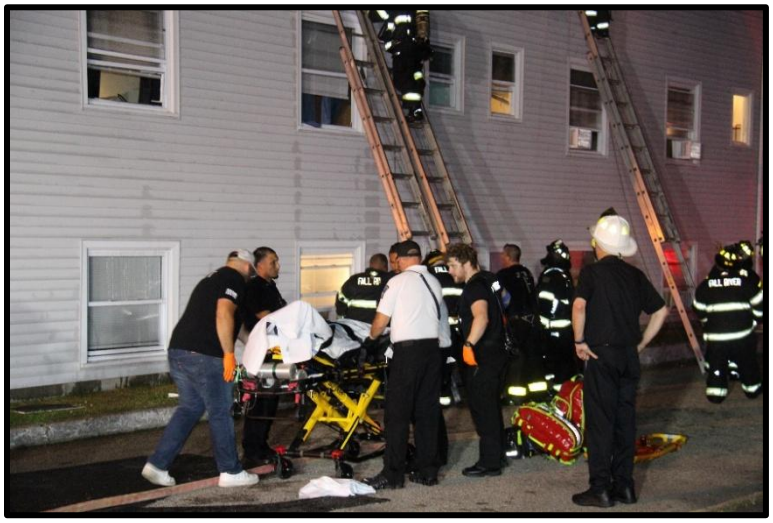
plywood filling the remaining portion of the window alongside the units. There was a single elevator lobby which was involved in the fire. Many residents had to be removed through smaller bathroom windows. These structural factors significantly complicated rescue and suppression operations.

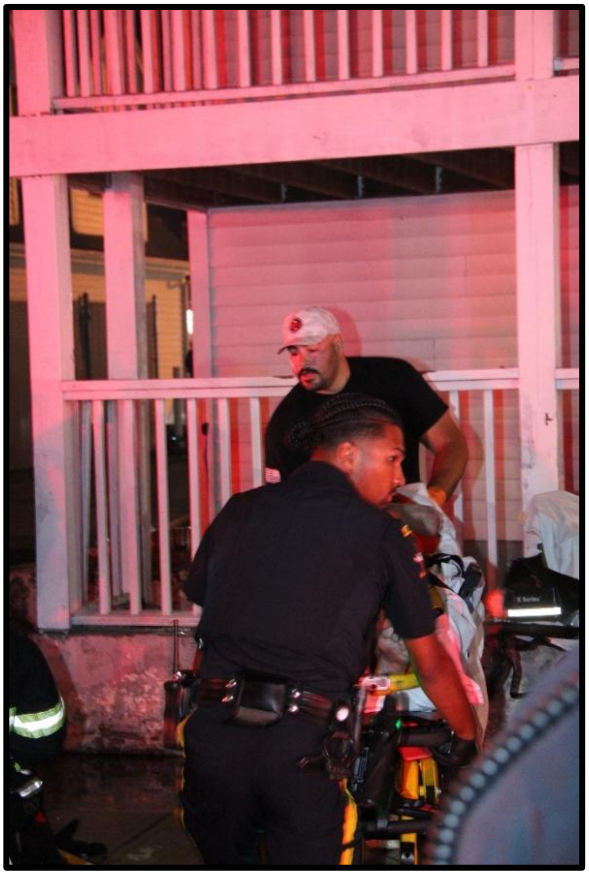
While multiple challenges were encountered including building construction and complex evacuations, decisive actions by command and crews mitigated further loss of life.

Key findings from this incident include the importance of crew integrity, accountability, clear communication, and pre-fire planning for high-risk occupancies. Additionally, the report emphasizes the value of shelter-in-place procedures in high-risk facilities and highlights the advantage of direct alarm transmission to the FRFD in lieu of private monitoring.

Recommendations incorporate lessons learned from this event, best practices from the National Fire Protection Association (NFPA), and findings from National Institute for Occupational Safety and Health (NIOSH) firefighter fatality investigations among other sources. These recommendations aim to improve firefighter safety, operational efficiency, and resident protection during future incidents.

The Gabriel House fire underscores the critical need for continuous training, rigorous pre-incident planning, and strong interagency coordination to safeguard both residents and responders.





ABOVE: *EMS CREWS WORK WITH FIREFIGHTERS TO BEGIN TREATMENT FOR RESIDENTS RESCUED FROM THIRD FLOOR WINDOWS*

RIGHT: *MEMBERS OF THE FRPD MOVE A PATIENT ON A STRETCHER*

II. About the Fall River Fire Department

The Fall River Fire Department (FRFD) provides fire suppression, assistance for emergency medical calls, fire prevention, and community risk reduction to the residents of Fall River, Massachusetts. The department responds to more than 7,000 calls annually, including over 300 structure fires. Medical assist calls account for approximately 23% of total call volume.

