Report of the Texas Forest Service Accident Investigation Team Hildreth Pool Road Bull Dozer Accident

> Montague County February 9, 2006

> > **Final Report**

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I. INTRODUCTION

This accident investigation is the Hildreth Pool road fire analysis of the dozer accident located in Montague County Texas on February 9, 2006. Our purpose is to determine the causal factors and make recommendations to reduce the potential high risk associated with night time fire fighting working around dozers.

The investigation team consisted of the following individuals:

Bob Scheel	Safety Officer, Texas Forest Service
Mark Ilg	Safety Officer, Texas Forest Service
Bob Yeager	Safety Officer, Kisatchie National Forest
Jamie Rittenhouse	Safety Officer, Florida Division of Forestry
Kenneth Meyer	Safety Officer, Umatilla National Forest

We appreciate the photographs of the accident site by David Cadle LEO National Grassland included in this report.

II. SUMMARY

The injured party, employee of United States Forest Service (USFS) from the Deschutes National Forest was in Texas assisting with the fire season of 2006. He was ordered up as Field Observer (FOBS) and assigned to Decatur Group. A request for Assistance was made to Granbury Incident Command Post (ICP) from the Montague County Judge. The injured party was dispatched at 1530 and arrived on location at 1615. FOBS tied in with the local Incident Commander (IC) on the fire at 1630, and completed traversing (GPS) at 1800, determining the fire was 50.7 acres. Division Supervisor (DIVS), Safety Officer (SOF2), and Task Force 7 were dispatched at 1604 and arrived at 1716. Task Force 7 consisted of; Task Force Leader (TFLD) Dozer E-287 with Swamper, Dozer E-346 with Swamper, and Engine E-345.

The fuels consisted of dense pockets of Cedars, Post Oak, Elm, and Green Briar (vines with thorns) with openings of short grass. The temperature was 61 degrees, humidity 30 percent and winds 11 miles per hour gusting to 18. The fire was approximately 80 percent contained by local resources prior to arrival of crews. Witness statements indicate fire behavior was; intermediate torching, with heavy fuels burning in the interior. The predicted weather indicated for a cold front to enter the area with high winds expected. If the fire reignites, it could move at 240 feet/minute with 6 to 7 foot flame lengths in the grass fuel types and 120 feet/minute with 20 foot flame lengths. Probability of ignition in both fuel types is 40-50% (see ICS-209 Att 1). Official sunset for that day was 1810.

The two dozer units were assigned to put in a fire break starting along the east flank working toward the north in tandem. Dozer unit E-287 was the lead dozer with dozer E-346 improving line behind him. Swamper E-346 was leading dozer E-287 along the north flank and Swamper E-287 was trailing dozer E-346. A decision was made by TFLD to have dozer E-346 back track the east flank mopping up. When the task was completed; dozer E-346 was directed by the DIVS to return and remain at the staging area (see map Att 2). Swamper E-287 remained behind to help engine E-345 mop up hot spots on the east flank.

Present at the staging area were: DIVS, SOF2, TFLD, dozer E-346, and FOBS (injured party). At approximately 1830, DIVS and TFLD directed dozer E-346 to improve line that a local dozer had put in on the west flank. According to witness statements FOBS stated since he had been around the fire twice, he knew where the existing dozer line and fence were located, and would show dozer E-346 where to start. FOBS had stopped E-346 near the dry creek to find a crossing. FOBS radioed E-346 to come toward the light (on his helmet) and wait for him on the dozer line. According to witness statements, after crossing the creek bed, FOBS directed dozer E-346 to create a new line instead of improving the old line. Dozer E-346 decided to knock the brush down to the fence and then improve the line back to the north. The brush was very thick consisting of post oak, cedar, elm and green briar. FOBS was directing the dozer through the brush from the front of the dozer.

According to witnesses at approximately 1930 dozer E-346 received a radio transmission from FOBS to again, come toward the light. E-346 dozer started in first gear toward FOBS helmet light. Dozer E-346 operator indicated that the light appeared intermittent either from the thickness of the brush or from FOBS turning his head. E-346 dozer lost sight of FOBS light and thought FOBS had cleared the area. E-346 dozer proceeded forward approximately 25 feet then stopped and called for FOBS, since he had no visual contact. Dozer E-346 operator turned and saw a light on the ground behind the dozer, and got off the dozer to look for FOBS. Dozer E-346 operator found the helmet belonging to FOBS and noticed FOBS lying on his back approximately ten (10) feet behind the dozer. At approximately 1943 dozer E-346 operator broadcasted the emergency via radio and requested assistance. SOF and TFLD arrived at 1945, 911 was notified by TFLD.

