STATE FIRE MARSHAL'S OFFICE

Firefighter Line of Duty Death Investigations

ANNUAL REPORT
FY 2003

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Firefighter Line of Duty Death Investigation
FY03 Annual Report

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TEXAS DEPARTMENT OF INSURANCE
STATE FIRE MARSHAL'S OFFICE
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Executive Summary

During state fiscal year 2003, the State Fire Marshal's Office (SFMO) conducted seven firefighter line-of-duty death investigations. These investigations were conducted under the authority of Texas Government Code Chapter 417.0075.

Investigations of these seven firefighter deaths provided unique insight into firefighting operations, equipment use, health issues and other aspects affecting the Texas fire service.

The SFMO continues to involve Texas fire service associations and fire-related state agencies in the investigation process. This involvement ensures that each investigation reflects a multifaceted view of the circumstances surrounding the tragedies and, equally important, provides team members with hand's on exposure to the problems facing the Texas fire service, thus maximizing the ability of the member's organizations to implement changes that will improve firefighter safety throughout the state.

Impacted Texas fire departments participated fully in the investigations, making statements, logs, equipment and other information available to the investigators.

With the assistance of the following organizations, the State Fire Marshal's Office continues refine investigation of line of duty deaths:

- State Firemen's & Fire Marshals' Association of Texas,
- Texas State Association of Fire Fighters,
- Texas Fire Marshal's Association,
- Texas Fire Chief's Association,
- Texas Commission on Fire Protection,
- Texas Forest Service
- Texas Engineering Extension Service, Emergency Services Training Institute, Texas A&M University System.

The State Fire Marshal's Office is truly grateful for the involvement of these organizations and their officers and members. Their contributions ensured that the

investigative effort provided meaningful assistance to the affected departments and that the reports added to the body of knowledge that will hopefully prevent firefighter line of duty deaths in the future.

LODD Investigation Authority

Effective September 1, 2001, House Bill 1450 amended Chapter 417, Texas Government Code by adding Section 417.0075 requiring the State Fire Marshal's Office (SFMO) to conduct an investigation if a firefighter dies in the line of duty in connection with a fire-fighting incident in this state.

The statute requires the SFMO to investigate the circumstances surrounding the death of the firefighter, including the cause and origin of the fire, the condition of the structure, and the suppression operation, to determine the factors that may have contributed to the death. The State Fire Marshal is required to coordinate the investigative efforts of local government officials and may enlist established fire service organizations and private entities to assist in the investigation.

LODD Investigation Program Impact

Since the inception of this program in September 2001, the State Fire Marshal's Office has conducted thirteen firefighter line-of-duty death investigations. Assessment of these investigations has revealed usable information that has led to revision of operational procedures and a strengthening of firefighter safety awareness within the Texas Fire Service.

While we believe that individual firefighter line-of-duty death investigation reports are helpful to the affected fire departments, it is the more global information drawn from this experience that will enable the fire service to implement safety measures that benefit all Texas firefighters.

Fortunately, the State Fire Marshal's Office has the support of many organizations in communicating fire service safety messages. Professional organizations are critical communication partners. Likewise state and federal agencies have a significant role in both communicating safety information and the development of public policies affecting firefighter safety. The following information illustrates firefighter safety policies and initiatives resulting from analysis of the investigation reports.

- The State Fire Marshal implemented policy encouraging members of the LODD Advisory Committee to ensure that "lessons learned" were taken back to their respective organizations and "optimally integrated" as appropriate. These efforts include direct contact with the affected fire department, improvements to training plans, firefighter certification requirements,

equipment design, standards/policy development, and professional organization outreach.

- The State Fire Marshal issued a "Red Border" Alert relating to heart attacks being the leading cause of on-duty firefighter deaths. This alert called on the Texas fire service to implement strategies to screen firefighters for heart disease and establish physical performance requirements and programs. This alert was distributed in partnership with various fire service organizations.

- The Texas Commission on Fire Protection, at their July 2003 meeting, established an ad-hoc advisory committee to review the current state of wellness and fitness of the Texas fire service and to recommend any action that the commission should take to address this important aspect of the job. The committee's 14 members include a variety of fire service personnel with knowledge and experience in wellness programs, exercise programs, labor/management relations, municipal budgeting, diet, fitness, and disability law.

