Rapid Lesson Sharing

Event Type: Bloodborne Pathogen Food Incident

Date: May 27, 2016

Location: The North Fire; Cibola National Forest and National Grasslands; New Mexico

He was eating his evening meal when he bit down on a "used" bandage that had been in the meal's mashed potatoes.

Fire Food – While this photo is from a 2011 fire in which no health problems were reported with meals, this RLS reminds us how just eating food can be another potential hazard for firefighters. The lessons from this medical incident provide relevant information on how to respond to such a potential foodborne illness exposure. Photo by Kari Greer, U.S. Forest Service.

NARRATIVE

By May 27 there were approximately 130 personnel assigned to the North Fire, being managed by a Type 3 Incident Management Team.

The Logistics Section set up a rotation with local restaurants to feed firefighters and support personnel.

Many resources were spiked-out at two remote spike camps. Food was prepared at the restaurants and delivered to the spike camps and ranger station, which was serving as the Incident Command Post.

EXPOSURE: Used Bandage in the Mashed Potatoes

On the night of May 27, at the beginning of a holiday weekend, an individual was eating his evening meal at a spike camp when he bit down on a "used" bandage that had been in the meal's mashed potatoes.

These meals had been prepared in individual "To Go" containers which were delivered in ice chests to the firefighters. Therefore, potential for exposure included up to 117 individuals who received and ate from these meals that evening.

This Incident-Within-an-Incident (IWI) was immediately reported up the chain of command to the Agency Administrator who quickly informed the Forest Supervisor and Forest Duty Officer.

Initial Response and Request for Assistance

The next day, the individual was taken to the Emergency Room for evaluation and advised of follow-up actions.

The Agency Administrator asked Forest Service law enforcement to begin an investigation. He also requested assistance from the Duty Officer to contact the local agencies responsible for food safety and mishaps.

Initial calls were placed to the New Mexico Environment Department's Environmental Health Bureau. But, because this was a Saturday on a holiday weekend, all calls went straight to voicemail. An "emergency" number for the New Mexico Department of Health, Public Health Division was tracked down, a call was made, and an on-call Epidemiologist Doctor soon responded and began the process for the department's response.

The Public Health Division's Epidemiologist was asked by the Agency Administrator to visit the fire camp to provide information to the others who had been potentially affected.

Forest's Bloodborne Pathogen Plan Implemented

The Agency Administrator asked the Forest to provide a Point of Contact to take the lead on this atypical Incident-Within-an-Incident. The Forest appointed the Forest Safety Manager to be this lead.

The Forest's Bloodborne Pathogen plan was implemented. This was an unusual incident. No one seemed to have experience with such a potential adverse medical situation impacting so many individuals. The Forest Safety Manager therefore reached out to the Regional Safety Program Manager for assistance. An Incident-Within-an-Incident Team was identified at the Forest level to manage some of the duties associated with this effort.

At the same time, the Public Health Division began its investigation and went to the restaurant to interview the owner. A possible "donor" of the bandage was identified. However, confounding the situation, the culprit bandage could have originated at the food's original source location and not the restaurant. The food item was purchased in bulk and had minimal handling by restaurant employees.

Erring on the side of caution, the Public Health Division recommended the restaurant worker undergo testing. This person voluntarily agreed to do so.

Initial Employee Care

While awaiting the test results of the restaurant worker, the Public Health Division's Epidemiologist was asked by the Agency Administrator to visit the fire camp to provide information to the others who had been potentially affected. Everyone involved was sensitive to these employees' concerns and, thus, wanted to make sure accurate information was provided.

In the meantime, the Forest and Regional Safety Managers were determining the best course of action to provide timely testing to any of the employees who were potentially exposed. The Critical Incident Team convened to develop the course of actions and a communication plan for all parties and employees involved.

In addition, a nearby "mobile" medical testing lab agreed to travel to the fire and test individuals on site. This was arranged to occur on June 4.

Highly Unlikely an Exposure Occurred

On June 2, the Public Health Division Epidemiologist received the donor's blood test results and traveled to the fire to give a presentation to all assigned fire and support personnel. The doctor relayed that, based on her investigation and experience, it was highly unlikely that an exposure had occurred.

She explained that the suspected (bandage) donor reported no cut on their fingers and the doctor found no evidence of blood in the workplace. She relayed that for a "true" exposure to occur, food has to be stained to the point that it appears "red" for the transmission of Hepatitis or HIV.

Preliminary results from the suspected donor's blood tests were negative for HIV and Hepatitis B, but positive for Hepatitis C. The doctor relayed that Hepatitis C requires follow-up testing to ensure that the infection was actually present. She then restated her adamant opinion that no exposure was likely

Information Packet

When the Public Health Division Epidemiologist made her presentation to the firefighters and support personnel on the North Fire, everyone was issued an "Information Package" that included:

- A partially completed hard copy CA-2, which they were instructed to complete and submit to the Incident-Within-an-Incident Team (Forest and Regional Safety Managers).
- Information concerning Hepatitis from the Centers for Disease Control Prevention.
- Information on filing an Office of Workers' Compensation Program (OWCP) Claim (CA-35a).
- Declination form for Hepatitis B testing (FS-6700-14) (to decline taking this vaccine).

to have occurred. The doctor made herself available following the briefing for anyone who wished to have one-on-one conversations. After the Agency Administrator's presentation several people availed themselves of this offer.