FRFD has a total complement of 182 firefighters organized across six engine companies, three ladder trucks, one heavy rescue, and two command vehicles. The department maintains a dedicated Training Division, which utilizes the FRFD training tower to ensure ongoing proficiency and preparedness. The Fire Prevention Division consists of eight full-time firefighters and officers, who are responsible for inspections of commercial and residential properties, complaint investigations, and public education initiatives. In addition, FRFD has a Right-to-Know Officer and an Emergency Management Agency (EMA) Director who oversees city-wide evacuation planning & emergency preparedness. The EMA director is also the Chief of Special Services, the volunteer-based organization that provides many services to the City, including first responder rehabilitation on incident scenes.

Fire investigations are conducted by a four-officer unit, who perform origin and cause investigations alongside their regular line or staff assignments. FRFD also participates in pre-incident planning and mutual aid coordination and references nationally recognized standards, including NFPA codes, to maintain firefighter and community safety.

***LEFT**: E5 OPERATES AT THE FIRE.*
***ABOVE:** C1 GIVES ORDERS TO CREWS PREPARING TO ENTER THE BUOLDING.*

III. Incident Timeline

Intro: The following is a chronological summary of benchmark events based on dispatch records, on-scene reports, and radio traffic. Throughout the first hour of the incident, there were additional calls regarding residents and assistance that are not detailed here.

- **21:38** – Fire alarm activation at Gabriel House, 261 Oliver St.
- **21:39** – Box alarm sent to stations (E2, E5, E9, L2, R1 & C3).
- **21:41** – Car 3(District Chief) on air; dispatch updates the DC that a phone call reported fire at the location.
- **21:43** – C3 on scene (assumes Command), requests additional engine and ladder.
- **21:45** – Command update: heavy fire, initiating rescues and evacuations, "Send me everybody."
- **21:45** – Car 2 (District Chief) responding to Oliver St.
- **21:46** – Heavy Rescue 1 (R1) reports "Faces in windows".
- **21:47** – E9, E12 & P1 dispatched.
- **21:47** – E5 calls for water; C2 directs all units to bring 24' ladders.
- **21:48** – E6 & L4 dispatched; all FRFD units now on scene or in route.
- **21:49** – Command orders ladders placed on all sides.
- **21:51** – Command repeats: "Bodies and ladders."
- **21:52** – C2 reports fire from B-side window; orders crews to knock down visible fire.
- **21:53** – E2 reports heavy fire and victims on Division 3 (3rd floor) in B/C corner.
- **21:54** – Command requests "all medical rescues you can."
- **21:57** – St. Anne's Credit Union parking lot designated as triage area.
- **22:05** – Command to C2 for an update; C2 responds, "Actively removing victims, beginning room-by-room search. Fire broke out on B side but has been extinguished."
- **22:07** – Car 1 (Fire Chief) on air; Car 5 (Deputy Chief)/C1 order recall.
- **22:09** – Command requests manpower recall; C5 reports four crews being called.
- **22:18** – C1 assumes Command; assigns C3 to Operations and C2 to Bravo Side; requests mutual aid medical rescues via Bristol County Control.
- **22:21** – Command requests hospital notifications and Mass Casualty Incident trailer.
- **22:29** – C2 requests Personnel Accountability Report (PAR).

- **22:29** – Command requests PAR from Fire Alarm; initial attempts delayed, restarts required.
- **22:34** – On-scene PAR conducted by Command; full accountability achieved in under 75 seconds.
- **22:37** – Situation Report: Fire knocked down, checking for extension, MCI declared, crews committed for extended operations.
- **22:38** – Recall crews begin secondary search and full extinguishment of remaining hot spots.

Summary: At this stage, the incident has stabilized. The fire is extinguished, and all viable victims have been removed. While crews remained on scene overnight, all significant actions for the purpose of this report have been completed.

Weather Conditions: At 2153 on July 13 the outdoor temperature was 67°F, dewpoint was 65°F, the humidity was 93%, the wind was out of the south at 5mph, the barometric pressure was 30.02 inches, there had been no precipitation in the last 24 hours, and conditions were fair (Wunderground, 2025, July 13).

AERIAL VIEW OF GABRIEL HOUSE WITH REFERENCES TO THE SECTORED SIDES, OLIVER STREET AND THE TRIAGE AREA

IV. Building Construction

Gabriel House was constructed in 1963 as a Type V wood frame building (City of Boston, 2024) and had been converted from a hotel into an assisted living facility in 1999. The structure was fully sprinkled and featured a single elevator. The main entrance was located on the second floor. During the fire, the elevator lobby was directly involved in the blaze, making elevator use for rescues impossible.

