

June 9, 2000

The purpose of this memorandum is to document my reasons for recommending the termination of Mr. Eric Schmidt from his position of Safety Engineer, GS-0803-13, during his probationary period. Mr. Schmidt entered into duty on June 20, 1999. Mr. Schmidt was hired at the step 6 level because it was anticipated that his unique blend of experience and expertise in fire fighting and safety engineering would be a tremendous asset in investigations of fire fighter fatalities, and the development of recommendations to prevent future incidents. I am making the recommendation for termination because of Mr. Schmidt's marginal performance in the conduct of fatality investigations and report preparation— a major duty of his position, and one of the critical elements of his performance plan. My efforts to provide guidance to Mr. Schmidt so that he could successfully perform his job, and an illustrative example of his marginal performance despite this guidance, are detailed below.

My concerns about Mr. Schmidt's performance first arose mid-December 1999 in relation to a fatality investigation he led at the beginning of December. I met with Mr. Schmidt and provided verbal guidance on standard procedures for collecting information, and the need to restrict information gathering during fatality investigations to those pieces of information which are needed to summarize the chain of events or that have direct implications for prevention recommendations. I also discussed with Mr. Schmidt the need to concentrate on fatality investigations rather than other research endeavors proposed by Mr. Schmidt during this conversation. Based on input from the Team Leader and other team members on the December investigation and previous investigations, I had concerns about Mr. Schmidt's abilities to work effectively as part of a team. I chose not to address this with Mr. Schmidt as I was operating solely on hearsay and I recognize that interpersonal dynamics are influenced by each individual's personality and perspective.

Because my concerns about Mr. Schmidt's performance arose at the end of the rating period which I also considered to be a training period for Mr. Schmidt, I thought the only fair and appropriate action for his performance evaluation was to give him a fully successful performance rating overall; and, for the conduct of fatality investigations specifically. I determined, however, that it was critical for me to directly observe Mr. Schmidt's performance during a fatality investigation, so that I would be in a better position to assess his performance and provide him with concrete guidance for improvement, if needed.

I accompanied Mr. Schmidt and two other investigators on a fatality investigation on January 18-20, 2000. My concerns about Mr. Schmidt's performance in the conduct of fatality investigations and his ability to interact effectively as a member of a Team were heightened by this direct observation. I discussed my concerns verbally with Mr. Schmidt and followed up with written guidance on February 14, 2000. The purpose of these discussions and written documentation was to provide Mr. Schmidt with concrete guidance for him to improve his performance. Areas identified for needed improvement were: identification of the types and level of detail that should be collected during an investigation; following standard procedures in gathering information, and working effectively as a Team member. It is noteworthy that the

written guidance states that one of the consequences of being unfocused when conducting an investigation is inefficient use of time. *It was explicitly stated in the verbal and written guidance that Mr. Schmidt would need to improve his performance in order to demonstrate successful performance prior to the end of his probationary period.*

In the written guidance to Mr. Schmidt, a meeting was prearranged for a month later to assess progress and performance. Mr. Schmidt and I met on March 17, 2000. At this meeting I pointed out that it was difficult for me to assess progress in the areas outlined in the February 14 written guidance because I did not have a product to evaluate. This was despite the fact that Mr. Schmidt, at a meeting of the investigating team and Team Leader following the January site visit, suggested that a draft would be available by the end of February. I indicated to Mr. Schmidt that I would provide feedback on a dry run of a forthcoming presentation he was to give on the NIOSH Fire Fighter Fatality Investigation and Prevention Program, and after receiving a draft report of the January fatality investigation. Mr. Schmidt gave the dry run presentation in April; I provided feedback to him that the presentation was satisfactory. A draft report of the January investigation was not provided until the beginning of June, and only after I imposed a deadline for some version of a draft.

At various times beginning in February, I and the Team Leader emphasized to Mr. Schmidt the need for a report to be drafted on the January investigation. At my March 17 meeting with Mr. Schmidt, he noted that he had just gotten dispatch tapes from the fire department. I expressed concern at that point as to whether the dispatch tapes were needed based on my involvement in the investigation. Although dispatch logs are routinely collected during investigations, dispatch tapes are not. Obtaining the dispatch tapes did not in my opinion seem like a fruitful area of inquiry. In late April/early May, Mr. Schmidt reported that he had received the transcriptions of interview tapes. I noted my concern about the decision to transcribe the tapes, and the delay introduced by awaiting these tapes. Though previously discussed for other investigations, taped interviews had never been transcribed before-- the time for transcription was always one of the factors in these discussions. At a May 2 Team meeting, Mr. Schmidt reported that a draft report from the January investigation would be circulated around the third week of May. On May 30, I inquired of Mr. Schmidt as to when I could anticipate a draft of the January investigation. He noted that it would not be available for several weeks, as he had only recently received the final interview transcripts, and he had scheduled travel in which he would participate in two new investigations, and conduct additional interviews associated with the January investigation. I questioned the decision to participate in additional investigations since a report for the January investigation had not been drafted. The scheduling of travel to participate in new investigations apparently arose out of a misunderstanding from a team meeting in which tentative teams were identified for pending investigations. It may not have been recognized by all Team members that scheduling of these investigations was not to be initiated until adequate progress had been made on pending reports. I also inquired as to the additional interviews that needed to be conducted for the January investigation. I agreed with the potential need for one of the interviews with a police officer who had been on the scene, but not the interviews of dispatchers which Mr. Schmidt proposed. I explicitly asked if there was any version of a draft of the January investigation that I could review. Mr. Schmidt replied that he had not initiated a draft of the

