10-13-2001 Channahon IL – Kenneth Frayne – FF PSD Training

Kenneth James Frayne
https://apps.usfa.fema.gov/firefighter-fatalities/fatalityData/detail?fatalityId=1231

Firefighter Frayne and other firefighters were participating in a dive rescue training exercise. Firefighter Frayne was performing the third exercise of the day. When he and his partner descended to a depth of 50 feet, Firefighter Frayne signaled his partner to accept a rope bag and then signaled that it was time to surface. When Firefighter Frayne’s partner reached the surface, he did not see Firefighter Frayne but assumed that he had gone to shore. Upon his arrival at the beach, the partner alerted an officer that he could not locate Firefighter Frayne. A search for Firefighter Frayne, on land and in the water, began.

Firefighter Frayne was found on the bottom of the lake and brought to the surface. When he was found, his mask and regulator were not in-place and his air cylinder was empty. Firefighter Frayne was brought to shore and ALS-level care was provided at the scene and enroute to the hospital. Upon his arrival at the hospital, Firefighter Frayne received aggressive care but was pronounced dead after more than 40 minutes of resuscitative efforts. The cause of death was listed as drowning. Over an hour passed from the time that Firefighter Frayne was discovered missing until he was found.

Name:  Kenneth J. Frayne
Rank:  Firefighter
Age:  28
Status:  Volunteer
Years of Service:  4
Date of Incident:  10/13/2001
Time of Incident:  1200hrs  
Date of Death:  10/13/2001  
Fire Department: Channahon Fire Protection District  
Fire Department Address:  24929 Center St., Channahon, IL 60410  
Fire Department Phone:  (815) 467-6767  
Fire Department Chief:  David Riddle  
Cause of Death: Firefighter Frayne died during dive rescue training.  
Funeral:  10/17/2001 @ 1000hrs Channahon United Methodist Church, 24751 Eames St., Channahon, IL  
Memorial Fund: Payable to the Kenneth J. Frayne Family, Channahon Fire Protection District, 24929 Center St., Channahon, IL 60410

http://www.firehero.org/fallen-firefighter/kenneth-j-frayne/

ROLL OF HONOR

Kenneth J. Frayne
- Firefighter
- Channahon Fire Protection District
- Illinois
- Age: 28
- Year of Death: 2001

Kenneth J. Frayne was a very loving husband, son, brother and uncle. Never have I met someone who was as thoughtful and kind as he was.

Ken was the oldest of four boys. When Ken was young, he became very interested in construction and soon after learning about it, started his own business. His business grew to become very successful.

Ken also enjoyed hunting. He often hunted deer and even went boar and bear hunting a couple of times.

Ken and I were married in 1998 after dating for a year and a half. We built a house where we lived for three years and Ken became a firefighter in our community. He loved being a firefighter and getting to know everyone in our community. He was very outgoing and had many friends. We were married for a little over three years at the time of his death on October 13, 2001.
I just want everyone to know what a wonderful person he was. He was my best friend and I miss him dearly. Not a day goes by that I don’t think of him. He was raised with all the qualities you look for in a mate. He was very loving, affectionate, honest, kind, and would help anyone who needed it. He has a great attitude about life and lived it to the fullest everyday.

Heaven gained a great soul when they took him. I only wish they’d have waited a little longer before they did. Ken died at only 28 years, but, in retrospect, those 28 years were filled with lots of love, friendship and a great ambition. He wanted to be the best he could be, which in all areas of his life, was achieved. He was the best husband, son, brother and uncle. I miss him dearly. May God bless and keep him.

**Channahon firefighter-diver dies**


COAL CITY, IL—

A Channahon firefighter died Saturday during a practice dive at the Coal City Area Club.

Ken Frayne, 28, of Channahon was pronounced dead in the Morris Hospital emergency room at 1:12 p.m., said Grundy County Coroner John Callahan. An autopsy was performed Saturday, but there were no preliminary results, pending information from toxicology tests.

A licensed dive company from North Carolina has been called to examine the equipment Frayne was wearing to check for a malfunction.

"They test the tank and the regulator and all of the equipment," Callahan said.

Frayne was with a group of department divers who started practice dives Saturday morning, the coroner said.

"They were all experienced divers diving together," he said. "They were not sure what happened when everybody came up (from a dive) but him."

No details on the firefighters death would be released by the fire department until Sunday or Monday, said Deputy Chief Don Welch.

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**Subj:** Re: PSDiver Death? Looking for more information  
**Date:** 10/18/2001 12:36:37 AM Central Daylight Time  
**From:** JMCEnterprise1@aol.com  
**Sender:** PublicSafety-owner@wateroperations.com  
**Reply-to:** PublicSafety@wateroperations.com
To: PublicSafety@wateroperations.com

Lake County Diver Supply, Hebron, IN. may be able to give you a little more info. I heard it was a body recovery drill from a vehicle. **Diver recovered in 50' of water with mask off and 100 PSI.** This is second hand info. Talk to Hank at the dive shop, he's a Lake County Sheriff's Deputy.

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**Subj:** Re: Question
Date: 10/18/2001 8:17:30 AM Central Daylight Time
From: Bombero400
To: MPhill9929

Mr. Phillips: My Deputy has forwarded your question to me. I'm the Chief of the Channahon Fire Protection District. The information you have is correct. The balance of the exercise is under investigation at this time, by a variety of agencies and interests. I wish I could tell you more, but right now, we just don't have any answers.

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**Volunteer Fire Fighter Drowns During Multi-Agency Dive-Rescue Exercise - Illinois**

**SUMMARY**

On October 13, 2001, a 28-year-old male volunteer fire fighter (the victim) drowned during a multi-agency dive-rescue exercise. The dive exercise included a dive coordinator, an assistant dive coordinator, and seven divers. The site of the incident was a man-made lake that is owned and maintained by a private club. The dive coordinator and assistant dive coordinator had sunk a boat and two mannequins in the lake to simulate a boating incident. Four of the divers, including the victim, were on their second dive when the victim failed to surface. Dispatch was notified of the missing diver, and additional search-and-rescue crews responded to the scene with two rescue boats. The victim was found in the area of his last known location, approximately 1 hour and 15 minutes after he was last seen by his dive partner. He was transported to a local hospital where he was pronounced dead.