The first responder from E-345 (Engine) arrived at the accident scene and monitored vital signs until EMS arrived at approximately 2010. After assessment by EMS, Life Flight was requested. Shortly after Life Flight arrived patient was loaded and departed by approximately 2040.

According to witness statements and evidence at the scene, the investigation team concluded that the injured party passed underneath the dozer between the tracks.

III. Analysis of Potential Causal and Contributing Factors

The following factors were evaluated in terms of possible causes or contributors to the accident occurring:

ELEMENT	Did not Contribute	Influenced	Contributed Significantly	Unknown
#1 – Human Factors				
Duties	• •		X	
Management (Incident Command Team)	X			
Compliance (deviation from policy)			X	
#2 Risk Management				
Job Hazard Analysis (JHA)	X			
#3 Weather				
Wind		X		
Temperature		X		
Relative Humidity		X		
Fuel Moisture		X		
Drought		X		
#4 Environmental Factors				
Terrain		X		
Vegetation/Canopy			X	
Slope	Χ			
Elevation	X			
Soil Condition	Χ			
Rock	X			

ELEMENT	Did not Contribute	Influenced	Contributed Significantly	Unknown
#5 Organization, Control (on-site)				
Supervision		X		
Communications		X		
Chain of Command	X			
Briefing / Tailgate Session	X			
#6 Qualifications, Training, Certification(s)				
CPR/First Aid	Χ			
S-232 Dozer Boss			X	
Dozer Operations	Χ			
TFLD	Χ			
DIVS	Χ			
SOF2	X			
#7 PPE				
Gloves	X			
Hardhat	X			
8" Leather, Non-skid Boots	X			
Eye Protection	X			
Equipment Noise			X	
Illuminating Devices (night usage)			X	

ELEMENT	Did not Contribute	Influenced	Contributed Significantly	Unknown
#8 Condition of Personnel Involved				
Work-Rest Ratio	X			
Shift Lengths	X			
Number of Consecutive On-Duty Days	X			
#9 Decisions/Actions Taken by Involved Personnel				
DIVSDecisions/Actions	X			
SOF2Decisions/Actions	X			
TFLDDecisions/Actions	X			
FOBSDecisions/Actions			X	
DOZODecisions/Actions		X		
Lookout			X	
Situational Assessments/Awareness			X	
Escape Routes (Dozer Operations)			X	
#10 Equipment				
Maintenance	Χ			
Dozer Lights	X			

IV. FINDINGS

Below is the team analysis of the findings that contributed and influenced their investigation.

#1. The decision to lead the dozer through the brush instead of the edge of the burn to show the operator where to start, compromised qualifications and training due to FOBS not having Dozer Boss qualification.

#3. Due to the forecasted weather, decisions were made to complete mop up and put in a complete fire break around the perimeter.

#4. The thick brush, green briar and terrain played a major role in not keeping a safe distance between the dozer and ground personnel. The green briar and heavy vegetation created a potential entanglement, slow movement and tripping environment.

#5. Briefing between FOBS and dozer operator should have been conducted to determine signals and procedures. Communication may not have played a direct role in the accident but through the investigation it was determined that the dozer operators had a difficult time hearing their portables over the dozer noise.

#6. Acting as Dozer Boss without the proper training and qualifications could have contributed to the spacing and visibility problems between the dozer and ground personnel.

#7 Equipment noise reduced the ability to hear verbal communication. Nighttime visibility, illumination and depth perception played a major role in this accident.

#9 The following decisions and actions could have contributed to the accident:

- The failure to maintain the 100 feet recommended distance.(PMS-410-1 Fireline Handbook)
- Not flagging the route
- Not being Dozer Boss qualified.
- Awareness of the environment at night.
- Escape routes may not have been identified and utilized.
- The operator did not stop after visibility was lost of ground personnel.

V. RECOMMENDATIONS

1. Ensure proper illumination is available for ground personnel.

2. Ensure hearing devises are available to assist dozer operators with communication.

3. Ensure proper qualifications are adhered to.

4. Ensure ground personnel are visible to operator at all time when working around equipment. If visibility is lost stop equipment and locate personnel.