report, but instead had been putting together a matrix of information from the transcribed interviews that would be useful in establishing a timeline for the fatal event.

I followed up with Mr. Schmidt on May 31 to inform him that I had decided he needed to cancel his travel for the new investigations and additional interviews associated with the January investigation, and concentrate on drafting the report from the January investigation. I provided guidance that in the draft report, he should note areas of uncertainty and missing information. I asked for some form of a draft report, which could include detailed outlines, by close of business on June 2, 2000.

On June 2, Mr. Schmidt provided me with three items that are described below, along with my assessment or concerns regarding each item:

- a 1-page outline of potential contributing factors to the fatal event. This outline was developed shortly after the January site visit. There does not appear to have been further refinement of the outline, including the development of draft recommendations suggested by these potential contributory factors.
- a 500 plus page matrix, which Mr. Schmidt indicated was a work in progress. The matrix included information from the transcribed interview tapes, reordered in an approximate time line. This matrix appears to have required substantial amounts of Mr. Schmidt's time. The utility and necessity of such a matrix is not clear, however. It is not clear that this matrix is necessary for sufficiently describing the sequence of events leading to the fatalities, or in identifying contributory factors for the purposes of developing recommendations to prevent future events. I am concerned that Mr. Schmidt has expended inordinate amounts of time on this exercise, in the absence of making progress on describing the sequence of events leading to the fatalities, and developing recommendations for the prevention of future similar events.
- a 2-page summary of the event. A summary is one component of the standard fatality report- it typically includes recommendations; this summary did not. Other parts of the fatality report were not provided, nor was an outline of proposed content provided. Missing components included the introduction, investigation, cause of death and recommendations/discussion sections.

It is not possible to assess from what has been provided by Mr. Schmidt whether he has minimized his fact gathering, per the February 14 written guidance, to those pieces of information which are needed to summarize the chain of events leading to the fatality, or that have direct implications for prevention recommendations. I have concerns, based on my involvement in the initial investigation, about Mr. Schmidt's continued inquiry into issues regarding the dispatchers and the potential presence of volatile materials on the deceased fire fighters' turnout gear. Though Mr. Schmidt did not tell me when I inquired about the additional interviews he had planned, he did share with a fellow investigating team member that he planned to conduct additional interviews to assess whether the deceased fire fighters might have had volatile materials on their turnout gear from their earlier response to a motor vehicle collision. In my verbal counsel to Mr. Schmidt following our January site visit, I discussed with him that even if the turnout gear was contaminated with volatile materials, available evidence suggested this was not a contributor to the fire fighter deaths. Information gathered during the investigation

indicated that the three fire fighters were killed during a significant fire event, probably a flashover. I discussed with Mr. Schmidt that it was unlikely that the presence of volatile materials on the turnout gear would have made the difference between life and death given the extreme temperatures to which the fire fighters were exposed. I also discussed with Mr. Schmidt that while there might be merit to fire fighters changing their turnout gear subsequent to responding to motor vehicle crashes, such a recommendation would have limited utility in preventing future deaths when fire fighters respond to a structure fire with the possibility of an event such as a flashover. I also discussed with Mr. Schmidt the variety of other contributing factors which were clearly related to the deaths, and recommendations which could help prevent future similar events, such as doing a "size up" of the fire scene, establishing and transferring incident command, establishing a system to account for all fire fighters on the scene, training, and adequate staffing.

It is clear that Mr. Schmidt has spent substantial amounts of time developing the matrix which is of questionable utility and necessity. He has also demonstrated poor judgement in delaying drafting of the report while awaiting dispatch tapes and transcribed interviews, and pursuing new investigations when the draft for the January investigation had not even been initiated.

Recognizing that the complexity of each case and other duties influence the time needed to complete each fatality investigation report, I have not dictated a mandatory time for development of a draft fatality investigation report. However, the importance of releasing reports in a timely fashion is continually emphasized to all investigators. Reports have been drafted by other staff for similarly or more complex events investigated in late December and January. Lead authors for these investigations, similar to Mr. Schmidt, have juggled multiple investigations and duties. One of these staff is a more junior level employee, the other the Team Leader. As well, the National Fire Protection Association, who conducted an investigation of the event at the same time as us and participated in our fire fighter interviews, reportedly is nearing completion of their report.

