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Premier Public Safety Services

TO: Oregon Fire Service

FROM: State Fire Marshal Incident Review Team

DATE: November 3, 2011

SUBJECT: High Cascade Complex Incident Findings, Recognitions and Lessons Learned

On August 29, 2011, the three Brownsville Fire Department Engine 64 personnel operating at a draft site along Mill Creek took refuge at their pre-planned safe zone as a precautionary measure while the wildland fire front passed nearby them. In the process, their portable radios stopped working and communication with their Task Force Leader and Group Supervisor was lost. Prior to losing communications when their radios became submerged, Engine 64 personnel advised their Group Supervisor and OSC Ketchum that they were taking refuge in their safe zone and they asked for a water drop in their immediate area. Smoke conditions prevented the water drop. Group Supervisor Barney lead a RIT consisting Engine 63 and Brush 11 down the road leading to the location of Engine 64 immediately after the fire front moved through the area. Although heat and smoke conditions were marginal, these units drove down the 460 yards of road leading to the draft site. All personnel were found in their safety zone and not in danger. Risks taken by the RIT in order to reach the draft site were reasonable according to the circumstances as they understood them to be at the time they were given the assignment by the OSC. In the end, no one was injured and equipment damage was very minor.

This incident occurred during less than 30 minutes of a seven-day deployment for the conflagration by a small overhead team and 8 task forces. The ORCA IMT's form 209 indicated that 290 buildings were threatened or at risk. Only 3 small out-buildings were lost to the fire. No residences or commercial buildings were lost. This complex of seven fires spread to over 108,000 acres and involved periods of erratic and extreme fire conditions. Our personnel made significant effort and care to achieve the desired structural protection goals while effectively building positive relationships with the reservations residents and leadership. All personnel deployed on this fire should be proud of their service and recognized for a job well done.

After SAFENET ID# 8LKU5HSAFE was received, Incident Commander Koellermeier was contacted and asked for a final report documenting the above incident. Based on the assertions in the SAFENET, Chief Koellermeier worked with several members of the "Red" Incident Management Team to complete an extensive written report which was completed in early October. Because information and perceptions about this incident were widely distributed via the "social media" and many Fire Chiefs had questions about the incident, the entire report was distributed widely. It provides an un-edited and transparent view of the perceptions, opinions and perspective of numerous people involved with the mobilization. On October 26th, IC Koellermeir, OSC Ketchum and DOSC LaBelle met in person with State Fire Marshal Wallace, Chief Deputy State Fire Marshal Walker and Emergency Response Unit Manager Ruiz-Temple to present a PowerPoint detailing the incident and surrounding issues and answer remaining questions of the OSFM leadership.

This document provides the official findings of the Office of State Fire Marshal. It also lists subjects to be explored for the annual "lessons learned" analysis of the 2011 fire season as we identify tips, techniques and tactics designed to improve the safety of deployed firefighters, better coordinate the management of future incidents and provide premier public safety services to Oregonians at future conflagrations.

While the questions raised by the SAFENET were answered and until the final reports of the incident were completed, the Red Team was side-lined. As soon as the Red Team personnel provided their final written report, the Red Team was placed back into the on-call rotation. Since the State Fire Marshal is entrusted with the safety of personnel he deploys to conflagrations, it is among his highest responsibilities to ensure that those deployed are lead and supervised in a safe manner. This action was (and may be in the future) a standard practice. It is not intended and should not be taken in a negative connotation and is not done as a punitive action. No one should imply anything negative went on until the outcome of an investigation into the allegations of the SAFENET is investigated and official findings of the State Fire Marshal are made. This memorandum contains the findings of the State Fire Marshal's Staff Review Team.

Based on all of the information received, including preliminary information and site visits that occurred on September 2, 2011, the 88-page written report, the PowerPoint used by the Red Team personnel and in-person Q & A, the following are our findings:

1. The multiple allegations made in the SAFENET are unfounded as safety violations or unreasonable risks.
2. Brownsville Engine 64 personnel preplanned their contingencies and the actions to be taken should their primary road out of the draft site be cut off and took appropriate actions following their plans. Their positive actions to ensure their safety were well-thought out and effective. This was not a "near miss". Their actions constituted a tactical withdrawal to their preplanned safe zone and no more.
3. The fire front had passed by before the RIT went down the roadway leading to the draft site. Photographs taken by cell phones and cameras at the time show that the RIT drove down the road leading to the draft site on the black side of the fire front, although they encountered residual heat and smoke as they did so.
4. Because communication with the Brownsville personnel was lost (their portable radios got wet), the RIT had no way of knowing in advance of arriving at the draft site that there personnel were safe and uninjured. Since firefighters "risk a lot to save a lot" and we had three personnel in an unknown situation, the risk taken by the RIT personnel was reasonable. And, they completed their assignment without injury.
5. Once OSC Ketchum declared "Emergency Traffic" over the radio indicating everyone except the directly involved personnel should not transmit over the radio, numerous un-involved personnel jammed up the radio traffic and complicated effective radio communication between the OSC who took command of the incident, the RIT and the Brownsville personnel.
6. OSC Ketchum was at the right place at the right time and effectively took command of the RIT operations immediately following the Brownsville personnel transmitting that they were moving to their safety zone while the fire front moved through the area.
7. Although the reactions of personnel at the scene soon after the incident were positive and initial evaluation of the incident was that it was not a situation requiring an independent investigation, some deployed personnel developed a degree of angst about the incident 24-48 hours later. This resulted in a small number of personnel who had issues with the actions or claimed lack of actions by the OSFM IMT personnel.