NIOSH investigators concluded that, to minimize the risk of similar occurrences, fire departments should:
• develop, implement, and enforce standard operating procedures (SOPs) regarding diver training
• ensure that each diver maintains continuous visual, verbal, or physical contact with his or her dive partner
• ensure that a backup diver and a ninety-percent-ready diver are in position to render assistance
• ensure that the dive coordinator stays informed about the rates of air consumption by divers
• provide divers with refresher training on the hazards of lung overexpansion injuries and prevention measures

INTRODUCTION

On October 13, 2001, a 28-year-old male volunteer fire fighter (the victim) drowned during a multi-agency dive-rescue exercise.

The National Institute for Occupational Safety and Health (NIOSH) was notified of this incident on October 16, 2001, by the fire department involved in this incident and the United States Fire Administration. On November 13, 2001, two safety and occupational health specialists from the NIOSH Fire Fighter Fatality Investigation and Prevention Program investigated this incident. Meetings were conducted with the Chief of the department, the county coroner, the attorney representing various fire departments involved in this incident, and the administrative coordinator for the fire department. Officers and fire fighters directly involved in the exercise and the search-and-recovery operation were interviewed. The NIOSH investigators reviewed the county sheriff’s police report, the emergency medical service (EMS) report, the medical examiner’s report, the dive department’s dive rescue standard operating guidelines (SOGs), an inventory of the victim’s dive equipment, medical records, and his training records. A site visit was conducted and the incident scene was photographed.

A review of the County Sheriff’s police investigative report, health records, and the victim’s autopsy report was performed by a U.S. Navy Diving Medical Officer (expert review) upon request by NIOSH investigators. Though medical findings were inconclusive, the medical examiner and the reviewing medical officer noted the possibility that an air embolism may have contributed to the drowning.

At the request of the victim’s fire department, an evaluation of the victim’s dive equipment was conducted by the U.S. Department of the Navy’s, experimental diving unit. An evaluation of an air sample was taken from the air tank and found to be free of any contaminants. The buoyancy compensator (BC) was tested and found to work as designed. Tests of the regulator system showed that it did not meet manufacturer’s specification for cracking pressure (pressure required in the second-
stage regulator to initiate air flow), and delivered a large amount of air with minimal effort. It is inconclusive whether the poorly regulated air flow from the regulator contributed to the victim running out of air.

The site of the incident is a man-made lake that is owned and maintained by a private club. The lake has a controlled access gate on the road leading to the beach. The staging area for the dive-rescue exercise was a sandy beach with a paved parking area, a boat ramp, and a restroom facility. Records of the depths and size of the lake were not available at the time of the investigation. The area of the lake where the dives were conducted was approximately 50 feet deep. The width of the lake at the incident site is approximately 250 feet. Based on interviews, the water visibility on the day of the incident was approximately 5 to 10 feet and the temperature was approximately 50° F.

The fire department involved in this incident consists of two stations with a total of 45 uniformed fire fighters. The department serves a population of approximately 8,000 in a geographic area of about 38 square miles. The department requires all new fire fighters to complete the training requirements for NFPA fire fighter level I and II certification and to serve a 1-year probationary period. The fire department requires all new dive team members to be Professional Association Dive Instructor (PADI) open-water certified. The victim was certified NFPA fire fighter level I and II as well as PADI open-water certified. The victim’s dive certifications included dry-suit diver, ice diver, surface ice rescue specialist, visual inspection procedures, and basic river rescue. The victim had 4 years of volunteer fire-fighting experience and 1 year of diving experience.

INVESTIGATION

A multi-agency dive-rescue exercise was organized by a dive coordinator and an assistant dive coordinator to familiarize area rescue divers with search patterns and working together. The exercise included a dive coordinator, an assistant dive coordinator, and seven rescue divers (the victim and Divers #1 to #6) from four fire departments. Before a scheduled briefing, the dive coordinator had sunk a 14-foot john-boat at the dive site. After removing the seats and cushions from the john-boat, the dive coordinator punched numerous holes in the boat and wedged half a cement block at each end of the boat. After sinking the boat, the dive coordinator dropped an adolescent (young adult) mannequin and a child mannequin into the water near the boat to simulate a capsized boat with two victims.

The briefing began at 0730 hours at the dive coordinator’s fire station with all present except Diver #1. The dive coordinator briefed everyone on the area and the scenario of the overturned boat and the two potential victims. He then described the search pattern to be used (a V-pattern). Note: The V-pattern uses a ski rope (having a handle on one end) and a line tender on the surface of the water or from a boat. A diver (lead diver) descends to
the bottom while holding on to the handle. Additional divers are then assigned to either the lead diver’s left or right side by the line tender on the surface. Each diver descends along the ski rope, meets up with the lead diver, and proceeds to his or her assigned position on either the lead diver’s left or right side (Diagram 1). The coordinator then reviewed the hand signals to be used for communicating while underwater.

The group arrived at about 0830 hours at the dive site, where Diver #1 joined them. The divers were in dry-suits but did not have any underwater communications systems. The dive coordinator used his personal pontoon boat to monitor the divers while practicing search patterns.

The initial dive lasted approximately 40 minutes. After exiting the water, the divers and dive coordinators conducted a debriefing on shore lasting approximately 15 minutes. Note: After completing the first dive, the victim did not change out his air tank. Diver #2 reported to NIOSH investigators that the victim had between 2000 and 2100 psi of air (a full tank would have 3000 psi of air) left in his air tank after the first dive. For the second dive, the dive coordinator paired the divers so that each set of divers would have a partner from a different department. The victim was the partner of Diver #1. Diver #2 and Diver #3 were paired together. Diver #6 did not have a partner. Diver #4 (having difficulty staying warm) and Diver #5 (having problems clearing his ears) stayed near shore and did not participate in any additional dives.

