Rapid Lesson Sharing

**Event Type**: Burn Injury/Scouting

**Date**: July 15, 2021

**Location:** Red Apple Fire
Monitor, Washington; Spokane District BLM, Oregon and Washington State Office

# This Burn Injury Story Focuses on Insights and Lessons on Fireline Scouting

*"I truly believe my training saved me."*

**Engine Captain 1**

During this burn injury incident, Engine Captain 1 dropped his radio here and was unable to locate it.

## Background

On July 13 at approximately 1910 hours, a fire of unknown cause was reported to Central Washington Interagency Communication Center (CWICC) in the Monitor area, northwest of Wenatchee, Washington. Local fire districts; Washington Department of Natural Resources; Bureau of Land Management; and U.S. Forest Service crews responded that evening. An adhoc Type 3 Incident Management Team was assembled and assumed command the next morning. Three days later, on the evening of July 16, the incident was transitioned to a Type 1 Incident Management Team.

## The Story

Engine 1 was sent on the original dispatch the evening of July 13 and worked until approximately 0100 when they bedded down for the night. The next day, this engine was utilized as a contingency and possible initial attack resource. They remained assigned to the Red Apple Fire the following day, July 15, and were to be working within Division A.

On July 15, 2021 at approximately 0830, Engine 1 and a local Severity Taskforce worked within Division A along the fire's west flank. These resources met with Division A Supervisor on Warner Canyon Road and developed the plan.

It was decided that Engine 1 and Engine 2 would work the active flank from the toe of the slope and progress with hand tools and flappers up the slope, tying-in the active fire flank back into cold black up the ridge. It was also decided that Engine Captain 1 would proceed upslope ahead of the crews from Engine 1 and Engine 2 to scout for potential containment opportunities—potentially utilizing dozer line.

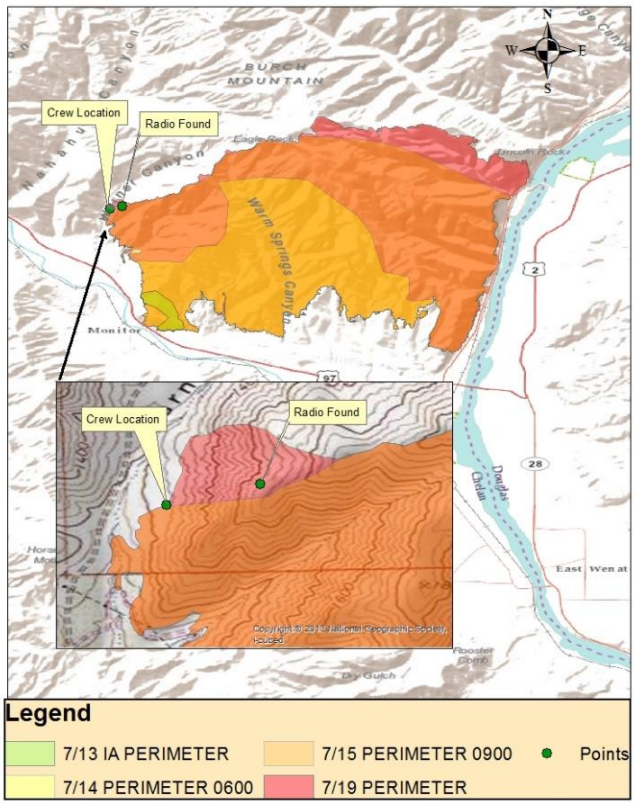
View from the two engine crews' location on the road, looking up to where Engine Captain 1, while scouting, escaped by quickly moving through the fire front.

## Timeline – July 15, 2021

**0830** – Engine 1 and the Severity Taskforce start working from the toe of the slope up the ridge.

**0900** – Engine Captain 1 proceeded upslope through the black on his scouting mission.

Red Apple Fire Progression




**0910** – Division A Supervisor receives a call on his cell phone from Engine Captain 1 stating that he had stepped out of the black to get some fresh air and the fire had switched directions and burned quickly through his location.

Engine Captain 1 also informed Division A Supervisor that he had received burns on his right hand, right ear, and "a little" on the right side of his face. During this burn incident, he dropped his radio and was unable to locate it.

Division A inquired more about the severity of his injuries and was told: *"It's not bad. I'll hike down the hill and we can talk about it."*

Engine Captain 1 assured Division A Supervisor that he didn't need medical attention.

**0920** – Engine Captain 1 meets with Division A at the vehicles along Warner Canyon Road. During this face-to-face interaction, Division A states: *"It would be good to get you looked at. If you don't think you need medical treatment, you should call the local Duty Officer and get his wishes."*

**0923** – Engine Captain 1 contacted the local Duty Officer, who informed Engine Captain 1 to start transport for a medical evaluation.

**0945** – Engine Captain 1 talks with the local Duty Officer again. It is decided that the engine module crewmember would transport him to the incident ambulance, where he could be evaluated and then sent to the local medical facility for further evaluation.

**1030** – Engine Captain 1 is evaluated by an ambulance assigned to the incident and is transported by a crew member to the local hospital in Wenatchee.

**1050** – Engine Captain 1 was evaluated at the hospital. It is determined he had received 1st degree burns to his hands and neck, 2nd degree burns to his ear, and also had smoke inhalation.

