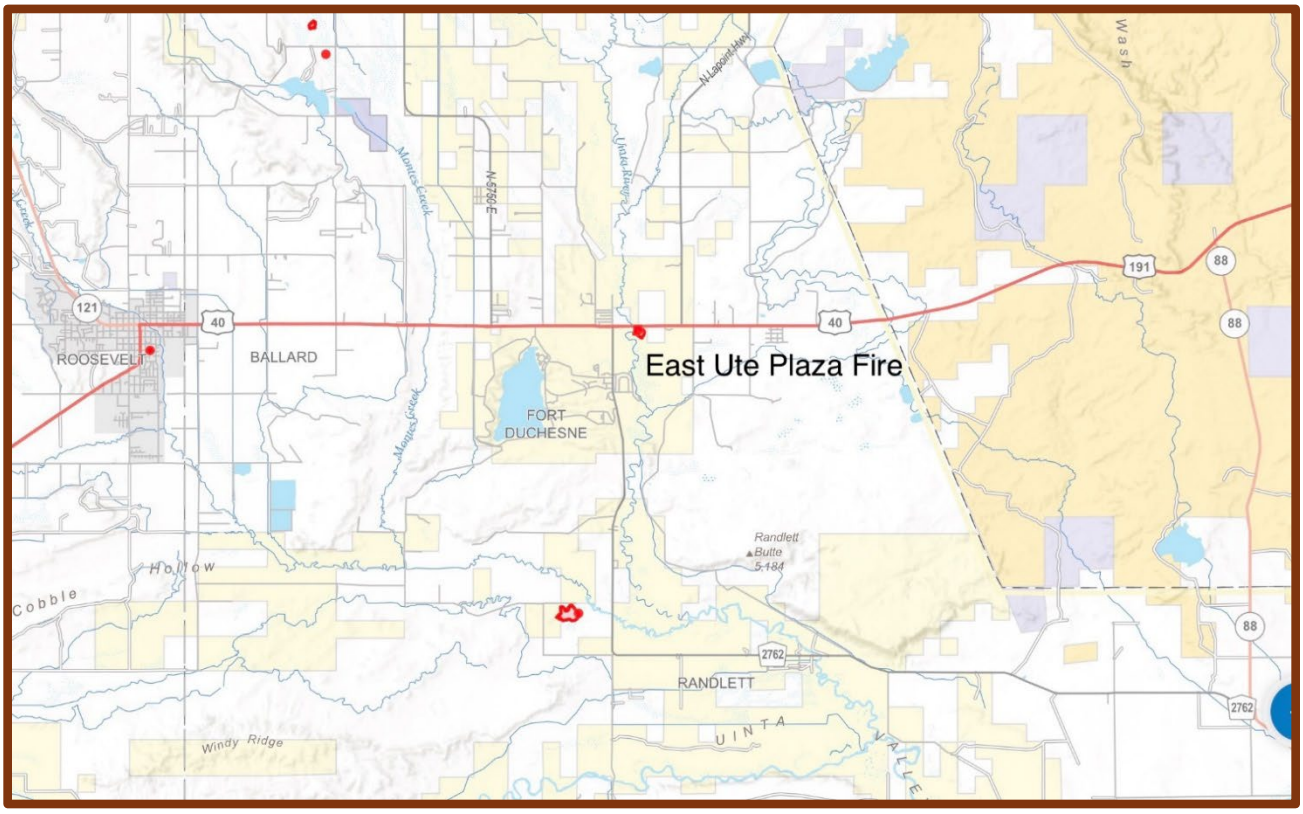
East Ute Plaza Fire Lessons Learned Review



Incident # UT-UOA-100037

On March 17, 2026, at 3:39 p.m., volunteer firefighting resources responded to the East Ute Plaza Fire, a human-caused incident that had started just south of Highway 40 on the northwest side of Fort Duchesne, Utah. The fire was on the boundary of Tribal lands and private property. Apparatus from three volunteer fire departments (VFD) were already on scene when federal firefighting resources arrived. A federal Wildland Fire Service (WFS, legacy BIA) Type 4 Incident Commander (IC) assumed command of the fire upon arrival. The VFD Type 5 IC transitioned into the Type 4 IC trainee role.