The victim, Diver #1, Diver #2, Diver #3, and Diver #6 deflated their buoyancy control devices (BCDs) and descended while being towed (at idling speed) away from the shore by the pontoon boat. The dive coordinator and the assistant dive coordinator were in the boat. The boat was heading west from the beach area with the divers in the V-pattern. When the divers were approximately 15 feet from the east shore, Diver #6 surfaced, signaled that he was alright, and swam back to the beach. Note: Diver #6 was having problems with his pressure gauge giving him a false reading. The dive coordinator continued driving the boat toward the west shore when the adolescent mannequin and boat were found (Diagram 2). All four divers then surfaced; Diver #1 surfaced with the adolescent mannequin. A surface marker was placed directly above the sunken boat with the pontoon boat (with the dive coordinator and assistant dive coordinator) positioned nearby. The assistant dive coordinator jumped into the water and assisted Diver #1 in getting the mannequin into the boat.

After getting the mannequin into the boat, Diver #1 and the victim descended to continue searching near the sunken boat. The victim and Diver #1 were to do circle patterns on the east and southeast side of the sunken boat. The victim tethered a rope to the sunken boat. The rope was used as a guide for the victim and Diver #1. The victim held on to the rope bag while Diver #1 held on to his other hand. Diver #2 and Diver #3 descended to do circle patterns on the north side of the sunken boat. The
divers continued with the search patterns trying to locate the child mannequin.

Diver #2 surfaced to get a lift bag to attach to the sunken boat to be used as an underwater marker. While Diver #2 was putting air into the lift bag, his regulator began free-flowing (a malfunction of the regulator results in a free flow of air rather than a termination of air), causing the lift bag to overinflate. The boat began to rise off the bottom at an angle. Diver #2 and Diver #3 surfaced and told the dive coordinator that the boat had begun to rise from the lake bottom but was lifting at an angle. Diver #2 corrected the problem with his regulator before the two divers descended to release air from the lift bag. The dive coordinator saw the rush of air that had been released from the lift bag. At approximately 1050 hours, the assistant dive coordinator saw two people surface at the shore and walk toward the vehicles. Note: It was later determined that this was Diver #5 and Diver #6. The dive coordinator also saw two sets of bubbles in the area that the victim and Diver #1 were searching. Diver #2 and Diver #3 surfaced (on the north side of the pontoon boat) at this time. After completing three to four sweeps near the sunken boat, the victim signaled to Diver #1 that he was going to surface. Approximately 2 to 3 minutes later, Diver #1 surfaced on the south side of the pontoon boat (Diagram 3). The victim was not seen again until he was located at approximately 1215 hours (Photo 1 and Diagram 2).

While the dive coordinator was talking to Divers #1, #2, and #3, he could see the truck with Divers #5 and #6 leaving the parking area. The dive coordinator then decided to end the exercise and head back to the beach. Diver #2 then asked about the victim’s location. The dive coordinator and assistant dive coordinator began looking for bubbles on the water’s surface (Photo 1). Not seeing any bubbles, they scanned the shoreline. Diver #1 then informed them that the victim had passed him the rope bag and had indicated that he was coming to the surface. They yelled to the diver on shore (Diver #4) to see if the victim was with him. He replied that he had not seen the victim. The dive coordinator then drove the pontoon boat to shore, dragging Diver #1 and Diver #2 behind the boat. Diver #3 stayed near the buoy of the sunken boat to search for the victim. When they reached the shore they searched the vehicles and the restrooms but did not find the victim. The dive coordinator then radioed Divers #5 and #6 to see if the victim had left with them. They replied that the victim was not with them. The dive coordinator and divers then realized that the victim must still be in the water. The dive coordinator called Central Dispatch to report that they might have a possible drowning. The dive coordinator set up command and assembled a team for the initial search (Photo 2). Diver #1 and Diver #2 changed out their air tanks and then swam back out to the buoy to conduct a search for the victim. They descended and searched near the sunken boat for approximately 15 to 20 minutes. They ascended and could see additional fire departments and dive crews arriving on the scene. They swam to shore where Diver #2 had his air tank refilled.
The dive teams that were dispatched had arrived on the scene with two dive-rescue boats (Dive-Rescue Boat #1 and Dive-Rescue Boat #2). The boats were deployed: Dive-Rescue Boat #2 searched along the shoreline, and Dive-Rescue Boat #1 worked near the dive buoy with divers searching the bottom. The dive coordinator had people searching up and down the road along the shore. He also had the search team in Dive-Rescue Boat #1 drag the sunken boat to the west shore to move it out of the way. Diver #2 replaced one of the search team’s divers who was having equipment problems.

The search team was using the V-pattern with Diver #1 as the tender on the surface. The divers searching along the bottom consisted of a lead diver, Diver #2 and another diver to his left, and two divers to his right. The search team had been searching the bottom for approximately 5 minutes when the diver to the left of Diver #2 tugged on his arm indicating that he had found the victim (at approximately 1215 hours). The two divers broke away from the group and moved toward the victim. **The victim was located to the southeast of the sunken boat’s original position at a depth of 50 feet. He was lying on his back, his mask and hood were off, his regulator was not in his mouth, and a couple of buckles were undone on his BCD. Diver #2 then attempted to fill the victim’s BCD with air from the victim’s air tank, but the air tank was empty.** The two divers then grabbed underneath the victim’s arms and inflated their own BCDs to bring the victim to the surface. **The victim’s weights (40 pounds) were still in place.** When the victim was brought to the surface he had blood coming from his nose and mouth. The victim was transported by Dive-Rescue Boat #1 to the shore where he was loaded into the ambulance. The paramedics removed his dive gear and clothing. He did not have a pulse and was unresponsive to advanced life support interventions. He was then transported to an area hospital where he arrived at 1233 hours. The victim was pronounced dead at 1312 hours.