  The commission has asked the committee to explore whether the commission should develop rules concerning fire fighter physical standards for the health, safety and wellness of fire fighters, and to recommend actions the commission could take to assure that any such rules would result in improved fire fighter health, safety, and wellness. The commission also asked the committee to recommend actions the commission can take to implement any such rules in a non-punitive fashion.

Overview of the Texas Fire Service

The Texas fire service is comprised of paid, volunteer and combination departments. Recently, the Texas Forest Service, a component of the Texas A & M University System, published results of a survey of 1,802 fire departments. The survey revealed:

- Of the 1,802 departments, 82% were volunteer, 6% were fully paid and 12% reported being a combination of paid and volunteer firefighters.

- 59,141 firefighters were reported, 68% volunteers, 32% paid. Of the volunteers, approximately 71% reported being "active."

FY03 Texas Firefighter Line-of-Duty Death Composite

The FY03 firefighter line-of-duty deaths resulted from a variety of causes and circumstances. The causes of these seven deaths continue to mirror the national firefighter death statistics as reported by the U.S. Fire Administration (USFA). Heart

attacks and vehicle accidents were noted in a recently released USFA report as the leading causes of death among firefighters across the nation.

The following table provides a snapshot of each FY03 Texas firefighter line-of-duty death incident. A full copy of the summary from each investigation report is included as an appendix to this document.

Firefighter Name	Date of Death	Incident Description
Michael DePauw	December 5, 2002	Heart attack - interior firefighting
Shawn Espinoza	December 13, 2002	Sudden cardiac death - attending EMS class
Gary Staley	January 19, 2003	Pending – interior firefighting
James Taylor	January 19, 2003	Vehicle accident - responding to emergency
Wayne Clarke	February 12, 2003	Sudden cardiac death - physical training
Stephen McGregor	March 8, 2003	Sudden cardiac death - wildfire suppression
Lance Mathew	March 18, 2003	Vehicle/pedestrian accident – responding to emergency

National Firefighter Death Composite

The United States Fire Administration (USFA) released its *Firefighter Fatalities in United States in 2002* in October 2003. This report provides an in-depth analysis of 100 on-duty deaths that occurred in the United States during 2002.

In the publication, USFA reports that:

- 38% of nationally reported 2002 firefighter on-duty deaths were caused by heart attack or stroke.
- 29% of the 2002 deaths were the result of vehicle collisions, including firefighters that were struck by, or fell from, vehicles.
- 12% of the 2002 deaths were attributed to structural collapse during fire attacks.
- The remaining deaths were attributed to other fire and non-fire related events.

LODD Investigation Report Distribution

Upon release, LODD investigation reports are sent to the affected fire department and are placed on the agency's Internet web site for access by the fire service, media and the public. National interest has resulted and the reports have been downloaded numerous times. The breakdown of downloads from inception through the end of September 2003 is as follows:

Placed on Internet	Number of Downloads	Firefighter and Department Name
July 2002	2136	Jay Jahnke, Houston Fire Department
September 2002	480	Vincent Davis, Dallas Fire-Rescue
October 2002	456	David Butler, Spring Branch Volunteer Fire Department
October 2002	367	Kevin Baker, Mid-North Volunteer Fire Department
October 2002	304	Roger Dunn, Clute Volunteer Fire Department
November 2002	353	Travis Wiens, Wichita Falls West Volunteer Fire Dept.
September 2003	5	Michael DePauw, Dallas Fire-Rescue
September 2003	4	Shawn Espinoza, Ranger Volunteer Fire Department
September 2003	Not yet released	Gary Staley, Porter Volunteer Fire Department
September 2003	6	James Taylor, Bonham Fire Department
September 2003	4	Stephen McGregor, Baird Volunteer Fire Department
September 2003	7	Lance Mathew, Labelle-Fannett Volunteer Fire Department
October 2003	No statistics available	Wayne Clarke, Dallas Fire-Rescue

In addition, the LODD information brochure was downloaded 1,485 times and the FY 2002 Annual SFMO LODD Investigation Report was downloaded 1,260 times.