The building lacked fire doors or other compartmentalization in the hallways, allowing smoke and heat to spread freely throughout hallways and common areas. Although no central HVAC system existed to distribute smoke, window-mounted air conditioning units were installed in each room. Each room had two windows: a larger living area window and a smaller bathroom window. In most rooms, the AC units were secured in the larger windows, with plywood filling the remaining gaps. In many cases, the plywood was fastened with screws to prevent the AC from falling out. Many residents had to be removed through the smaller bathroom windows, further complicating rescue operations and increasing risk for both residents and firefighters.

Each wing of the facility included a large outdoor “porch” area that served as a fire escape. During this incident, these areas were used as temporary areas of refuge where residents were brought to avoid smoke and superheated gases before being safely transferred to the designated triage area.

The building construction, layout, and unique modifications presented significant challenges for fire suppression, rescue, and occupant evacuation. Understanding these structural features is critical for planning and response to high-risk residential and assisted living facilities.

FRONT VIEWS OF GABRIEL HOUSE SHOWING THE “PORCHES” AT EACH LEVEL

V. FRFD Response Actions

Upon arrival, Car 3 assumed Command and immediately identified heavy fire at the main entrance on the second floor. The scene was unusually quiet, with no visible evacuation underway, prompting the District Chief to request additional companies (E9 and L4) immediately. The elevator lobby was already involved in fire, making elevator use impossible for rescues.

Engine 5 was ordered to advance hose lines through the main entrance. The captain deployed two 1¾" lines simultaneously, effectively knocking down the main body of fire in the lobby and east-side hallway. This aggressive initial suppression was critical in creating tenable conditions for subsequent rescue operations and likely saved multiple lives. NFPA 1700 (NFPA, 2021) states "If the building is of combustible construction or not fully sprinklered, applying water to the fire area as quickly as practical from the interior or exterior is a critical task. Emphasis must be given to getting the first stream on the fire."

FIRE CREWS WORK WITH THE ASSISTANCE OF PD TO RESCUE RESIDENTS WHILE SIMULTANEOUSLY ATTACKING FIRE THAT EXTENDED OUT A WINDOW.

Meanwhile, fire was visible from a second-floor window on the B side of the building. The District Chief of Car 2 ordered crews to knock down the flames, allowing ladder companies to safely access windows to continue to rescue occupants.

Due to the rapid knockdown of the main body of fire and the immediate need to conduct rescues, the Incident Commander (IC) did not initially order the building's Fire Department Connection (FDC) to be supplied. While feeding the FDC could have enhanced sprinkler performance for prolonged operations, the urgent priority was removing residents

from life-threatening conditions. This decision highlights the IC's need to balance resource deployment with critical rescue tasks during high-risk incidents. The pump operator who connected to the FDC reported that the system maintained sufficient pressure throughout the incident, and although the connection was made, it was never necessary to feed water into the system. Immediately supplying the FDC would not have affected the overall outcome of the fire or the number of injuries and fatalities. The municipal water connection provided adequate volume and pressure, maintaining sprinkler flow until the system was manually shut off later in the night.

CREWS RESCUING A RESIDENT FROM A WINDOW

Command declared an "all hands" rescue operation. All companies on scene actively deployed ladders to second- and third-floor windows with assistance from police officers and members of FREMS. Ladder operations required adaptation to the building's unique layout, including window AC units secured with plywood, and varying window sizes that impeded rescues. Of the 27 residents rescued using ground ladders, the majority were on the Bravo and Charlie sides of the building.

Firefighters performed interior rescues under high heat and heavy smoke conditions, accessing stairwells, hallways, and individual rooms. Residents with mobility or cognitive impairments required additional personnel for evacuation. Accountability and crew integrity were a challenge during initial operations. Officers were sometimes not aware of each member's location

The best estimate from firefighters on scene was that 26 residents were carried out of the building by both fire and police personnel. Firefighters also initiated immediate medical care until Fall River EMS personnel assumed patient care. The triage area at St. Anne's Credit Union parking lot facilitated efficient transfer and treatment of victims. Recall crews were subsequently assigned to overhaul and fully extinguish remaining hot spots.

VI. Fire Investigation

The joint investigation into the Gabriel House fire was conducted by the Bristol County District Attorney's Office, State Police Detectives assigned to that office, the Fall River Fire Department, the Fall River Police Department, and the State Police Fire Investigation Unit assigned to the State Fire Marshal's office. Investigators were supported by contracted electrical inspectors, the State Police Bomb Squad, the Collision Analysis & Reconstruction Section, and the Drone Unit.