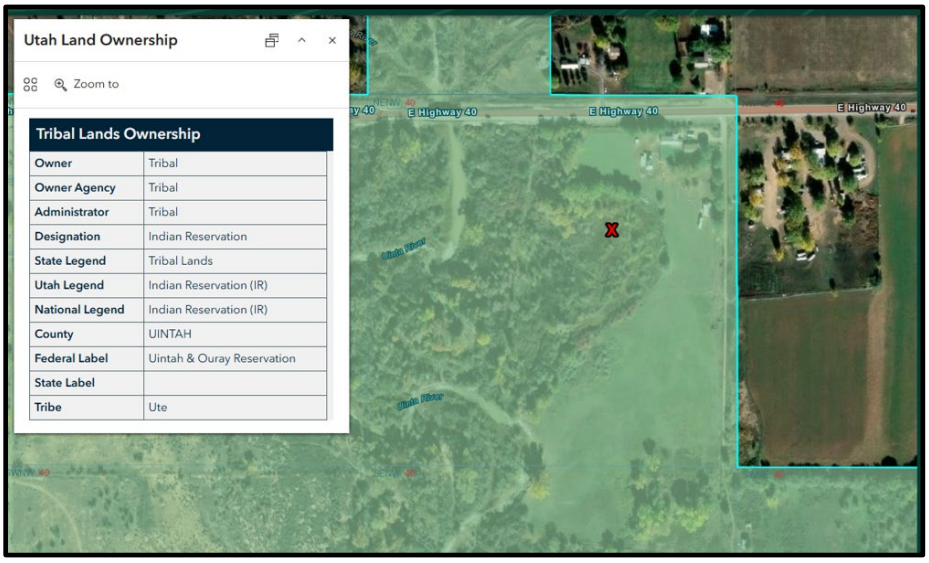


Figure 1: Land ownership and estimated (original) point of origin for the East Ute Plaza Fire.

The IC and IC Trainee were focused on the south end of the fire when a WFS (legacy BLM) engine staffed with two engine boss (ENGB) qualified personnel arrived on scene. (Due to the early season timing, no seasonal firefighters had been onboarded yet.) The highway was closed when the WFS engine arrived, so they turned on their overhead red lights to enable them to navigate the traffic on the roadway. They immediately noticed firefighters engaging in direct attack on the northeast corner of the fire near Highway 40. They turned south on the private driveway and checked in with the IC. The IC told them to begin working on the north end of the fire near the highway. The IC had noticed that the wind changed direction about the time the federal WFS engine arrived. Up until that point, the fire had been pushed to the southeast. But now the wind was pushing it to the north. Many resources on scene reported feeling erratic winds. However, overall, in the IC's opinion, the fire had shifted from spreading generally southeast early on, to spreading in a more northerly direction.

The WFS engine crew spoke with the IC about conducting a burn out operation because they didn't consider direct attack a viable option. The fire was nearing the junction of Highway 40 and the Uintah River. They were hoping to use both the highway and the river as control features to contain the fire.

They were worried that the fire would either spot across the highway on the northeast corner or burn along the river under the bridge on the northwest corner (north of Highway 40) before the direct attack operation could stop it. The IC told them to go ahead and conduct the burn out if they could do so safely. Then the IC Trainee called the VFD engine on the north end of the fire to inform them of this pending burn out operation. The engine expressed concern about burning due to the winds. The IC Trainee told the VFD engine to tie-in with the WFS engine and discuss the operation.

After checking in with the IC and receiving their assignment, the WFS engine drove back to the north end of the fire and saw a local homeowner using a garden hose and thought he was one of the volunteer firefighters. They asked him to leave the area as it was going to be included in their planned burn out operation.

One of the WFS ENGB gathered the suppression resources on the north end of the fire to give them a briefing on the planned firing operation (this WFS ENGB became the Firing Boss). A VFD engine crewmember expressed his concern regarding the shifting winds to the Firing Boss. The Firing Boss stated that the direct attack plan was moving too slowly to be able to hold the highway to the north. The other WFS ENGB headed toward the river near the northwest corner to do some minor chainsaw prep work to prepare for the burn out operation.

The plan was to burn two sections of control line (see Figure 2). The first was a small section from east to west along the highway toward the Uintah River to stop the northerly progression. The second section was from the main fire along the river back toward the highway to the north, securing the corner and stopping the fire from going under the bridge.