LODD Investigation Protocol

Upon notification of a firefighter LODD, the SFMO:

- Dispatches the closest Deputy State Fire Marshal to provide immediate assistance, gather preliminary information and to secure the scene.
- Designates an SFMO Deputy State Fire Marshal as the Incident Team Leader (ITL), who is responsible for coordinating the investigative efforts of SFMO with local fire and law enforcement agencies. Additional SFMO personnel may be sent to assist, depending on the nature of the investigation.
- Requests additional assistance from the Fire Ground Operations Task Force and the Benefits Task Force, as appropriate.
- Notifies Texas Department of Insurance executive staff and Public Information Office as well as state, federal, and national fire service organizations and agencies.

When the SFMO Incident Team Leader (ITL) arrives at the scene of a LODD, the ITL meets with local fire and law enforcement officials to determine what investigative efforts are underway and coordinates the deployment of SFMO personnel. Additional resources may be requested from local, state, and federal agencies. The LODD ITL is responsible for coordination and preparation of the final LODD report.

SFMO and local investigators conduct a fire scene investigation to determine the origin and cause of the fire. LODD incidents involving wild fires may require assistance from Texas Forest Service investigators. If the fire is determined to have been caused by intentional or negligent action, SFMO investigators coordinate any criminal investigation with local law enforcement. An origin/cause determination report is prepared for the ITL.

SFMO inspectors and local fire and building inspectors may conduct an examination of the condition of the building where the LODD occurred. The building is examined for compliance with state and local fire codes and for conditions that may have led to rapid fire or smoke spread or the entrapment of the deceased firefighter. If the building was equipped with any automatic fire protection systems such as fire sprinklers or fire alarms, these system are examined to determine if they performed properly during the fire. A report is prepared for the ITL.

The Fire Ground Operations Task Force assists SFMO in evaluating the tactics used in fighting the fire, utilization of personnel and equipment, performance of protective equipment, and fire scene communications. The Texas Commission on Fire Protection may be requested to conduct an examination of firefighter personal protective equipment for compliance with national standards and adopted state rules. The National Institute for Occupational Safety and Health conducts free testing and evaluation of firefighting breathing apparatuses and components. Reports from these groups are prepared for the ITL.

The Benefits Task Force assists survivors of deceased firefighters with grief counseling and information on state, federal, and private death benefit programs. These benefits may exceed $900,000, depending on the incident. Additional benefits to survivors include college tuition waivers at state universities and colleges for the children and spouse. Critical incident stress debriefing and counseling can be arranged for to assist other firefighters in the loss of their friend and co-worker.

Information on conducting a traditional fallen firefighter's funeral is available for those families and fire departments that request assistance.

As the on-scene investigation into the LODD concludes, the ITL meets with all investigative groups and task forces to ensure consensus is reached regarding the origin and cause of the fire and the cause of the LODD. Additional investigation may be required before a final determination is made. The ITL coordinates any off-site or continuing investigative activities with local authorities.

When all aspects of the LODD investigation have been completed, the ITL prepares a draft report of the LODD investigation using a standard narrative format. Upon

completion of the draft report, it is distributed to the task force entities that participated in the investigation for review and comment. A final review session is conducted with all participants before submission to the State Fire Marshal for final approval and presentation to the Commissioner of Insurance. The report is made available to the fire department of the deceased firefighter and released to the public. An electronic version is posted on the Texas Department of Insurance/State Fire Marshal's Office Internet web site.

LODD Outreach Program

To ensure that the Texas fire service was knowledgeable about the LODD process, the SFMO developed and delivered a comprehensive outreach program.

- Electronic copies of the enabling statute, brochure, and individual firefighter LODD investigation reports are available on the TDI Internet web site. Several national fire service web sites have provided links on their web sites directing users to the investigative reports.

- SFMO personnel continue to distribute LODD program materials and to make presentations to fire service groups such as the East Texas Arson Investigator's Conference, Gulf Coast Fire Prevention Conference, West Texas Arson Investigators Conference and the Harris and Cass County Fire Fighters Associations.

- A presentation regarding the SFMO LODD Investigation program was made at the International Association of Fire Chiefs Fire-Rescue International conference in Dallas. National interest in the program was high.

- The LODD program remains a primary focus at the annual State Fire Marshal Conference. Approximately 150 local fire marshals attend, providing a unique opportunity to disseminate information to those otherwise unable to attend regional venues.

Recommendations

Based on the conditions found during the FY03 LODD investigations, the SFMO makes the following general recommendations. Incident-specific recommendations are incorporated into each LODD report:

Medical Screening

- Fire departments should make every reasonable effort to screen firefighters for heart disease in an effort to reduce the number of heart attack deaths.