**CAUSE OF DEATH**

The death certificate listed the cause of death as drowning.

**RECOMMENDATIONS AND DISCUSSION**

_Recommendation #1: Fire departments should develop, implement, and enforce standard operating procedures (SOPs) regarding diver training._

Discussion: Operational protocol, minimum equipment, personnel requirements, qualifications for team membership, and issues of training, drills, health, and safety should all be addressed in the SOGs. Operational protocol should address the needs of beginning all dives with a full tank of air and remaining in constant contact with a dive buddy. SOGs should be reviewed in-house, at a minimum, on an annual basis to see whether any changes are necessary. Every team member should have a copy of the
SOGs, and each member should sign a statement indicating that he has read, understands, and agrees to abide by them. The multi-agency dive-rescue exercise was not considered formal training. It was considered to be a scheduled monthly gathering of multiple-area dive-rescue teams, allowing dive members a chance to become more familiar with working together.

**Recommendation #2: Fire departments should ensure that each diver maintains continuous visual, verbal, or physical contact with his or her dive partner.** ² ³

Discussion: Effective underwater communication refers to the capability to communicate between divers and from a diver to the surface. The divers present at this incident were able to communicate by using recognized dive signals such as a "thumbs-up" to indicate they were okay. Fire departments should follow OSHA safety standard 29 CFR 1910.424(c)(2) by ensuring that a diver be line-tended from the surface or accompanied by another diver in the water who is in continuous visual contact during the diving operations. The victim was a volunteer fire fighter and was not covered by OSHA regulations. However, following OSHA standards would provide additional protection for fire fighters who face unique environments and hazards associated with technical rescue operations. Effective communication and continuous visual contact are two ways in which divers can convey any equipment or medical problems they may be experiencing.

**Recommendation #3: Fire departments should ensure that a backup diver and ninety-percent-ready diver are in position to render assistance.** ¹

Discussion: Public Safety Diving states that "in addition to having the normal duties of divers, a backup diver must be ready to act as a replacement if the primary is unable to perform for any mission, and he must be ready to render assistance if the primary runs into trouble. Because of the complex nature of diving, it's always possible that the backup diver will experience a problem when called. Following a policy of having contingency plans in place, it's best to have a second backup diver available, wearing an exposure suit and with his gear fully checked and functioning. If the backup diver is called on to make the descent, the ninety-percent-ready diver completes the dressing process so that he is fully ready to enter the water. With a ninety-percent-ready diver in place, the redundancy and safety of an operation increase dramatically."

**Recommendation #4: Fire departments should ensure that the dive coordinator stays informed about the rates of air consumption by divers.** ¹

Discussion: Public Safety Diving states that "The dive coordinator needs to stay informed about the rates of air consumption, since excessive consumption may indicate an equipment problem, fatigue, or an inexperienced diver." This information should be gathered by the tender.
Public Safety Diving states that "the tender should note the diver’s time of entry and their starting tank pressure. They should monitor the diver’s air bubbles, recording their breathing rate every 5 minutes, and they should continuously assess the diver’s status."

Recommendation #5: Fire departments should provide divers with refresher training on the hazards of lung overexpansion injuries and prevention measures.¹

Discussion: Public Safety Diving states that "there are several different types of lung overexpansion injuries, including arterial gas embolism, pneumothorax, mediastinal emphysema, and subcutaneous emphysema. Each of these are induced when the diver holds his or her breath for any reason during an ascent while on self-contained underwater breathing apparatus (SCUBA) or surface-supplied air. SCUBA divers are trained to breathe continuously and normally underwater, but there are many situations in which a diver may unwittingly, or unconsciously fail to follow this rule. Some of these situations occur while equalizing, dealing with mask-related problems, working hard or concentrating, while managing buoyancy, or when overweighted. If a diver is overweighted, there is an increased risk of making an uncontrolled rapid ascent. Divers who use their dry suits to control buoyancy may experience trouble with controlling their buoyancy, resulting in an uncontrolled ascent. This could result in a carotid sinus reflex and unconsciousness during ascent." In his review, the evaluating U.S. Navy Diving Medical Officer stated that "running out of air and diver inexperience are significant risk factors for air embolism" and that "a possible contributing cause may have been air embolism."

REFERENCES


INVESTIGATOR INFORMATION

This incident was investigated by Mark McFall and Jay Tarley, Safety and Occupational Health Specialists, Division of Safety Research, NIOSH.

EXPERT REVIEW

Expert review was provided by James L. Caruso, M.D., U.S. Navy Diving Medical Officer.
Diagram 1. Search-and-Rescue V-Pattern

Diagram 2. Aerial View of Incident Site
Diagram 2. Aerial View of Incident Site

Diagram 3. Aerial View of Incident Site When Victim Failed to Surface

~75 FEET

Diagram 3. Aerial View of Incident Site

Photo 1. Aerial View of Incident Scene
Photo 2. View of Incident Scene from Beach
HONORING CHANNAHON FIRE PROTECTION DISTRICT

HON. JERRY WELLER

OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES

Wednesday, November 14, 2001

Mr. WELLS. Mr. Speaker, I rise today to honor the Channahon Fire Protection District (FPD) for its years of excellent service and commitment to the community.

The Channahon Fire Protection District was organized over 50 years ago. It protects over 38 square miles which includes Interstate 55, 11 miles of the I & M Canal, over 11 miles of the Des Plaines River as well as more than 8,000 residents.

Last year, the Channahon FPD responded to over 700 calls which is quite remarkable when you consider that 90 percent of the 45
November 14, 2001

members on the department are volunteers. Channahon FPD was also successful in winning two Fire Act Grants during the first year they were offered.