The area of origin was determined to be a resident's room on the left (Bravo) side of the second floor, measuring approximately 8 feet by 10 feet. Examination of burn patterns, smoke damage, charring, witness statements, and video evidence supported this determination.

Investigators found no evidence of intentional ignition. There were no indications that cooking equipment, heating appliances, lighting, electrical outlets, or other appliances caused ignition. No candles, incense, or related items were identified. The damaged remains of a battery-powered scooter were recovered and examined; battery failure was ruled out as a contributing factor.

An oxygen concentrator and multiple smoking materials were located in the room of origin. Investigators developed ignition hypotheses involving both items. Due to the extent of the damage and the loss of the room's occupant, investigators were unable to confirm or rule out an electrical or mechanical failure involving the concentrator or the improper use or disposal of smoking materials.

The official classification of fire cause is undetermined with two possible accidental ignition sources: smoking materials or an oxygen concentrator failure.

Regardless of ignition source, the presence of medical oxygen in the room of origin and other rooms throughout the facility was identified as a significant factor in the rapid fire growth and spread. Oxygen-enriched environments allow for easier ignition, higher burn temperatures, and accelerated fire development.

In addition to origin and cause, investigators initiated a review of the property's compliance with the Massachusetts Comprehensive Fire Safety Code and State Building Code. This review is being conducted by the Fall River Fire Department Fire Prevention Bureau, the Department of Fire Services' Code Compliance & Enforcement Unit, DFS fire protection engineers, and the Bristol County District Attorney's Office. Due to the volume of records and the need for regulatory cross-checking, this portion of the investigation remains ongoing (Massachusetts Department of Fire Services [DFS], 2025).

VII. Challenges and Operational Issues

Building Construction

Gabriel House was a Type V wood-frame structure (City of Boston, 2024), fully sprinkled, with one elevator and a second-floor main entrance. Use of the elevator for rescues was impossible due to fire involvement in the lobby. There were no hallway fire doors and many rescues required removal through smaller bathroom windows.

Operational Staffing Challenges

The initial Box Alarm dispatched five apparatus (16 firefighters) and one District Chief, all of whom arrived in under four minutes. Two additional apparatus were added almost immediately upon C3's arrival, bringing the total to 22 firefighters on scene in the early minutes of the incident. Ultimately, even after all available FRFD units were committed, 33 firefighters were on scene in under 15 minutes.

MANY RESIDENTS WERE RESCUED THROUGH THE SMALLER BATHROOM WINDOWS BECAUSE OF THE AC UNITS IN THE LARGER WINDOWS

NFPA 1710 recognizes that incidents at high-risk occupancies like Gabriel House present many challenges, including large numbers of residents, mobility limitations, and the need for simultaneous fire attack and rescue. The standard for these high-risk occupancies calls for 42 firefighters within the first 10 minutes (National Fire Protection Association [NFPA], 2020).

The firefighters committed to this incident professionally carried out their assignments under extremely difficult conditions. Nonetheless, additional manpower may have allowed for safer, more efficient operations with reduced fatigue and lower risk of injury.

Communications

Rapidly deteriorating conditions in the initial stages of the fire caused the IC to call for an "All Hands Rescue" shortly after the first hose lines were deployed. Because of this, face-to-face communications were primarily used, and assignments and progress were not consistently transmitted over the radio.

THE PORCHES AT THE END OF EACH WING WERE USED AS AREAS OF REFUGE UNTIL RESIDENTS COULD BE MOVED TO COLLECTION AREAS BY FIREFIGHTERS, POLICE OFFICERS OR EMT'S

Evacuation Complications

In fully sprinkled Type I or II buildings, residents are generally able to shelter in place, with most rescues occurring via interior hallways and stairs. Type V buildings, however, present a significantly higher risk of rapid fire spread through void spaces and potential structural collapse. At Gabriel House, the combination of heavy fire and extreme heat made shelter-in-place an unviable initial option. Evacuations were further complicated by residents' mobility limitations and cognitive impairments; some opened doors to their rooms, allowing smoke to enter and necessitating more immediate rescues. Porches served as temporary refuge areas until patients could be moved to established triage points.

Ground Ladder Operations

Numerous ladder rescues were immediately needed from different height windows. In addition, the first floor was half underground, and rescues needed to be performed on all three floors simultaneously. These conditions created a situation where the same size ladders needed to be repeatedly thrown at different heights where a different size ladder would've been used under

normal conditions. This caused firefighters to act in a manner inconsistent with training, but they adapted and successfully made dozens of rescues over ladders.

Crew Integrity and Accountability

The revised OSHA Respiratory Protection Standard, issued on January 8, 1998, requires a minimum of two firefighters to remain outside a structure while at least two others conduct interior firefighting operations. The only exception to this requirement is when an immediate rescue situation exists (Occupational Safety and Health Administration [OSHA], 1998).