- Fire departments must encourage applicants to be forthright in disclosing medical conditions that may endanger their lives or the lives of other firefighters or civilians.

  If an applicant indicates a medical condition that poses a significant risk of injury or death, the department may choose to assign the applicant to non-emergency duties that would not subject the applicant to undue stress or physical exertion. Medical screening may be required to make a final decision in permitting applicants to undergo firefighting training and assignment as active firefighters.

- Active firefighters and applicants that will operate fire apparatus should undergo periodic medical screening to detect conditions that could cause them to become incapacitated and lose control of the vehicle.

Firefighting Strategy and Tactics

- Pre-Fire Planning

  A pre-fire planning program should be implemented to enhance tactical decision-making on the fireground. The use of pre-fire plans will enable responding personnel to determine the most accessible water supply, geographical building layout including: means of access, potential exposure problems, occupancy hazards, proper positioning for defensive operations, etc.

- Incident Management System

  Officers assigned the responsibility for a specific tactical level management component at an incident should directly supervise and account for the companies and/or crews operating in their specific area of responsibility.

  The Incident Management System should be utilized at all emergency incidents. The adoption of the Incident Management System is recommended to ensure the effective use of common terminology during large scale and mutual aid incidents. Command must provide strong and clear direction for the incident.

- Personnel Accountability

  A Safety or Accountability officer should be assigned to assure that accountability is accomplished.

  Company unity must be maintained to facilitate accountability. All supervisors shall maintain a constant awareness of the position and function of all personnel assigned to operate under their supervision. This awareness shall

serve as the basic means of accountability that shall be required for operational safety.

The incident commander should initiate an accountability and inventory worksheet at the beginning of operations and should maintain that system throughout operations.

- Rapid Intervention Teams

The incident commander should evaluate the situation and the risks to operating crews and should provide one or more rapid intervention crew/company commensurate with the needs of the situation.

A Rapid Intervention Team (RIT) replacement team should be assembled when the original RIT is assigned to conduct a rescue effort during a prolonged fire attack.

Consideration should be given to establishing RIT teams for each division/sector actively involved in firefighting or high-risk activities.

- Emergency Scenes On or Adjacent to Roadways

Fire departments should develop, implement, and enforce standard operating procedures (SOPs) regarding emergency operations for highway incidents.

Fire departments should ensure that personnel wear appropriate protective clothing, such as a high-visibility reflective safety vest, while operating at an emergency scene at or adjacent to a roadway.

Fire departments should ensure that fire fighters establish a protected work area before turning their attention to the emergency.

Fire departments should consider limiting or restricting the response of their members in their privately owned vehicles to high-volume limited access highway incidents.

Fire departments should develop and implement pre-incident plans regarding traffic control for emergency service incidents.

Protective Equipment

- Protective clothing and protective equipment shall be used whenever firefighters are exposed or potentially exposed to hazards. All personnel, including engineers, support personnel, fire prevention, and medics, should be required to wear full protective equipment when operating in or around the fire ground.

- SCBA air cylinders should be maintained not less than 90% full on breathing apparatus and extra cylinders kept on emergency response vehicles. Low air cylinders should be segregated from full cylinders until filled.

Buildings and Fire Protection Systems

- Installation of floor level exit signs and illumination of exit paths may help occupants and firefighters to escape when standard exit signs and lights are obscured by smoke.

Fire Department Vehicles

- Fire department vehicles, including ambulances and utility vehicles, should not be loaded beyond the manufacturer's gross vehicle weight rating listed on the label attached to the vehicle. Overloaded vehicles may affect handling and result in excessive braking distance. Weight calculations should include the maximum number of passengers and their personal equipment, and full water and fuel tanks.

- All fire department members who drive fire service vehicles should meet the objectives specified in NFPA 1002, *Standard for Fire Apparatus Driver/Operator Professional Qualifications.*" Chapter Two applies to all fire department vehicles, including administrative vehicles and ambulances. Other chapters of NFPA 1002 follow with objectives for operators of specialized apparatus such as pumpers, aerial apparatus, etc.

- Drivers and passengers should wear safety belts at all times the vehicle is in motion.

