

GREEN SHEET

California Department of Forestry and Fire Protection (CAL FIRE)

Informational Summary Report of Serious CAL FIRE Injuries, Illnesses, Accidents and Near-Miss Incidents



Inmate Firefighter Fatality

August 18, 2012

Buck Incident

12-CA-RRU-080142

12-CA-CSR-000062

California Southern Region

A Board of Review has not approved this Summary Report. It is intended as a safety and training tool, an aid to preventing future occurrences, and to inform interested parties. Because it is published on a short time frame, the information contained herein is subject to revision as further investigation is conducted and additional information is developed.

SUMMARY

The following is the Informational Summary Report of an incident, which occurred when an inmate experienced an unknown medical emergency while sleeping at the incident base and subsequently died.

CONDITIONS

Weather (at Sage RAWS at 0514 hours - RRU):

Temperature- 72⁰ Fahrenheit

Relative Humidity – 63%

Winds – Calm

SEQUENCE OF EVENTS

On August 14, 2012, Fenner Canyon Crew 2 was assigned to the Buck Fire (Vegetation Fire) as part of Strike Team 9389G. The strike team arrived at the Sage Fire for check-in and was assigned to perimeter control on the Buck Fire as part of extended attack resources during the first operational period. At 6:00 p.m. the crews began direct fire line construction with hand tools on Division Z of the Buck Fire with short breaks taken every 30-45 minutes based on chainsaw refueling cycles. The strike team continued working during the second operational period of August 15, 2012, until 6:30 p.m. During the assignment, adequate supplies were provided including water, Gatorade and sack lunches. Strike Team 9389G was returned to camp for 12 hours rest, inmate custody assumed by California Department of Corrections and Rehabilitation (CDCR) officers, in order to be available for assignment the following day.

On August 16, 2012, at 8:00 a.m., inmate custody exchanged to CAL FIRE, and Strike Team 9389G was assigned to mop up and patrol of a 2 to 3 mile section of line in Division Z. Much of their time was spent removing wildland fire hose. The crews returned to their Emergency Crew Transports (ECT) at 8:30 p.m. for rest on the fire line overnight. They experienced no significant smoke or fire conditions during the operational period. The following morning, August 17, 2012 at 7:30 a.m., Strike Team 9389G returned to the incident base and custody of the inmates was transferred to CDCR.

On August 17, 2012, at approximately 5:00 p.m., CDCR officers took crews to dinner at the incident base. Following dinner, while the crew was being escorted back to the inmate crew sleeping area, an inmate vomited. The CDCR officer accompanying the crew had the inmate sit down. The officer observed the inmate was sweating profusely and offered him water. The inmate advised the officer that he was also experiencing a headache. After notifying his partner CDCR officer, they decided to have the inmate seen by the Medical Emergency Response Team (MERT) for evaluation.

The MERT medical staff evaluated and treated the inmate for possible dehydration. Medical personnel were advised he had been having headaches for several weeks prior to this incident. Because of the complaint of headaches, and additional episodes of vomiting, the medical staff consulted with the MERT physician, who was assigned to the Vallecitos Fire. After the phone consultation, the physician opted to see the inmate and he arrived at the Buck Fire MERT tent by 6:45 p.m. to evaluate. Upon arrival of the physician, the inmate was feeling better and asked to return to the crew. The physician examined the inmate and placed him off duty for three days, and was to be re-evaluated the following day. The inmate was returned to the sleeping area that night.

On August 18, 2012, at approximately 5:15 a.m., CDCR officers were waking the inmate crews up for the day's assignment and discovered the inmate that was previously seen by the MERT, to be unresponsive. CDCR officers simultaneously notified base medical personnel and made a 911 call via cell phone to report the incident. The call was transferred to the CAL FIRE/Riverside County Fire Department Emergency Command Center (ECC) at 5:35 a.m. and an emergency response was dispatched to the scene. The ECC made notification to Buck Communications, and notifications were made to the Incident Commander, Safety Officer and Medical Unit Leader as outlined in the Incident Action Plan. It was determined that no other inmates from Strike Team 9389G were having medical issues.

The inmate was transported by private paramedic ambulance at 6:10 a.m. to a local hospital. Evaluation and testing was performed at the local hospital to evaluate for dehydration and it was determined there was no dehydration or rhabdomyolysis. The inmate was transferred on the evening on August 18, 2012, to another hospital for a higher level of care and to satisfy custodial requirements.

On August 19, 2012 at 12:30 p.m., the inmate firefighter succumbed to his medical emergency and was pronounced dead.

INJURIES/DAMAGES

Due to the undetermined cause of death, the Riverside County Coroner will be investigating.

SAFETY ISSUES FOR REVIEW

- All assigned personnel, regardless of agency, must be briefed on and follow the emergency procedures outlined in the Incident Action Plan (IAP).
- Supervisors must ensure instructions are clear and understood for assigned personnel.
- Supervisors should monitor the health and welfare of their assigned personnel.