FIREFIGHTERS THREW SEVERAL DIFFERENT SIZE AND TYPE LADDERS TO MAKE RAPID RESCUES

At Gabriel House, Command was confronted with an extreme life safety emergency. The number of trapped residents required an immediate rescue-focused strategy, and the two-in/two-out standard had to be excepted. NFPA 1550 states that “Company officers shall maintain an ongoing awareness of the location and condition of all company members” and “where assigned as a company, members shall be responsible to remain under the supervision of their assigned company officer" (National Fire Protection Association [NFPA], 2022). At Gabriel House, crews frequently split and rejoined throughout operations to reach occupants quickly. While this increased risk to firefighter safety, it directly contributed to the successful rescue of dozens of residents who otherwise may not have survived.

This situation reflects a recurring theme in NIOSH firefighter fatality investigations, where lapses in crew integrity or deviations from two-in/two-out have been identified as contributing factors in firefighter line-of-duty deaths. Unlike those tragic cases, Gabriel House demonstrates that such exceptions may be unavoidable under extraordinary life-saving circumstances but also highlights the importance of Command recognizing and mitigating the additional risk whenever standard protocols must be altered.

VIII. Lessons Learned/Reinforced

1. Early Recognition and Reporting of Fire Conditions

At this incident, additional resources were requested even before operations began due to information from 911 calls being relayed to the Incident Commander by dispatch. This reinforces the need for prompt identification and communication of fire conditions by both dispatch and command. Dispatchers must relay all information to responding units while they are in route, and command must continually update crews over the radio as conditions evolve. Delays or incomplete information can endanger both firefighters and occupants.

2. Rapid Establishment of Command Structure

A formal command structure should be established immediately on high-risk, multi-story incidents. Early assignment of Operations, Division/Group Supervisors, and Sector Officers ensures coordinated efforts for suppression, rescue, and medical operations.

3. Adequate Staffing for High-Risk Facilities

Gabriel House demonstrates the need to treat certain assisted living facilities as high-rise analogs under NFPA 1710. While the building was not classified as a high-rise, the building type and concentration of vulnerable residents created operational demands similar to those faced in high-rise occupancies. Less firefighters on scene were forced to conduct multiple critical tasks, stretching crews thin and increasing risk.

NIST has proven through its Fireground Field Experiments that more staffing accomplishes tasks more quickly (Kerber & Madrzykowski, 2010). This also reduces firefighter fatigue and overall risk to both responders and occupants. NFPA establishes minimum staffing standards intended to reduce these risks and ensure effective incident operations, particularly in high-risk occupancies (NFPA, 2020). Future planning should ensure manpower levels at these types of incidents meet or exceed NFPA recommendations for similar structures, whether through increased hiring, use of mutual aid, or both.

4. Crew Integrity and Accountability

Maintaining crew integrity is essential. While crews breaking apart at Gabriel House did not result in injuries, this practice is hazardous and can have catastrophic consequences. Officers must always know the exact location of all members and provide immediate, accurate PARs when requested.

5. Communications and Assignments

All major assignments and status updates must be transmitted over the radio, even if orders are

given face-to-face. This ensures situational awareness, prevents duplication of effort, and supports decision-making by Command.

6. Recalled Firefighters and Equipment Integration

During the Gabriel House fire, many recalled firefighters arrived on scene with only their personal protective equipment (PPE). Without SCBA packs, radios, or hand lights, these members were unable to enter the building safely until equipment was exchanged with personnel already operating inside. This created accountability concerns, delayed deployment, and introduced safety risks. Compounding these challenges, empty SCBA cylinders could not be refilled on scene and had to be shuttled to the nearest station, limiting the availability of full bottles at critical times. While the dedication of recalled personnel was invaluable, the lack of on-scene resources complicated their safe and effective integration into operations.

7. Building Layout and Rescue Challenges

Building design, including open corridors without fire doors, elevator lobby involvement in the fire, and AC units that take up the larger windows in each room, complicate evacuations and rescues. Pre-incident planning and awareness of structural hazards improve operational safety.

8. Medical Operations and Triage

High-risk facilities housing vulnerable populations demand coordinated rescue and EMS support. Critical actions include rapid establishment of triage areas, prompt hospital notification, requesting MCI supply caches, and creating casualty collection and transport areas, along with the early integration of EMS (Massachusetts Department of Public Health, Office of Emergency Medical Services [MDPH-OEMS], 2016). Due to FREMS' limited experience with the Incident Command System (ICS), the FRFD must initially integrate leadership positions into the patient care sector until senior FREMS officers arrive on scene.