Appendix A

FY2003 Investigation Summaries

The following summaries were extracted from individual line of duty death investigation reports. The full text the individual reports (with the exception of the Porter LODD which remains under investigation) is available on the TDI Internet web site. The summaries are listed in date order.

Captain Michael DePauw
Dallas Fire-Rescue, December 5, 2002

A 30-year veteran fire captain, age 51, died of a heart attack while leading his engine company during initial interior fire attack at a two-alarm residential fire on December 5, 2002.

On December 5, 2002 at approximately 8:10 p.m., Dallas Fire-Rescue received a call reporting a fire in a residence at 6737 Briar Cove Drive. Captain Michael DePauw and his crew on Engine 56 were dispatched and arrived at the fire at approximately 8:17 p.m. Fire was found in the attic area of the two-story residence.

Captain DePauw was with firefighters from Engine 56 and other units in a second floor bedroom when he collapsed. He was immediately carried down the stairs and out to the front lawn where cardiopulmonary resuscitation (CPR) was started.

Firefighters used an Automatic External Defibrillator (AED) to attempt to restore Captain DePauw's heart rhythm. Two treatments were administered without success when paramedics began other advanced cardiac life support (ACLS) measures. DePauw failed to respond to treatment.

Captain DePauw was placed in the ambulance, which left the scene of the fire and arrived at the hospital at approximately 8:41 p.m. ACLS procedures had continued during the trip to the Medical City Hospital.

The Dallas County Medical Examiner ruled that Captain DePauw died of atherosclerotic and hypertensive cardiovascular disease.

Captain Michael L. DePauw served in Dallas Fire-Rescue for over 30 years. He is survived by his wife and five children.

Firefighter Shawn Michael Espinoza
Ranger Volunteer Fire Department, December 13, 2002

A volunteer firefighter, age 29, died of a suspected heart attack after completing written testing at an Emergency Medical Technician class on December 13, 2002.

Shawn Michael Espinoza, a member of the Ranger Volunteer Fire Department, had been complaining of chest pain earlier in the day, but attributed the pain to a pulled muscle sustained during a foot ball game with his children. He had completed taking written EMT tests at the Texas State Technical College (TSTC) Annex in Breckenridge, Texas when he excused himself to the restroom. When he failed to return after 10-15 minutes, a classmate went to check on him and found him lying on the floor of the restroom. CPR was initiated and 911 was called.

Espinoza failed to respond to on-scene resuscitative efforts and was transported by ambulance to Stephens Memorial Hospital where he was pronounced dead a short time later.

Firefighter Shawn Michael Espinoza served in the Ranger Volunteer Fire Department for seven months. He is survived by his wife and two children.

Firefighter Gary L. Staley
Porter Volunteer Fire Department, January 19, 2003

Firefighter Gary L. Staley, age 31, died of undetermined injuries while conducting interior fire attack at an automobile showroom fire on January 19, 2003. Staley was a member of the Porter Volunteer Fire Department (VFD).

Staley was with three other firefighters and was advancing a hose line into the showroom area of an automobile restoration facility and parts store when the fire rapidly increased in intensity causing the hose team to withdraw from the building. Staley and the other team members separated as they attempted to exit the building.

The other three firefighters on the hose team made their way independently to the outside of the building. Two of the firefighters sustained critical burns and were hospitalized. The third firefighter sustained minor burns to his hands and was treated on the scene.

An attempt was made to locate Staley and remove him from the building, but intense heat and the potential for collapse prevented the rescue team from advancing more than a few feet into the building.

Many other area fire departments responded to the multiple alarm fire and after the fire was brought under control, firefighters entered the building and found Staley but

he was deceased. Staley's body was transported to the Harris County Medical Examiner for autopsy. The cause of the fire and the firefighter's death remains under investigation.

Firefighter Gary L. Staley served in the Porter Volunteer Fire Department for two and one-half years. He is survived by his daughter and his parents.

Firefighter/EMT-I James Edward Taylor
Bonham Fire Department, January 19, 2003

Firefighter/EMT-I James Edward Taylor, age 28, died from injuries sustained in a motor vehicle accident while responding to another serious traffic accident occurring on January 19, 2003. Taylor was an employee of the Bonham Fire Department.

Taylor was a passenger in the front seat of a Bonham Fire Department ambulance when another vehicle crossed the center line and struck the ambulance head on. Taylor was killed instantly and his body was trapped in the front passenger seat area. A post-crash fire consumed much of the cab of the ambulance.