As discussed above, one of the areas in which I counseled Mr. Schmidt in January and February was the need for him to improve in how he worked with other team members. Most fire fighter fatality investigations are conducted by teams rather than individuals. Team work is critical for maximizing the quality of the investigation and report. It initially appeared that Mr. Schmidt had improved his effectiveness in working as part of a Team. I had not observed any negative interactions with other staff, nor had any been reported to me by the Team Leader or team members. However, recent events and information raise these concerns again, and are specific to the January investigation.

The investigation team consisted of two other investigators in addition to Mr. Schmidt. Although I accompanied the investigating team, it was clear that my role was as an observer. One of the investigators retired a couple of months ago, leaving Mr. Schmidt and a junior investigator as the investigating team. It is noteworthy that one of the consequences of not having an earlier draft report is that opportunities were missed to get input on the investigation findings and recommendations from the retired senior investigator. The junior investigator made

substantial contributions to the January site visit, and unlike Mr. Schmidt, participated in all of the fire fighter interviews and took extensive notes. (Mr. Schmidt was sick the day of the fire fighter interviews and spent the day in his hotel room). I had incorrectly assumed that Mr. Schmidt and the junior investigator had routinely gotten together to talk through the investigation findings, recommendations, and the development of the report. In following up with the junior investigator, however, I learned this was not the case. Particularly telling was that the junior investigator was not involved in discussions about the need to conduct additional interviews. Mr. Schmidt scheduled travel to conduct the interviews without seeking the junior investigator's input on whether additional interviews were needed, nor inquiring as to the junior investigator's interest and availability to participate in these interviews. Mr. Schmidt did ask the junior investigator if there were questions or areas of inquiry the junior investigator would like Mr. Schmidt to pursue. However, it appears that the junior investigator was not completely informed as to the scope and rationale for these additional interviews; he was informed about the planned re-interviews of some fire fighters, but not the interviews of the police officer or dispatchers. As lead investigator, Mr. Schmidt should have actively involved the junior investigator in the development of investigation findings and recommendations. The failure to adequately involve the other investigator contributes to inefficiency, especially since the junior investigator was directly involved in a critical aspect of the investigation that Mr. Schmidt was not, the fire fighter interviews, and potentially compromises the quality of the report by not taking advantage of the other investigator's observations, expertise, and perspective.

I consider performance on the January investigation seminal for several reasons: the assignment was made at a time when I believed that Mr. Schmidt should no longer have been in training mode; the investigation was more complicated than previous investigations led by Mr. Schmidt, but not exceedingly complex; I and the Team Leader clearly identified this as a high priority investigation; I had direct knowledge on which to base my assessment of Mr. Schmidt's performance; I provided Mr. Schmidt with concrete guidance on areas for improvement; and, the investigation has spanned across nearly 5 months, and encompasses the bulk of the period for which forthcoming midyear evaluations will be based.

Performance on the January investigation is illustrative of deficiencies evident in other investigations, but is not entirely representative of his performance in the conduct of fatality investigations throughout the year. Taken as a whole, I consider Mr. Schmidt's performance in the conduct of fatality investigations and report writing marginal throughout the year. Since entering into duty, Mr. Schmidt has been assigned to 9 active investigations, serving as lead author on 4 of these investigations. Of the reports on which Mr. Schmidt has served as lead author, one of the reports has been finalized, another is nearly final. Both of these reports are good, though relatively straightforward. Mr. Schmidt demonstrated some excellent work in one of these reports, developing a recommendation for a National Fire Protection Association standard setting committee and proposing follow-up activities. The other report was for the December investigation on which I first counseled Mr. Schmidt. This was an extremely straightforward case, with one recommendation. The amount of time for completion of this report, 6 months, is long for a report of such limited scope. The two remaining reports on which Mr. Schmidt has been assigned lead authorship are the January investigation, chronicled in detail

above, and an investigation conducted in late March/early April, for which I do not have direct observations or products on which to assess progress. The issue of Mr. Schmidt being unfocused in investigations does not appear to come into play in investigations in which he is not the lead author. Working effectively as a team member has been an issue in several investigations involving different team members. It is not apparent that Mr. Schmidt is making substantive contributions to investigations and reports led by other staff, as would be expected based on his extensive knowledge and expertise.

At the GS-13 level, Mr. Schmidt should be able to perform relatively independently. Mr. Schmidt should not require close monitoring and supervisor input to ensure he focuses on priority activities, uses good judgement, works effectively with team members, and works efficiently. As well, Mr. Schmidt's contributions to fatality investigations should consistently be at a higher level than junior level investigators in terms of quality, complexity, and innovation. Unfortunately, this is not the case. I consider Mr. Schmidt's performance throughout the year in the conduct of fatality investigations marginal for a Safety Engineer, GS-13, Step 6. Because the conduct of fatality investigations is such a critical part of Mr. Schmidt's position, I am recommending termination during the probationary period.

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