9. Shelter-in-Place Procedures

Staff and residents must be trained in shelter-in-place and compartmentalization strategies, including maintaining closed doors and using designated refuge areas, while also recognizing when conditions require prompt evacuation to triage or transport points. While shelter-in-place was not feasible at Gabriel House, it should be strongly considered whenever appropriate.

10. Mutual Aid Considerations for MCI Response

Mutual aid during a mass-casualty incident in Fall River presents a challenging command situation. All our mutual aid partners are both paramedics and firefighters, which creates a dilemma: assigning them to backfill our stations may reduce the number of medical resources available on scene, while calling them directly to the incident could leave the city largely

unprotected. Command must carefully weigh these trade-offs and consider requesting assistance from agencies outside our usual mutual aid partners when necessary.

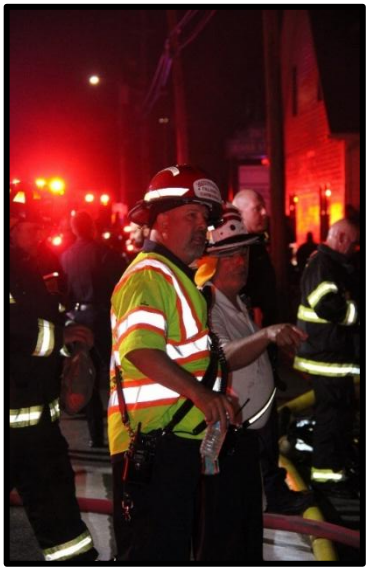
11. Pre-Fire Planning and Drills

Annual inspections, fire drills, and pre-fire plans remain invaluable. Training staff and residents, mapping rescue challenges, and simulating shelter-in-place operations improve readiness and reduce risk during high-casualty events.

12. First Responder Rehab Must be a Top Priority during MCI Incidents at High-risk Facilities

At the fire, the Special Services Unit provided critical rehab support, including water, cold towels, benches, snacks, and other refreshments. Their presence helped responders recover quickly from intense physical exertion and stressful conditions, likely preventing dozens of injuries among firefighters, EMS personnel, and police officers. This underscores the importance of integrating dedicated rehab resources into all high-risk incidents.

RIGHT: *FIREFIGHTERS IN ONE OF THE REHAB STATIONS SET UP AT THE INCIDENT*



LEFT: *SPECIAL SERVICES CHIEF RICHARD AGUIAR & COMMANDER CHRIS CARON DISCUSS PLACEMENT OF REHAB SUPPLIES ON THE SCENE*

IX. Recommendations

The following recommendations incorporate lessons learned and reinforced from the Gabriel House fire, as well as nationally recognized standards from the National Fire Protection Association (NFPA) and findings from National Institute for Occupational Safety and Health (NIOSH) firefighter fatality investigations. We are making them available to all public safety agencies based on the experience gleaned from the tragedy at the Gabriel House.

1. Permanently Assign District Chief Aides to Enhance Command Effectiveness

- DC Aides allow chiefs to focus on strategic oversight while managing operational details, communications, and accountability.
- Aides can monitor interior crews, exterior conditions, and resource assignments in real time, reducing operational delays.
- Aides function as liaisons with EMS and other support units, ensuring coordinated patient care and incident response.
- Particularly in multi-story, high-risk residential fires like Gabriel House, Aides can be an integral part of the Incident Command structure, assisting at multiple levels to ease the burden on the IC.
- Assigning Aides permanently ensures consistent command support across all shifts and incidents, standardizing best practices for large-scale or complex operations.
- ***Sources:*** *Ciarrocca & Harms, 2011; Varone, 1997*

2. Crew Integrity and Accountability

- Officers must maintain constant awareness of the location and assignments of all crew members.
- Personnel Accountability Reports (PARs) must be executed immediately and accurately when requested.
- Crew integrity must be strictly enforced; freelancing or separating from assigned teams poses unacceptable risk.
- ***Standards:*** *NFPA 1561, NIOSH 2021-10*

3. Assignments and Communications

- All major assignments, progress updates, and completion of tasks must be transmitted over the radio, even when initially given face-to-face.
- Command and all crews must maintain shared situational awareness to prevent duplication of effort or gaps in coverage.
- ***Standard:*** *NFPA 1225*

4. Ground Ladder Training and Equipment Selection

- Emphasize proper ladder choice based on task, building layout, and personnel capacity.
- Train for safe deployment angles and fatigue management.
- Include drills for second- and third-floor rescues, including access via smaller egress points like bathroom windows.
- ***Standard:*** *NFPA 1932*