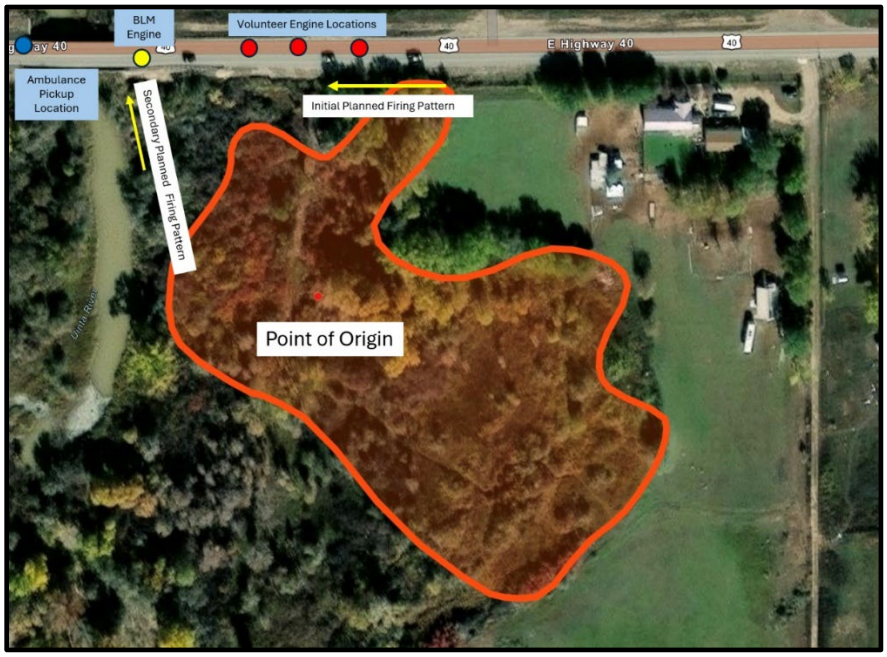


Figure 2: Estimated fire size (approx. 5.5 acres) when burn out operation began.

Figure 3: Left – View from the roadway looking toward the Uintah River bridge. Right – Looking east from the Uintah River bridge.

Figure 4: Left – View from the northeast corner looking toward the Uintah River bridge. Right – Looking southeast toward the fire from under the Uintah River bridge, showing the continuous fuel concern.

As they gathered up and began briefing, the IC Trainee called over the radio and asked them to wait for a Firing Boss Trainee from a local volunteer department (who was on another part of the fire) to come and get some training experience. The Firing Boss and the other WFS ENGB were concerned with the timing as they saw the fire actively moving toward the highway and were eager to begin burning.

They held off briefing the firefighters on the north end of the fire until the Firing Boss Trainee arrived on scene. The Trainee arrived on one of two VFD engines reassigned to help support the burn. This new group of firefighters were nervous about conducting a burn out because they believed that the winds were too erratic. Howevre, they did not voice their concerns up the chain of command.

Once the Firing Boss Trainee arrived, the Firing Boss began the briefing. The Firing Boss asked if anyone from the volunteer departments wanted to carry the drip torch and be the igniter. A firefighter from the Firing Boss Trainee's engine raised his hand and was designated as the igniter. The rest of the volunteer firefighters were assigned to the holding crew and told to monitor the north side of the highway. They decided to start ignitions, but no one had a lighter. Therefore, the igniter walked to his engine to retrieve one. When he got back, the fire had progressed too close to their location. They changed the plan and decided not to implement the first section of the burn along the highway from east to west. At this point, the Firing Boss Trainee thought the burnout operation had been called off and began watching for spot fires on the north side of the road. For the next few minutes, everyone watched for spot fires, put out hotspots on the edge, and pretreated the north side of the road.

The Firing Boss, the igniter, and the other WFS ENGB walked to the vulnerable west corner of the fire near the bridge. While the Firing Boss and the other WFS ENGB walked out the planned ignition line to reaffirm the plan, the igniter took a photo (see Figure 5). They liked what they saw, so they hiked back to the highway and began briefing the igniter. They asked the igniter if he was comfortable lighting that section. He replied that while he didn't have much burning experience, he could do it.