On June 4, the mobile testing lab traveled to the fire. Eighty-one individuals requested and were given screening blood tests. Also on June 4, the Forest Supervisor sent emails to each unit's Agency Administrator with information regarding this incident, how the Forest was responding, and how it was providing for the care of all those affected.

Paperwork/Administration/Follow-Up Care

The Agency Administrator and the Incident Management Team recognized the heavy workload with processing CA-2s and other paperwork. They therefore requested support from the Albuquerque Service Center (ASC) Incident Finance Branch as well as from the Human Resource Management (HRM) Worker's Compensation personnel. A team traveled to the fire to be in place on June 4 to assist in processing CA-2s as well as to help the fire's personnel catch up on incident time. In addition, this team brought a Department of the Interior Incident Business Specialist to assist with this agency's personnel.

- All CA-2s for U.S. Forest Service employees and ADs were entered into the "eSafety" system, the Forest Service's new, fully integrated Safety and Occupational Health (SOH) and Workers' Compensation (WC) incident reporting and case management system.
- To ensure that this IWI's broad scope and impact was captured, non-USFS employees were also entered into eSafety for tracking purposes only. When Forest Service personnel return home they will be able to print a clean "correct" copy for their personal records. (In the multiple hard copy forms filled-out at the spike camps there were errors/omissions that the HRM experts were able to correct that would have, in all likelihood, caused the handwritten ones to be rejected by the system or Department of Labor.)
- At the request of their Human Resource Department, CA-2s for New Mexico State personnel were scanned and emailed to the appropriate party.
- CA-2s for DOI personnel, as well as other non-New Mexico State agencies, were copied. Individuals will be provided their original copies to enable their home units to appropriately process the CA-2s per their system.
- Those individuals who elected to have the screening or later vaccinations—or both—were issued a resource order/S number to pay for follow-up treatments at their home units. These treatments include the full series required for Hepatitis A/B, as well as the follow-up blood screening at the six-month and twelve-month post-exposure time frames.

Take-Home Packets

Take-home packets were provided to all potentially affected North Fire personnel that included:

- A copy of the CA-2 and memorandum of the incident.
- Information with instructions on follow-up treatments:
  - Hepatitis vaccinations – the full series required for HEP A/B as soon as possible.
  - Blood screening tests – 6 months and then 12 months from time of exposure.
- Resource order/S number to authorize payment to the North Fire.
  - Charges will be paid by the local unit's Purchasing Agent. These expenses will be covered by the S number provided to each employee for the follow-up treatments.

LESSONS

This "Unconventional" Incident-Within-an-Incident Prompted Everyone Involved to Think Beyond an "Accident" in Planning for Future Incidents

- Recognize the complexity early and bring in the right people for the task.
  - ✓ Consider using the IMT Safety Officer as the IWI IC. Besides fire operations, the Type 1 and 2 Safety Officer levels are trained in—and have extensive experience with—the health and safety of fire personnel. Using the North Fire's Type 2 Safety Officer for the IWI IC would have minimized lag times with on-scene assistance.
  - ✓ Having HRM experts in illness/injury on scene served several purposes. They provided expertise in processes that should prevent eSafety rejections and future issues with Department of Labor claims. They knew what was required and who could have access to prevent personally protected information (PPI) of the affected individuals. They took the workload off the Incident Management Team.
  - ✓ Defer to and involve Dispatch and Incident Finance experts to issue resource order/S numbers to provide a funding mechanism for follow-up care at the home unit.
- Establish clear lines of communication, roles, and points of contact early at all levels (Incident, Forest, and Regional). Redefine or reaffirm quickly as the incident unfolds and involves people or other agencies that may not be aware of or have experience in how the Incident Command System is managed.
- Ensure that all Incident Management Teams, even at the Type 3 level, have an Incident-Within-an-Incident Plan.

Follow-up information is critical. Every potentially affected individual, regardless of agency, was provided a take-home packet of information and forms to continue with long-term testing and care, including payment processes.

- Forest and Regional Safety Program Managers can provide important information on bloodborne pathogens, etc.
- Follow-up information is critical. Every potentially affected individual, regardless of agency, was provided a take-home packet of information and forms to continue with long-term testing and care, including payment processes.
- Involve local regulatory agencies (Department of Health, Food, and Environment) early and rely on their expertise and information. Ask these experts to address the potentially affected individuals and provide them the necessary information directly. In this incident, the Public Health Division Epidemiologist Doctor was happy to travel to the fire camp and speak to those affected.
- Think "outside the box" to minimize further impacts to affected individuals. While not every fire/incident will be in proximity to a large metropolitan area, it's worth checking on mobile testing labs and their availability. Being able to bring this "service" directly to fire camp was critical in reducing further stress and minimized disruption to fire operations as much as possible.

- Every unit should be providing annual bloodborne pathogens training.
- Make sure to keep the P-Code open long enough to pay for long-term follow-up care.

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- Capture the incident in eSafety. Non-Forest Service resources can be entered into eSafety under the "Safety Hazard" module.
- Reach out to the home units at the appropriate level. Home unit supervisors appreciated the Forest Supervisor reaching out to them about the incident and how the Cibola National Forest and National Grasslands was "taking care of" their employees.

This RLS was submitted by:

The Acting Forest Fire Management Officer

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