Channahon FPD believes in a commitment to excellence as shown by their continuing education programs for Department members. Tragically, the Channahon Fire Protection District recently experienced the loss of Firefighter Kenneth J. Frayne in the line of duty. Ken was a four-year member of the department and died while performing dive rescue training. Ken was twenty-eight years old and left behind his wife of three years, Deborah Frayne. I know the entire Department will miss Ken and his dedication to the service. I will keep Ken and Deborah in my thoughts and prayers.

Since the attack on September 11, 2001, the whole country is more aware of the importance of our firefighters and their critical role in our national defense and security. Channahon FPD members and volunteers are excellent examples of our nation’s citizens at their finest. It has been my privilege to serve Channahon FPD as part of my 11th Congressional District. I look forward to serving and working with them in the years to come.

Mr. Speaker, I urge this body to identify and recognize other institutions in their own districts whose actions have so greatly benefited and strengthened America’s communities.
IN THE
APPELLATE COURT OF ILLINOIS
THIRD DISTRICT
A.D., 2005

DEBORAH FRAYNE, Special Administrator of the Estate of Kenneth J. Frayne, Deceased, Plaintiff-Appellant, v. DACOR CORPORATION, MINOOKA FIRE PROTECTION DISTRICT, COAL CITY FIRE PROTECTION DISTRICT, SHAWN ANDERSON, BRAIDWOOD FIRE PROTECTION DISTRICT, BRAIDWOOD FIRE DEPARTMENT, CRAIG KASHER, MARES ITALY, HTM SPORT S.P.A., HEAD USA, INC., HTM USA HOLDINGS, DACOR INTERNATIONAL and LAKE COUNTY DIVERS SUPPLY, INC., Defendants-Appellees.

Appeal from the Circuit Court of the 13th Judicial Circuit, Grundy County, Illinois No. 03--L--20

Honorable Lance R. Peterson, Judge, Presiding.

JUSTICE SCHMIDT delivered the opinion of the court:

This case arises out of the tragic death of Channahon firefighter Kenneth Frayne as Frayne trained to rescue others. Plaintiff, Deborah Frayne, as special administrator of the estate of her husband, Kenneth Frayne, filed this action seeking to recover damages following her husband's drowning in a lake at the Coal City Area Club (the Club). Kenneth Frayne was a scuba diver
for the Channahon Fire Protection District, participating in a multi-agency dive rescue training exercise at the time of his drowning. The defendants relevant to this appeal are the various fire protection districts and employees thereof who also participated in the exercise. The defendants moved for summary judgment claiming statutory immunity. The circuit court of Grundy County granted defendants' motion. Plaintiff appeals.

BACKGROUND

The training exercise mentioned above took place on October 13, 2001. In addition to Mr. Frayne from the Channahon Fire Protection District (Channahon), other area rescue teams represented in the training exercise included the Coal City Fire Protection District (Coal City), the Braidwood Fire Department and Braidwood Fire Protection District (Braidwood), and the Minooka Fire Protection District (Minooka).

At issue in this appeal are counts V through XVI of plaintiff's third amended complaint. These counts are directed against Minooka, Braidwood, Craig Kasher (a Braidwood employee), Coal City, and Shawn Anderson (a Coal City employee).

Plaintiff alleges that Minooka purchased and became owner of the scuba diving equipment used by Mr. Frayne during the exercise. Plaintiff continues that Minooka was, in fact, supervising and controlling the lake as part of its participation in the training exercise. Plaintiff further alleges that the fire protection entities had an agreement among themselves to participate in dive training exercises on a regular basis.

Plaintiff claims that pursuant to that agreement, Coal City requested and obtained permission from the Club to "use, occupy and control a part of the lake and its adjacent land to conduct the multi-agency dive training exercise." Plaintiff maintains that these entities controlled every facet and imaginable detail of the training exercise. Plaintiff argues that it was, therefore, (the duty of these entities) to exercise a reasonable degree of care and caution with regard to, not only the equipment used in the dive, but the parameters, conditions, and rules of the exercise itself. Plaintiff alleges that the breach of one or more of these duties proximately caused the death of plaintiff's decedent.

Defendants claim that as local public entities or employees they are immune from liability for the drowning of plaintiff's decedent in a body of water over which they had no control as defined by the statute. 745 ILCS 10/3--110 (West 2002).

Jody Ritz is the Club manager. The Club is run by its officers and a 13-person board. The Club charges an annual fee and has various activities including fishing, boating, and camping. There are no scuba activities or lessons allowed at the Club apart from the dive training exercises conducted by the fire protection districts. The Club covers 1,000 acres and includes a main
lake. The Club is primarily accessed by key at the front entrance which opens an electronic gate.

Shawn Anderson was one of the 13 board members of the Club. At the October 9, 2001, monthly meeting, the board discussed using the Club's facilities for a dive training exercise. The board agreed to allow the firefighters to use the lake for the exercise. There was no written contract between the Club and the firefighters and no fee was charged for the use of the lake.

The exercise took place on October 13, 2001. Ritz was at the Club during the time of the exercise and spent approximately 40 minutes in the vicinity where the exercise was occurring. No other club members were in the area where the exercise was taking place and Ritz was unaware of any interaction between other members of the Club and the divers.

According to Ritz, the firefighters determined which particular members of the municipalities would take part in the exercise. All of the equipment was supplied by the firefighters. The firefighters determined the parameters of the operation, including how long they would be there and who was responsible for cleaning up when they left. The Club put no restrictions on the divers concerning the type of dive training exercises they would perform or how long the exercise would last. No one from the Club gave any order or direction to the firefighters. No one from the Club controlled the activities of the dive team or supervised what they were doing.

Each of the participating fire protection districts had a dive coordinator of its own who took part in the training exercise. Ed Wrobel and decedent, Kenneth Frayne, participated from Channahon. Rich Arnold and Mike Thompson participated from Minooka. Coal City was represented by Shawn Anderson, Tony Mauro, Willie Wrenn, and Tim Schulz. Craig Kasher was the only representative from Braidwood. Ed Wrobel testified in his deposition that the Coal City dive team was responsible for safety precautions with respect to activities that were being conducted in the lake.