The Firing Boss stayed high on the bridge to observe the firing operation and the igniter hiked down the embankment to the river. The other WFS ENGB also hiked down to staff the hardline off the engine to hold the northwest corner near the bridge. The igniter hiked as far as he could to the south—only about 150 feet—along the river toward the main fire. Once the vegetation got too thick to walk through, the Firing Boss gave the order to begin firing. The igniter began firing but did not start walking toward the highway. He was trying to follow the direction he was given to use a chevron pattern while burning. Both the Firing Boss and the other WFS ENGB had to coach him to begin walking so he would not get caught in the heat that would be created by his ignition operation. The igniter began walking north toward the bridge in alignment with the original plan to seal off the vegetation stringer going under the bridge, securing the northwest corner (see Figure 2). As the igniter made it to the embankment near the bridge, he turned the corner and began burning east along the highway. He thought he heard the WFS ENGB with the hose say things were looking good. He was intending to burn to the end of the guard rail on the highway. There was a lot of noise from the fire and from the pump running up on the roadway. It was difficult to hear clearly.

Figure 5: Left – Image depicts fire activity near the northeast corner just prior to burning. Right – Photo taken by injured firefighter just before he started burning. Time stamp on both images is 17:11 (5:11 p.m.).

Figure 6: Left – View of the embankment from the northwest corner of the fire. Right – View from the roadway looking down the same embankment.

Once he rounded the corner, the Firing Boss told him to quit firing and come up the embankment. The igniter did not hear this order and kept firing to the east toward the end of the guard rail as he had originally planned. The embankment was steep with no vegetation (see Figure 6). The Firing Boss, at the top of the embankment near the roadway, again yelled for the igniter to cease igniting and come up to the road. But the igniter kept lighting to the east.

The Firing Boss made several attempts to get the igniter's attention to stop lighting. He had to back away from the burn as he thought *"Wow, it's getting hot"* in reference to the heat coming off the corner behind the igniter. The smoke was becoming thick. It was therefore difficult to see once the igniter rounded the corner. The igniter felt the heat, too. He stopped lighting and began to hike up the embankment. The igniter slipped and fell. As he was getting up, his knee gave way and he fell back down. The igniter had a history of knee subluxation (temporary dislocation). He attempted to get up again and his knee gave way again. On his third attempt, he was able to stand up. The winds shifted from out of the west and as he began to move up the embankment, his flame-resistant clothing (Nomex) caught fire.

The Firing Boss heard a *"blood-curdling scream"* and started moving along the road to get a better view through the smoke. The screaming stopped and the smoke opened up enough for the Firing Boss to see the igniter was on fire and was able to make it to the guard rail.

The Firing Boss turned around to grab a hose from one of the volunteer engines to put out the fire on the igniter. As he turned to grab the hose, the igniter made it up to the edge of the roadway where holding crew members helped the igniter over the guard rail and up onto the roadway. The Firing Boss then sprayed the igniter off with the hose from the engine.

A firefighter from a VFD engine took command as the Incident Within an Incident (IWI) IC and, at 5:23 p.m., he called for an ambulance. Fortunately, the ambulance station was very close by. The ambulance parked on the other side of the bridge, across the Uintah River. The burned firefighter was able to walk to the ambulance under his own power. He was packaged and was inside the ambulance by the time the IC and IC Trainee made it to the scene. By 5:44 p.m. the ambulance was enroute to the local hospital.

As the igniter was packaged in the ambulance, the local county fire warden arrived on scene. He noticed some volunteer firefighters not wearing proper personal protective equipment (PPE). He told them to either put on their PPE or leave the fire.

The final fire size came in at just under 10 acres. The fire was contained and controlled the next day.

The burned firefighter received second and third degree burns over seven percent of his body. He was transported to the local hospital and, by midnight that evening, was admitted into and treated by the University of Utah Hospital Burn Center.

Figure 7: Final fire perimeter after containment (9.58 acres).

Findings, Discussion and Lessons Learned

Finding 1. This fire was caused by a private citizen burning organic waste on a high-fire danger day.
Discussion: Landowner-burning is a high-risk activity in this area. It was proving to be an especially risky year to conduct these kinds of burns. Broad public outreach will likely be more important in years like this, as snowpack measures were at record lows and temperatures were at or near record highs for this time of year.
Lesson Learned 1. It is in everyone's best interest to spend extra effort to coordinate messaging and increase public outreach in wildfire prevention.