8. OSFM IMT personnel briefed ORCA IMT, Warms Springs Reservation and BIA personnel in an effort to determine if anyone believed an independent investigation unit should be called to the scene to fully investigate the incident. No one believed that an outside investigation was warranted. OSFM personnel were also briefed three days after the incident and agreed with the initial findings pending the receipt of the Red IMT's final reports.
9. ORCA Division Q Supervisor Chris Orr and Structural Protection Group Supervisor Chris Barney reportedly worked closely and effectively prior to the incident, as confirmed by both still and video photography taken just prior to the incident. Although Chris Barney was in a trainee status under the OSFM IMT requirements he worked under ORCA Division Q Supervisor Chris Orr a fully qualified 310-1 Division Supervisor.
10. Accusations of OSFM IMT members "covering up" the incident or any untruthfulness were unfounded.

Recognitions:

1. Brownsville Fire Department: Chief Kevin Rodgers, Lt./EMT Joe Kirk and Firefighter Alex Parker
2. Operations Section Chief John Ketchum, Chief Keno Fire Department
3. Group Supervisor Chris Barney, Battalion Chief, Portland Fire Department
4. Incident Safety Officer Mark Matthews
5. Canby Engine 63 crew
6. Clackamas County Brush 11 crew
7. Incident Commander Doug Koellermier, Chief of Operations, Bend Fire Department
8. Deputy Operations Section Chief Richard LaBelle, Chief, Scio Fire Department
9. Numerous other personnel who assisted in accumulating information, who wrote incident reports, and who assisted in the development of the well-documented final report of the incident.

Lessons Learned:

1. Established trigger points with assigned and attentive lookouts should be in place for at least every stationary assignment such as a drafting site.
2. Personnel should use caution to protect portable radios from getting too wet or immersed in water.
3. In situations were the primary access into an area can be cut off, should the fire burn over the area unexpectedly, a safe zone and a secondary avenue of exit from the hazard area should be planned in advance as the Brownville Engine 64 crew did very effectively.
4. If "Emergency Traffic" is declared over the radio, personnel not directly involved in the apparent or reported emergency situation should not transmit

on the radio until normal radio traffic is resumed or move to a different tactical channel/talk group for all other radio communication.

5. SOPs should be updated to designate the specific phrase to be used to identify that a potential emergency incident is in progress and everyone not directly involved in the incident must not transmit on that frequency/talk group until the situation is resolved and regular radio traffic is resumed.
6. Every deployed Incident Commander shall notify the Office of State Fire Marshal immediately if an out-of-the-ordinary event or occurrence involves any of the resources deployed by the OSFM to the incident.
7. The use of social media to provide "friends" with up-to-the-minute and/or frequent updates from tactical positions during a work assignment must be discouraged. This practice leads to in-accurate, misleading, and problematic reports of incident perceptions that may or may not be a witnessed description of the reported event or incident. Time spent on the fire line should be focused on the firefighting assignments and operations and not having your cell phone "at the ready" and the individual's focus on the sensationalism of an event rather than their personal safety, the safety of their coworkers and successfully completing their assigned tasks.
8. All incident reports should be required to be turned in no later than at check-out during demobilization. If further investigation or information is needed after demobilization, the OSFM should assign an investigation team to gather the desired or needed information.
9. The OSFM should develop an Incident Investigation Team comprised of personnel not deployed on a particular conflagration. When an incident within an incident occurs, add pre-planned review personnel to the deployment as appropriate so that the Overhead IMT on the fire can continue their normal assignments with little interruptions or distractions while a potential incident within an incident is investigated appropriately.
10. The SOP involving an incident within an incident should be reviewed and updated.

11. If personal conflict among deployed personnel can not be effectively resolved effectively by supervisors during a deployment, the Incident Commander should be authorized to demobilize one or more individuals or crews so that incident management focus can remain on the emergency incident and not on interpersonal dynamics among OSFM deployed resources at the scene of the incident.
12. Prior to completion of each operational period, all equipment and vehicles must be fueled, maintained and readied for the next operational period before going out of service and into a rest period. Personnel that are in their SOP-mandated rest period must use the time to rest in order to maximize their physical and mental safety over the course of the incident.

As the official review committee of the High Cascades Complex incident and all of the personal observations, written reports and verbal comments, we adopt these findings. Recognitions and lessons learned will be forwarded to the appropriate parties for additional action in the near future.

Mark Wallace

Mark Wallace, State Fire Marshal

Jim Walker

Jim Walker, Chief Deputy State Fire Marshal

Mariana Ruiz-Temple

Mariana Ruiz-Temple, Emergency Response Unit Manager