## Observation/Lesson on Using the Medical Incident Report

Using the Medical Incident Report (MIR) that day was thought of but not used. The initial thought by Division A Supervisor was a "Green" severity and Engine Captain 1 could walk out to the vehicle and be transported by his crew.

Another thought by Division A Supervisor, was how the perception across the radio transmissions could have triggered a level of response the fireline leadership felt was not needed.

During initial attack or large fires, we still see medical transportation to emergency rooms or to incident medical personnel that is never communicated via Command or a local unit's repeater to Dispatch. We need to explore the human dynamics of the why and how we can change our culture to understand that it is OK to report and use the MIR.

*"I then made a swift decision—due to experience and training in this fuel type—to move quickly through the fire front into the black."*

## Engine Captain 1's Perspective – in His Own Words

I was scouting for options to tie the fire's edge into cold black up high on the ridge. I had moved off the active fire edge to get some fresh air.

Soon after, the wind made a sudden shift and the fire behavior picked up rapidly. It quickly went from a smoldering edge to an active running fire. I had to rapidly evaluate my available options:

- Going downhill, I was concerned that the fire moved cross-hill below me. Also, it was steep and I didn't want to run downhill and fall in the rocky terrain.
- Going uphill was too steep and I couldn't cover enough ground in time.
- I did briefly think about pulling my shelter, but I felt that I didn't have enough time.

Looking south from from where Engine Captain 1 dropped his radio as he moved through the fire front.

*"I felt that as I went throught the flames, being crouched and tucking my head with my hard hat helped to protect my face and neck."*

I then made a swift decision—due to experience and training in this fuel type—to move quickly through the fire front into the black.

I noticed an area with less sagebrush, less fire activity, and chose that area as I continued to cross the fire front into the black.

While I moved cross-slope, I tripped and fell. I quickly stood back up and proceeded in a crouching stance. I felt that as I went throught the flames, being crouched and tucking my head with my hard hat helped to protect my face and neck.

Looking west from where Engine Captain 1 dropped his radio.

As I made it to the black, I noticed I didn't have my handheld radio. I felt pain in my hands and quickly assessed them and used my phone to look at my face for any burns.

I used my cell phone to notify Division A and shared with him what had happened. I then proceeded down the line back to the engine that was parked at the bottom.

## Three Lessons I Want to Share

1. In a scouting mission, I felt comfortable due to the time of day, my experience, and my familiarity with that fuel type. The situation changed so quickly—and that was unexpected.
2. We rely on radios as our primary communication tool. What is our alternative plan when we don't have a radio and need to reach out?
3. If you know your plan, share it. It goes back to accountability and people knowing where folks are scouting and engaged. If a Lookout is posted, do they know where you are scouting?

## Thoughts and Lessons on Fireline Scouting from the Frog Fire Fatality Learning Review Report

**The 2015 Frog Fire Fatality Learning Review report pointed out several key lessons on fireline scouting, including:**

Scouting fireline can be hazardous and often involves the person who is providing leadership for the fire (IC, DIVS). Scouting is clearly a dangerous activity and has not received the attention it deserves in our research efforts or training curriculum.

Investigating the underlying deep assumptions associated with how we scout fires now could provide valuable insight into our current fire culture. Why do firefighters feel the need to scout fire? Why do we currently often scout alone? What dynamics would change if we scouted in pairs or groups of three? What sort of dialogue should occur before deciding to scout a fire? What dialogue should happen (and with whom) during the scouting effort? Are there less risky ways to get the same information without putting an individual at risk? Are there technologies that could provide information to us that would reduce the need for scouting (drone, Google Earth maps, etc.)?

Our training in the area of scouting wildfires may be outdated (or non-existent) for the complexity we face in today's wildfire environments. Not only should classroom experiences focus on scouting, but hands-on simulations associated with the decision to scout, the practice of scouting, and the dangers associated with it need to be developed.

The Panther Fire (2008), The Devil's Den Fire (2006), and the Sawtooth Rx Entrapment (2003) are just a few recent examples of incidents in which people died while scouting. These incidents may offer insights about how to develop the specific training that could help our fire personnel become better informed about scouting a fire and the associated risks.

***To truly learn from this burn injury incident, we need to listen and understand, firsthand, what Engine Captain 1 experienced in his small margin of time and space.***

## Conclusion

The burn injury of a wildland firefighter is a significant event that should cause pause, reflection, and learning throughout the wildland fire community and supporting organizations. Conditions can change rapidly, including as we are scouting. Many times, the identification of escape routes and safety zones are part of the scouting mission.

- With any scouting mission, do we truly have a good understanding of the risk upfront?
- As humans, do we normalize risk when we are doing routine missions?

To understand why actions and decisions made sense at the time, we must evaluate the context in which they were made. We therefore need to make sense of this burn incident by thinking about the issues and conditions that surrounded this burn injury event. To truly learn from this burn injury incident, we need to listen and understand, firsthand, what Engine Captain 1 experienced in his small margin of time and space.

**What is Normalization of Risk?**

Normalization of Deviance Part 1

Normalization of Deviance Part 2

**Additional Lessons on Fireline Scouting**

Frog Fire
Woodward Fire Extraction
Camden Fire Burn Injury
Jack Creek Fire Burnover
Mustang Fire Near-Miss

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