5. Pre-Fire Planning and High-Risk Facility Drills

- Update and expand pre-fire plans for high-risk occupancies, mapping rescue challenges and shelter-in-place zones.
- Conduct annual walkthroughs and coordinated drills with staff and residents, including evacuation and shelter-in-place procedures.
- Create a "High Risk Facility" team to coordinate these changes.
- Increase staffing in the Fall River Fire Department's Fire Prevention Bureau to accomplish these goals.
- ***Standard:*** *NFPA 1620*

6. Create and Disseminate Emergency Preparedness Guides

- Develop an emergency preparedness guide that residents can use for incidents at any high-risk facility or high-rise building. Each facility will provide a form with information specific to their building.
- The guide will have information to prepare residents in the case of a multitude of potential emergencies.
- Create a section specific to fire emergencies to explain actions to take, and those to avoid in a fire or smoke event.
- Make the guide available in multiple languages and by print or QR code.
- Coordinate training with FREMS, FRPD, and building management.
- ***Source:*** *New York City Fire Department [FDNY], n.d.*

7. Legislative / Code Changes for Assisted Living Facilities and other High-Risk Occupancies

- In 2003 two fatal nursing home fires occurred in Hartford, CT and Nashville, TN. Following those tragedies the Centers for Medicare and Medicaid Services (CMS) altered its fire safety standards, adopting the NFPA Life Safety Code (LSC) thus mandating sprinkler requirements for all Medicare/Medicaid participating facilities. The NFPA

introduced the sprinkler requirement for existing nursing homes in the 2006 edition of the LSC (U.S. Government Accountability Office, 2004).

- Pursue adoption of the same codes for assisted living facilities and other occupancies that house vulnerable populations (e.g. group homes, boarding houses, day cares, sober homes, shelters, etc.).
- DPH inspects nursing homes at least every 9-15 months to assess compliance with federal standards of care. It includes performance metrics across five categories: Administration, Nursing, Resident Rights, Kitchen/Food Services, and Environment (Commonwealth of Massachusetts, n.d.). Advocate for these surveys to also assess compliance with Federal requirements for life safety and emergency preparedness.
- ***Standards:*** *NFPA 101, 99.*

8. Staffing Levels and NFPA 1710 Compliance

- Continue to staff four firefighters on 6 of the 10 apparatus, with the long-term goal of full four-person staffing across the department.
- Alter dispatch policies for high-rise or high-risk structures, ensuring adequate personnel to safely perform rescue, suppression, and medical operations.
- Recommend and advocate for a state-funded grant program, similar in nature to the US Fire Administration's SAFER Grant, designed to assist municipalities and departments around the Commonwealth with increasing staffing in a fiscally responsible and sustainable way.
- ***Standard:*** *NFPA 1710*

9. Equipment and Support Vehicle Acquisition

- Acquire a dedicated support vehicle with mobile air cascade/compressor system to refill SCBA cylinders on scene.
- Equip the vehicle with a cache of SCBA packs, radios, hand lights, and other deployment-ready gear.
- Use the vehicle as the central point for outfitting recalled personnel and maintaining accountability.
- Ensure the vehicle provides scalability to sustain extended or large-scale operations without relying on off-site resources.

10. Mutual Aid and City Coverage

- Use mutual aid communities to increase staffing at the incident and request resources from outside normal mutual aid communities (MA Statewide Fire Mobilization Plan, East Bay communities in RI) to ensure continuity of emergency services in the city.

11. Provide ICS assistance to EMS providers during Mass Casualty Incidents

- Ensure coordinated rescue and EMS support at incidents in high-risk facilities with vulnerable populations.
- FRFD officers should initially assume Medical Branch ICS positions until senior FREMS officers arrive. This is especially true after normal working hours when all senior FREMS officers are not immediately available.
- Rapidly establish triage and casualty collection/transport areas.
- Notify CMED & hospitals promptly and request MCI supply caches as needed.
- Integrate EMS personnel early into the patient care sector.
- ***Source:*** Massachusetts Department of Public Health, Office of Emergency Medical Services [MDPH-OEMS], 2016.

X. Conclusion

The Gabriel House fire on July 13, 2025, was one of the most complex and challenging incidents in Fall River Fire Department history. Responding personnel faced rapidly advancing fire conditions, extreme life safety hazards, and a majority of residents with mobility and/or cognitive limitations. Despite these challenges, FRFD firefighters, along with Fall River Police and EMS personnel, conducted fire suppression, rescue, and medical operations with exceptional skill and professionalism. Their efforts resulted in the rescue of 53 residents and prevented further loss of life.

This incident highlights the importance of pre-incident planning, ongoing training, clear communications, crew integrity, and accountability in complex emergencies. It also identified areas for operational improvement, including staffing for high-risk facilities and the value of permanently assigned District Chief aides. Lessons drawn from national standards, including NFPA codes, NIOSH investigations, and NIST field studies, provide guidance for addressing these challenges.