Craig Kasher from Braidwood stated that the exercise was one of several "cross trainings" in which Channahon, Braidwood, and Coal City routinely participate. Kasher stated that the "dive training exercise was supervised by Shawn Anderson of the Coal City Fire Protection District." Anderson would provide direction with regard to each drill. Kasher further remarked that he did not know who was controlling, supervising, managing, operating, or maintaining the lake in the area where the dive was being conducted at the time it was being conducted.

Richard Arnold of Minooka also participated in the dive. It was Arnold who supplied the allegedly defective scuba regulator to Kenneth Frayne. Arnold stated that he did not know who was controlling, supervising, managing, operating, or maintaining the lake at the time of the dive. In his opinion,
Shawn Anderson was supervising the dive activities that were being conducted in the water that day.

Shawn Anderson is a lieutenant and dive coordinator for Coal City. He has been a board member of the Club since 1996. As a rule, scuba diving is prohibited at the Club apart from dive training exercises. Anderson noted that since the training exercise at issue included entities other than Coal City, it was necessary to obtain specific board approval for use of the Club. Anderson brought a request to the board and received its permission to use the Club. Similar requests had been made in the past and permission was received on prior occasions. According to Anderson, no restriction of any kind was imposed on the firefighters by the Club.

Anderson claimed that the general idea of the dive was to have the divers search for and locate a sunken boat in which mannequins were placed. No restrictions were placed on the divers as to the area of the lake that they could search. Like all others that were at the lake that day, Anderson testified that he did not see anyone out on the water other than the dive participants.

It was Anderson's belief that Jody Ritz was supervising the lake that day. He based this belief on his knowledge that Ritz is the Club manager and was present at the Club during the exercise. Anderson admitted that he controlled the dive activities "to a limited extent as the dive training coordinator." Anderson stated that a "diver below" flag was placed at the site where the training was being conducted. This flag consisted of a 3-foot-round inner tube and a 1 ½-foot flag that sticks up. The purpose of the flag was "a precaution or warning sign to let other boaters know that we had divers below."

The defendants mentioned above filed a joint motion for summary judgment, claiming statutory immunity from any liability arising out of decedent's injuries, which was ultimately granted by the circuit court. This appeal followed.

ANALYSIS

We review an order granting summary judgment de novo. Espinoza v. Elgin, Joliet & Eastern Ry. Co., 165 Ill. 2d 107, 649 N.E.2d 1323 (1995). Summary judgment is a drastic means of disposing of litigation and is only appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Espinoza, 165 Ill. 2d at 113. On a motion for summary judgment, it is the movant who bears the burden of persuasion and the initial burden of production. Hall v. Flowers, 343 Ill. App. 3d 462, 798 N.E.2d 757 (2003). Furthermore, we must consider the affidavits, depositions, admissions, exhibits, and pleadings in the record in a light most favorable to the nonmoving party. Hall v. Flowers, 343 Ill. App. 3d at 469. Defendants who move for summary judgment may meet their initial burden of production by either: (1) affirmatively showing that some element
of a cause of action must be resolved in their favor; or (2) demonstrating that plaintiff cannot produce evidence necessary to support the plaintiff's cause of action. *Hall v. Flowers*, 343 Ill. App. 3d at 470. If the defendants satisfy their initial burden of production, the burden shifts to the plaintiffs to present some factual basis that would arguably entitle them to a favorable judgment. *Rice v. AAA Aerostar*, Inc., 294 Ill. App. 3d 801, 690 N.E.2d 1067 (1998).

Defendants filed a "joint motion for summary judgment" pursuant to section 2--1005 of the Code of Civil Procedure. 735 ILCS 5/2--1005 (West 2004). The joint motion alleges that section 3--110 of the Local Governmental and Governmental Employees Tort Immunity Act (the Immunity Act) (745 ILCS 10/3--110 (West 2002)) provides them with immunity from liability for plaintiff's injuries.

Affidavits attached to the motion all state that the lake was not owned, supervised, maintained, operated, managed, or controlled by the affiants' respective fire departments or fire protection districts. Plaintiff filed a motion to strike these affidavits which was granted by the circuit court prior to its ruling on defendants' motion for summary judgment. This ruling is not contested by defendants on appeal.

Plaintiff argues that the trial court erred in finding as a matter of law that the municipal entities and their employees were entitled to immunity where the competent evidence before the court failed to establish that defendants were not supervising or controlling the lake in which the fatal dive occurred. Plaintiff correctly notes that section 3--110 of the Immunity Act states as follows:

"Neither a local public entity nor a public employee is liable for any injury occurring on, in, or adjacent to any waterway, lake, pond, river or stream not owned, supervised, maintained, operated, managed or controlled by the local public entity." 745 ILCS 10/3--110 (West 2000).

Plaintiff correctly observes that if defendants engaged in any of the six enumerated activities specified in section 3--110 (owned, supervised, maintained, operated, managed, or controlled), immunity under the Act would not attach. However, plaintiff avers that the circuit court erred in finding as a matter of law that defendants did not supervise or control the lake at the time of the dive. We disagree.

After reviewing the facts of this case as they were presented by the parties and the applicable law, Judge Peterson found that "control of the dive with supervision of the dive does not equal supervision of the body of water." The
trial court based this ruling on *McCoy v. Illinois International Port District*, 334 Ill. App. 3d 462, 778 N.E.2d 705 (2002). In *McCoy*, the plaintiff's decedent was a longshoreman assisting the untying of a docked vessel when he fell into the Calumet River and drowned. The defendant port district was responsible for the maintenance of the facilities on the properties near the water. Defendant also collected fees for use of those facilities and supplied fresh water to docked vessels. Furthermore, the port district maintained the sea/dock wall from where plaintiff fell. *McCoy*, 334 Ill. App. 3d at 464.