5. Ensure the facts and findings of this report are made available to all interested personnel.

Attachments

Incident Status Summary (ICS-209)

1: Date 02/09/2006	2: Tir 202		iitial Update XX	e Fina 	ıl	4: Incide TX-TX			5: Incide Hildreth H	
6: Incident Kin Wildland Fire	٥	: Start Date Time 2/09/2000 1510	ς U	: Cause J nder stigatio	er Commander			10: IMT Type 2	11: State- Unit TX-TXS	
12: County Montague 13: Latitude and Longitude Lat: 33° 38′ 59″ Long: 97° 46′ 9″ Ownership: TX-TXS 14: Short Location Description (in reference to nearest town Between cities of Montague and Bowie										
			(Current	Situa	tion				
15: Size/Area Involved 26 ACRES	N	Contained or MMA Percent	17: Expected Date: 02/09 / Time: 1715			18: Line to	o Build	19: Cos to Dat	SIS Date	ed Controlled
21: Injuries this Reporting Perio		: Injuries Date:	23: Fatalities	24: Strue	cture I	nformatio	n			
1		1	0	Туре	of Str	ucture	# Thre	atened	# Damaged	# Destroyed
25: Threat to Hu Evacuation(s) in				Reside	nce		1	1	0	0
No evacuation(s	s) immi	nent		Comme	cial Pi	roperty	1	L	0	0
Potential future No likely threat				Outbuild	ling/O	ther	2	2	0	1
26: Communitie 12 hours: 24 hours: 48 hours: 72 hours: 27: Critical Rese 1. 2. 3. 28: Major proble critical resource Due to predi fire reignites types and 12	ems and s needs cted c , it cou 0 feet/	d concerns (identified a old front uld move	& amount, in p control probler bove to the Inc moving into at 240 feet/i	riority or ns, social cident Ac o the ar minute	der): l/politi tion Pl rea, h with	cal/econor an. igh winc 6-7 foot	nic con l cond	cerns or itions e lengt	impacts, etc.) are expecte hs in the gr	ed. If the ass fuel
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46: Cooperating and Assisting Agencies Not Listed Above: See main incident 209.

	Approval Information									
47: Prepared by: Dena Sickels, SITL(T)	48: Approved by:	49: Sent to: TICC by: Dena Sickels, SITL(T) Date: 02/09/2006 Time: 2230								
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North Central Texas Initial Attack Hildreth Fire Incident Accident 02/09/2006 50.7 Acres 33 38.963 X 97 46.234

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Attachment 3 (7 Photographs)



Photograph showing the thickness of the under store



Photograph showing clearance under dozer





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1. Location:	2. System Area	3. Date of		Month	Day	Year	Case/File Number
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Pool Road							
5. Nature of Incide	nt: Bull Dozer acciden	t on wildfire		6. Offe	nse:		
							1
7. Date / Photo:	8. Location of Photo:						9. Camera Type:
02-10-2006	Hildreth Pool Road f	ire					Sony, digital camera
10. Time / Photo:	11. Investigated by:		12. Photog	raphed by	:		13. Film Type:
13:34 p.m.	David Cadle					3 inch disk	
14. Descriptio	on: photo of the tree wh	ere the victi	m was locate	ed. Note	the areas	on the	Incident Type:
tree where	e the flagging is located	I, these are t	rack marks le	eft by the	dozer		
15. DOB:							
SSN:							
	Height/Weight:						



15. Status: x Open Suspended	16. Closed By: Arrest	Exception Unfounded
17. Reporting Officer:	18. Assisting Officer:	19. Supervisor:
Date:	Date:	Date:





1. Location:	2. System Area	3. Date of		Month	Day	Year	Case/File Number		
Hildreth	Private Land	Occurrence:		02	09	2006	7526619		
Pool Road									
5. Nature of Incide	nt: Bull Dozer accident	on wildfire		6. Offe	nse:				
7. Date / Photo:	8. Location of Photo:						9. Camera Type:		
02-10-2006	Hildreth Pool Road fi	re					Sony, digital camera		
10. Time / Photo:	11. Investigated by:		12. Photog	raphed by	•		13. Film Type:		
13:34 p.m.	David Cadle		Da	wid Cadle			3 inch disk		
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17. Reporting Officer:	18. Assisting Officer:	19. Supervisor:
Date:	Date:	Date:





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17. Reporting Officer:	18. Assisting Officer:	19. Supervisor:
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1. Location:	2. System Area	3. Date of	Month	Day	Year	Case/File Number
Hildreth	Private Land	Occurrence:	02	09	2006	7526619
Pool Road						
5. Nature of Incident: Bull Dozer accident on wildfire		6. Offense:				
7. Date / Photo:	8. Location of Photo:		I			9. Camera Type:
02-10-2006	Hildreth Pool Road fi	re				Sony, digital camera
10. Time / Photo:	11. Investigated by:	12. Photog	raphed by	:		13. Film Type:
11:29 a.m.	David Cadle		wid Cadle			3 inch disk
14. Descriptic	on: photo of the scene o	f the resting place of the	victim. 1	Note the	tree in	Incident Type:
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1. Location:	2. System Area	3. Date of	Month	Day	Year	Case/File Number
Hildreth	Private Land	Occurrence:	02	09	2006	7526619
Pool Road						
5. Nature of Incide	nt: Bull Dozer accident	on wildfire	6. Offe	ense:		
7. Date / Photo:	8. Location of Photo:					9. Camera Type:
02-10-2006	Hildreth Pool Road fi					Sony, digital camera
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This is a copy of the original interview document omitting the injured party's name.

Interview with Injured Party April 28, 2006

Questions to Injured Party from Bob Yeager:

- Q. Did you receive an in-briefing and IAP when you arrived at the assignment in Texas?
- A. Yes, I received an IAP and very good briefing from Charisse at Granbury, another briefing by the DIVS and IC in Decatur, and by the IC on the fire.
- Q. Do you feel the fuels or vegetation were unusual or different than you were accustomed to?
- A. No nothing unusual, I had worked in the same type of vegetation before.

Following are bullet statements from Injured Party during the re-cap of the accident:

- I had been given orders from the previous day to go to Abilene and had to be there by 08:30 for the morning briefing so I left Granbury at 06:00. I was two miles from Abilene when Charisse called and said they didn't want me and to return to Granbury. I arrived back in Granbury around 11:00.
- I received a briefing and IAP from Charisse in Granbury.
- I traveled to Decatur for the assignment.
- I received a briefing at the Ramada Inn at Decatur from the DIVS and IC right before going out for lunch.
- I arrived at the fire and tied in with the IC.
- The IC married me up with a guy from the volunteer fire department to be my assistant and an extra set of eyes. The rest of the strike team arrived at this time.
- Tow Sikorsky (S-61) helicopters were working the fire, the fire was almost contained, one of the helicopters dropped a load of water in our proximity where there wasn't any smoke or fire (NE corner), we were able to get out of the way but some of the trailing portion of the load landed on the two of us. It was dark looking water. This safety issue was addressed right away. Soon afterward the helicopters left the fire.
- I walked around the fire using GPS to map it, while we were walking the fire line when we ran across a dozer on the back line (north end). We waited at a distance until the operator saw us, he stopped, and motioned for us to pass by.
- We finished walking around the fire and turned in our findings to the IC.
- I tried to call the report in to Charisse, but had bad cell phone, and radio, coverage at the fire site, so I went to a hill about 5 miles away where I was able to talk.
- I turned in the fire report to Charisse and then went back to the fire.
- I was asked by the DIVS to go to the southwest corner of the fire to determine the best place to put in a piece of line. I knew it was going to be a dozer line since there weren't any crews on the fire.
- I called the DIVS and told him where the line should go. I turned around and moved a few feet and was knocked to the ground by a falling tree, I could not get back up, I was pinned to the ground by the tree.
- I tried calling over and over on my radio but did not get a response. I was screaming to the dozer operator and calling over and over on the radio.

• I never saw the dozer, I didn't see any lights, and I thought the dozer had backed over me.

Injured Party's opinions:

I've worked where there were dozers being used on fires before, they always had a dozer boss assigned to each dozer. Why didn't they have a dozer boss assigned to this dozer? Why was the dozer moving without someone assigned to direct?

I didn't see the dozer and undoubtedly he didn't see me which put both of us in the wrong place at the wrong time.

Injured Party's suggestions to possibly prevent future accidents:

- 1. Assign a dozer boss to every dozer.
- 2. More lighting on the dozers.
- 3. Better communication capability with dozers.