The recommendations presented in this report covering DC aide assignments, enforcement of crew accountability, communications protocols, ladder operations, pre-fire planning, emergency preparedness guides, legislative updates for assisted living facilities, and alignment with NFPA 1710 staffing standards, are intended not only for FRFD but are applicable to any fire department facing similar high-risk incidents. By implementing these measures, departments can strengthen operational readiness, improve coordination, enhance firefighter safety, and better protect residents in multi-occupancy and assisted living facilities.

Ultimately, the Gabriel House fire serves as a testament to the professionalism and dedication of first responders. Applying the lessons learned and recommendations from this incident can help any fire department respond more effectively to complex emergencies and safeguard both personnel and the communities they serve.

XI. Acknowledgements

Before offering thanks to those who stood with us during and after the Gabriel House fire, we must first pause to honor the lives that were lost and the many others forever changed by this tragedy. Their memory is the reason this report exists. By documenting what happened, our goal is to ensure their loss was not in vain and that the lessons learned will help keep others safe in the future.

The Fall River Fire Department extends its deepest gratitude to the many individuals, agencies, and organizations whose efforts during and after the Gabriel House fire were instrumental in saving lives, supporting first responders, and assisting displaced residents.

We thank the firefighters, police officers, EMTs, private citizens, and mutual aid partners who risked their lives that night to rescue occupants and support operations. Their courage and selflessness reflect the highest traditions of public service.

The American Red Cross responded quickly, as it always does, to provide relief and assistance to displaced residents and their families. We also give special recognition to Director Richard Aguiar and the Fall River Emergency Management Agency, including the Special Services Division, for their work at the scene and their continued coordination in the days that followed.

We are grateful to the medical teams at St. Anne's Hospital, Charlton Memorial Hospital, and Rhode Island Hospital for their skill and dedication in treating the many patients transported from the fire.

Our Chaplain, Father Michael Racine, is deeply thanked for his presence, counsel, and compassion both at the fire and in the aftermath. We also thank Father Rob Nemkovich, Pastor Tom Mello, and their teams for providing comfort and support to displaced residents at the Timao Center. In addition, we recognize the many local charities and community organizations that came together to aid the residents in the weeks that followed.

The people of Greater Fall River rose to the occasion in a profound way, supporting residents, families, and first responders alike. Your unity and generosity embody the very best of our community.

We extend appreciation to Mayor Paul Coogan and his administration for their steadfast support of the department, the residents, the victims and their families. We especially thank Mayor Coogan for recognizing the urgent need to increase staffing and for committing to fully staff all engine companies with four firefighters immediately following the fire. Our gratitude also goes to the City Council for their ongoing support of the fire department and its mission.

At the state and federal levels, we are thankful for the immediate support of Representatives Alan Silvia, Steven Ouellette, and Carol Fiola. We extend special thanks to Senator Michael Rodrigues for his enduring commitment to public safety in Fall River and across the

Commonwealth. We are also grateful to Governor Maura Healey not only for the financial support provided in the aftermath, but also for her personal message of encouragement to our members. At the federal level, we thank Congressman Jake Auchincloss, Senator Edward Markey, and Senator Elizabeth Warren for their outreach and continued offers of assistance.

We also thank State Fire Marshal Jon Davine and the Department of Fire Services for their invaluable assistance with the investigation, code compliance, and ongoing support.

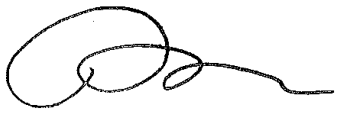
Our gratitude extends to the Professional Fire Fighters of Massachusetts and their Peer Support Team for ensuring our members received the care and resources they needed to begin processing this tragedy. We also thank IAFF President Edward Kelly and his team, who responded directly to the fire scene. Their compassion and leadership made a profound difference, insisting I rest during the earliest hours and preparing me for the storm that followed.

We are grateful to District Attorney Thomas Quinn and his staff for their guidance, as well as to the Fire Chiefs Association of Massachusetts and the Bristol County Fire Chiefs Association for their support throughout.

Finally, we thank the retired chiefs of the FRFD, along with current and retired chiefs from across the country, who reached out with words of encouragement and solidarity. The brotherhood among chief officers remains strong, and your support has been a source of strength.

The support received at every level (local, state, and federal) demonstrates the collective strength of our community and our shared commitment to protecting and caring for one another in times of crisis. If anyone who offered support has not been mentioned here by name, please accept our sincere apology. No one was intentionally left out, and every effort, large or small, is deeply valued and remembered.

Stay safe,



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Fall River Fire Department

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