The *McCoy* plaintiff admitted that the defendant did not "own" the Calumet River in which the decedent drowned, but argued that section 3--110 of the Immunity Act should not attach since the defendant "plays a role in the maintenance, control, supervision and management of the river by conducting business on [it] and through its responsibility for the sea walls that contain the river." *McCoy*, 334 Ill. App. 3d at 466. Noting that the plain language of section 3--110 is unambiguous, the appellate court in *McCoy* agreed with the lower court's finding that although the defendant maintained all the facilities surrounding the river, such actions did not equate to owning, supervising, maintaining, operating, managing, or controlling the body of water which is the river. *McCoy*, 334 Ill. App. at 468. Judge Peterson took note of this distinction when concluding that although the defendants may have controlled and supervised the dive, they did not control or supervise the lake.

Even when viewing the facts in the light most favorable to the plaintiff, there is no evidence suggesting that defendants could exert any minimal control over the lake. As the trial court noted, the firefighters were nothing more than guests. The uncontradicted deposition of Ritz makes it clear that defendants had no right to grant or deny anyone access to the lake or any portion of it. In fact, for defendants to conduct this exercise, they were required to receive permission from the board of the Club.

While the firefighters' movement on the lake was seemingly unrestricted, the record reveals that they had no authority to control the lake whatsoever. Ritz stated:

"They could use our lake, but they can't cord it off. Our members have the right to any waters out there and the fire department cannot rope it off or say they can't come in here. The members are the ones that are paying for all the club and they get the use of all the waters all the time."

Ritz's statements regarding the firefighters' inability to deny access to the lake to anyone are buttressed by Anderson's testimony regarding the firefighters' use of the boat ramp. Anderson stated it was necessary for the firefighters to move their vehicles away from the boat ramp "because we can't block entrance if somebody wanted to come out there."

While the plaintiff notes that defendants, or at least some of them, controlled and supervised almost every aspect of the dive itself, including everything...
from what type of equipment would be used to who the dive partners would be, the trial court correctly found that the defendants, as a matter of law, did not supervise, control, or maintain the lake and, therefore, are immune under the plain language of the Immunity Act. As such, we hold the circuit court of Grundy County correctly granted defendants' joint motion for summary judgment pursuant to section 3--110 of the Immunity Act and section 2--1005 of the Code of Civil Procedure.

CONCLUSION

For the foregoing reasons, the judgment of the circuit court of Grundy County is affirmed.

Affirmed.

BARRY and LYTTON, JJ., concur.

FRAYNE, DEBORAH SPECIAL ADM VS. DACOR CORPORATION HTTPS://WWW.DOCKETINDEX.COM/FRAYNE-DEBORAH-SPECIAL-ADM-VS-DACOR-CORPORATION-CASE-DETAILS-D2A738A09840C12D5C3EC63F556F43EE.HTML

State       | County           | Court, Source or Jurisdiction
------------|------------------|----------------------------------
IL          | GRUNDY COUNTY    | -                                |

Case Number | Disposition | Case Type
2003L20     | -           | L - LAW (L)

Case Status Jurisdiction Date Filed Judge
-                     -               05/12/2003 -

Plaintiff(s)
Full Name
→ FRAYNE, DEBORAH SPECIAL ADM
→ FRAYNE, KENNETH J ESTATE OF

Defendant(s)
Full Name
→ DACOR CORPORATION
→ MINOOKA FIRE PROTECTION DISTRICT
→ MINOOKA FIRE DEPARTMENT
→ VILLAGE OF MINOOKA
→ COAL CITY FIRE PROTECTION DISTRICT
→ COAL CITY FIRE DEPARTMENT
→ VILLAGE OF COAL CITY
→ BRAIDWOOD FIRE PROTECTION DISTRICT
Commitment beyond the badge

http://www.morrisherald-news.com/2013/05/17/commitment-beyond-the-badge/a2jmkl/?page=1

Community remembers first responders who made ultimate sacrifice
Friday, May 17, 2013  By: Eric Lutz

On an April night 25 years ago, Michael Lappe learned how quickly life could be lost.

He was eight years into a career as a Chicago cop, working some of the toughest streets in the city, when he responded to a domestic disturbance call involving a mother and an adult son.

Lappe had just finished interviewing the mother, the victim of the disturbance, and was looking to speak with the son.

But the son didn’t want to cooperate.

From a different room in the house, he ordered the police to leave.

With his gun drawn, Lappe walked down a hallway toward the kitchen, expecting the subject to be sitting at the kitchen table.

Little did he know, the man was actually hiding behind the stove, about to ambush the 32-year-old officer.
Lappe was shot in the throat.

He dropped to the ground, his gun falling from his hand. Overhead, the police and the subject exchanged rounds.

He knew he was about to die.

As his colleagues carried him out of the house, Lappe used his last moments of consciousness to ask his partners to tell his wife and two small children he loved them.

Lappe would survive, but his story speaks to the sacrifice every man and woman who wears the badge of law enforcement or emergency response undertakes every day. The danger that looms over every workday begun.

During his keynote address at the annual Grundy County Law Enforcement Managers Association Memorial Service Thursday morning, Lappe shared his story of recovery and determination in a ceremony that honored fallen law enforcement officials and emergency responders.

“Celebrate the good in life and take nothing for granted,” Lappe told the officers and firefighters in attendance. “Don’t waste the gift of life.”

It was a warm, sunny morning on the front lawn of the Grundy County Courthouse.

A crowd of both officers and civilians alike were gathered to pay tribute to those who had sacrificed their lives in the name of public safety.

After a rousing rendition of the national anthem from Jim Cornelison, the anthem singer for the Chicago Blackhawks, they did just that.

Plainfield Fire Chief Dave Riddle, formerly of the Channahon Fire District, spoke in memory of Channahon Firefighter Kenneth J. Frayne, who died in the line of duty in 2001.

“It is our duty to be sure his passing was not in vain,” Riddle said, holding back tears. “It’s our duty to remember Ken.”