The driver of the other vehicle was also killed instantly and her vehicle also caught fire after the crash. The cause of the crash has been attributed to the driver of the vehicle that struck the ambulance being distracted.

Firefighter/EMT-I James Edward Taylor served in the Bonham Fire Department for six months. He is survived by his spouse and two children.

Fire-Rescue Recruit Wayne Clarke
Dallas Fire-Rescue, February 12, 2003

A firefighter recruit, age 46, collapsed and died of a heart condition while participating in physical training in a basic firefighter academy class on February 12, 2003.

Wayne Clarke, a firefighter recruit of Dallas Fire-Rescue, was on his third trip up the stairs of a six-story fire training tower when he complained of pain in his leg and neck and was not able to continue. An instructor and three other recruits carried Clarke down the stairs of the tower.

When they reached ground level with Clarke, he was conscious but unresponsive to verbal stimuli and his skin appeared ashen. His condition deteriorated rapidly as he became unresponsive, stopped breathing and went into cardiac arrest. Instructors and recruits performed CPR and Clarke was taken to a local hospital.

Clarke failed to respond to resuscitation efforts and was pronounced dead at 9:07 AM. The autopsy report stated the cause of death was due to cardiac hypertrophy.

Fire-Rescue Recruit Wayne Kevin Clarke had been employed by Dallas Fire-Rescue for nearly three months. He is survived by his wife and two children.

Firefighter Stephen Leigh McGregor
Baird Volunteer Fire Department, March 8, 2003

Firefighter Stephen Leigh McGregor, age 62, died of sudden cardiac death while operating a farm tractor to construct fire lines at a field fire on March 8, 2003. McGregor was a member of the Baird Volunteer Fire Department (VFD).

Firefighters on the scene observed McGregor's tractor turn into an area of the field that had been burned over and stop. When the fire was brought under control, firefighters noticed the tractor had not moved and that McGregor was slumped over in the tractor cab.

Firefighter McGregor failed to respond to initial resuscitation efforts by on-scene firefighters and ACLS treatment during the trip to the hospital and he was pronounced dead on arrival at the hospital. The hospital medical records attributed the cause of death to sudden cardiac death.

Firefighter Stephen Leigh McGregor served in the Baird Volunteer Fire Department for two and one-half years. He is survived by his wife and adult son.

Lieutenant Lance Charles Mathew
LaBelle-Fannett Volunteer Fire Department, March 18, 2003

A 20 year-old volunteer fire lieutenant died when he was struck by a tractor-trailer truck at the scene of a traffic incident.

On March 18, 2003 at approximately 2:37 a.m., the LaBelle-Fannett Volunteer Fire Department (VFD) was notified by the Jefferson County Sheriff's Office of a traffic incident with minor injuries in the eastbound lane of Interstate 10 near milepost 833. Firefighters were alerted of the call via the radio paging system. The dispatcher realized the location of the call was in the Hamshire VFD's service area and she, in turn, notified that department. Hamshire VFD was sending a fire engine to the scene.

LaBelle-Fannett VFD Lieutenant Lance Mathew and firefighter George Dearborne responded directly to the incident scene in their personal vehicles while other firefighters and medics traveled to the fire station to pick up the ambulance.

Firefighter Dearborne arrived first, parked on the inside westbound shoulder directly across from the original incident, and walked across the median to the to assess the situation. Dearborne advised personnel by radio that one person had sustained hand injuries at the incident. No fire or EMS apparatus had arrived at the scene.

Lieutenant Mathew arrived shortly after Dearborne and parked his personal vehicle directly behind Dearborne's. Mathew alighted from his truck and walked across the grassy median toward the original incident.

Lieutenant Mathew stepped out into the eastbound lane of traffic directly in front of an oncoming truck. The driver of the tractor-trailer had no time to react and was unable to stop, and the right front part of the truck-tractor stuck Mathew.

Lieutenant Mathew was thrown by the impact to the grassy median approximately 170 feet east of the point of impact. Lieutenant Mathew sustained catastrophic injuries. The Jefferson County Medical Examiner ruled Lieutenant Mathew died of severe craniocerebral injuries.

Lieutenant Charles Lance Mathew served in the LaBelle-Fannett Volunteer Fire Department for over two years. He is survived by his parents.