“Jimmy demonstrated the true meaning of love,” Steffes said. “He loved his community so much he died to protect it.”

Sgt. John Severson and Chief Brent Dite, both of the Morris Police Department, recalled two public servants from the history of Morris.
Marshall Enoch T. Hopkins, who was born in 1824, served 24 years on the force before being shot dead in the line of duty in 1878.

“We need to remember the sacrifice he made,” Severson said.

Almost 50 years later, in 1935, Morris Patrolman Clarence R. Roseland was gunned down while serving the law. His great-granddaughter, Emma Roseland, sang “America the Beautiful” at the ceremony Thursday.

“[Roseland] performed his duties without reservation,” Dite said. “That ultimately cost him his life.” Lappe’s service didn’t cost him his life, but it was close.

Four days after a subject shot him from four feet away, Lappe woke up, unable to speak or move his legs.

His wife, by his bedside, handed him a pad of paper, upon which he wrote: “Bad guy?”

Dead. He’d shot himself during the ensuing shoot-out with police.

Lappe was told he may never walk again.

But through almost five months of ups and downs, he worked hard to recover, trying to — as he put it Thursday morning — turn tragedy into victory.

“I wasn’t going to let evil win,” Lappe said.

He didn’t.

He soon returned to the force in a limited capacity, and helped establish the “Police Survivors” organization, which serves police officers who sustained life-threatening injuries as they recover.

The Joliet Police Department Pipes and Drums Corps played “Amazing Grace.” The Grundy County Honor Guard posted colors at the beginning of the ceremony and performed the firing party.

Morris Police Officer Steve Huettemann played “Taps” and Pastor Steve Larson, chaplain of the Morris Police Department, gave the invocation and benediction.

Grundy County Board Chairman Ron Severson thanked the officers and firefighters present for their service, giving them credit for making the county, state and nation what they are.

“Without them,” he said, “society would fall into chaos.”
Grundy County Sheriff Kevin Callahan said the officers and firefighters were “true heroes,” who know “each day might be their last.”

“It is not the badge they wear over their heart that makes them special, but the call and commitment to serve others,” Callahan said.

A moment of silence was also held for former Grundy County Sheriff Terry Marketti, who died last December of natural causes.

It was Marketti’s idea, Callahan said, to bring Cornelison to the event.

When Marketti passed, Grundy County Sgt. Tanya Paquette reached out to Cornelison, who accepted the invitation.

“It’s important to support their sacrifice,” Cornelison said after the event. “I was honored to be here.”

Police, firefighters and civilians in attendance took pictures with Cornelison, who sang before the Blackhawks 4-1 win over rival Detroit Redwings in Game 1 of the Western Conference Semifinals Wednesday night.

In the end, though, the focus was on remembering those who had sacrificed for their communities.

“We must remember what these people stood for and died for,” Callahan said. “It’s not how they died that made these people heroes, but how they lived.”

Remembering Grundy County’s heroes
http://www.morrisherald-news.com/2015/05/20/remembering-grundy-countys-heroes/agwqsaq/

May 20, 2015 By MIKE MALLORY -

Grundy Law Enforcement Managers Association holds annual

CHANNAHON – As his young son’s playful voice echoed through the gymnasium, Ken Allen spoke about his own father, who died when he was just 3.

“My memories are so short,” an emotional Allen said to the crowd gathered Wednesday morning at Minooka Community High School South Campus in Channahon.

“It is difficult to know if something is real or made up.”

Allen explained to those in attendance at the Grundy County Law Enforcement Managers Association’s annual memorial service that his son
isn’t much younger than Allen was when the boy’s grandfather, Morris firefighter James Allen, died fighting a fire 30 years ago. The annual service honors fallen police and firefighters.

“I’ve struggled with ‘why’ for years,” Allen said. “Today gives me memories that allow me to create one of my father as a real hero.”

James Allen was 6 feet 6 inches tall, his son said, and was noticed when he walked in a room not just for his height, but also for his personality. He volunteered as a firefighter to protect his community.

Keynote speaker Channahon Police Chief Steve Admonis addressed Allen’s feelings and encouraged him to keep expressing those feelings.

“Emotions are good,” Admonis said to Allen and the loved ones of others being honored. “They show true love. Never cover them up.”

Morris Police Department Deputy Chief John Severson spoke in memory of patrolman Clarence Roseland, who was shot and killed Feb. 3, 1935, when he interrupted a kidnapping and robbery in progress.

Roseland’s great-grandchildren Adam and Emma Roseland sung the national anthem and “God Bless America” at the event.
Roseland’s grandson Keith Roseland said his father Wayne, who died last year, would have loved to see the portion of Route 47 dedicated to Clarence Roseland, as he drove past it to work every day.

The other fallen Morris officer also honored with a road dedication and at the memorial Wednesday was Marshal Enoch Hopkins, who was shot and killed Sept. 14, 1878, while attempting to arrest two drunk and disorderly men. Morris Police Chief Brent Dite honored Hopkins, saying he created the model of a Morris Police Officer.

“He was a great and honorable man,” Dite said.

At the time, Hopkins’ funeral was the highest attended in Morris history. “The words ‘thank you’ will never be enough,” Dite said.

Also honored was Channahon Firefighter Kenneth Frayne, who died in a multi-agency rescue drill in October 2011. Channahon Fire Protection District Chief John Petrakis spoke in memory of Frayne.

Admonis said to the crowd, full of agencies across Grundy County, that few are meant to do law enforcement. Just like the military, he said, they are warriors in their communities.

He thought of a conversation he had with a colleague, about the burden that comes with seeing things in the line of duty that people aren’t supposed to see.

“Some things are kept inside and never spoke of,” Admonis said. Admonis encouraged those in law enforcement to not be deterred by negative media attention of the actions of some police officers.

“Less than 1 percent of us get in trouble,” Admonis said. “The rest of us play by the rules.”