Finding 2. Cross departmental/agency relationship building is key to successful, safe, and effective firefighting.
Discussion: Volunteer firefighters are critical initial attack resources. They are frequently the first resources on the scene of an incident. Cross training and relationship

building efforts among departments and agencies are critical to successful fire management operations. While most everyone involved in this incident agreed that much effort and emphasis has been placed on building relationships between federal firefighting resources and volunteers, more effort in this area would be highly beneficial. While some responders recognized familiar faces, all interviewees on this incident reported not knowing some firefighters from other departments or their experience levels and capabilities. Building critical relationships and trust in this fast-paced, stressful, and time-critical environment makes firefighting much more effective.

Lesson Learned 2. Interagency resources in the area stated they had worked on their relationships through fire response and coordinated training. Expanding these opportunities will help build trust, enhance relationships, and allow people to better understand each other's knowledge and experience. Building stronger relationships can help people feel more comfortable in voicing their concerns.

Finding 3. There were several breakdowns in communication during this incident.

Discussion: The dynamic situation led to changing plans and these changes led to communication breakdowns. For example, the specifics of the firing operation were unclear to many firefighters who were interviewed during the Lessons Learned Review process. The initial firing operation was canceled and there was not a clearly communicated decision to resume burning.

Lesson Learned 3. The firefighters that were interviewed all agreed that everyone on scene should be aware of the task, purpose, and end state of any operation during wildland firefighting. At times, the objectives are obvious and need little confirmation. During other times, detailed briefings are necessary and, ideally, firefighters should feel confident in expressing concerns.

Finding 4. Resources responding to the incident were arriving and engaging the fire without proper PPE.

Discussion: The interviewed firefighters agreed that PPE is critical for effective firefighting operations. The firefighter involved may not have survived this event if he was not wearing his Nomex flame-resistant wildland firefighting clothing. There were many reports of people not wearing PPE while engaged in wildland firefighting operations. The nature of volunteer work makes this a more challenging issue than for full-time firefighters. While it may be more challenging, all fire leaders on scene agreed that firefighters need to be properly outfitted before they engage. Many ideas were discussed as possible solutions to this problem.

Lesson Learned 4. One of the VFD chiefs and several VFD firefighters identified the benefit of issuing an extra set of gear that they could carry in their personal vehicles. Another option was to increase the PPE inventory on each apparatus to account for volunteers who might have to respond without their gear.

Finding 5. Resource accountability in dynamic situations is a challenging but critical task.

Discussion: Resource accountability becomes more challenging when people are repeatedly changing roles or moving around from apparatus to apparatus on a regular basis. On this incident, several people moved around to fit the emerging needs of the situation. Accountability of resources is considered a key responsibility of fireline leaders. Everyone should know who they are working for and systems should be in place to ensure assigned supervisors know where their subordinates are at all times. Interviews conducted during this review uncovered instances in which fireline leaders humbly admitted they did not always know where their subordinates were located.

Lesson Learned 5. While the "fog" of firefighting caused some confusing circumstances on this incident, those fireline leaders firmly committed to being more diligent with respect to resource accountability in the future.

Finding 6. During fast-moving initial attack events, a heightened situational awareness and quick access to pre-identified escape routes are critical to maintaining firefighter safety.

Discussion: Multiple interviewees expressed that they wished they had a better understanding of the situation. For example, the igniter stated that he had been focused on a particular ending point (tunnel vision), and that if he had just looked around, he would have noticed that the leader's intent had been accomplished and he could have stopped burning and hiked out earlier.

Finding 7. The Nomex flame-resistant clothing worn by the injured firefighter has been collected and sent to the National Technology and Development Program (NTDP). This report from NTDP will be included as an attachment to the final report posted on the Wildland Fire Lessons Learned Center's website.

Commendations

Incident Within an Incident (IWI)

A VFD firefighter showed exemplary initiative in taking command of the IWI. He ensured critical information was relayed and the injured firefighter received the necessary care.

Accident Review Participation

Personnel were extremely receptive to the review process. All personnel contacted by the review team agreed to be interviewed—contributing to a successful learning opportunity.

Volunteer Fire Departments

During the course of this review, the review team encountered volunteer fire departments that are actively taking steps to elevate their department to improve interagency relationships and meet the high demands of wildland fire.

Lessons Learned Review Team

Adrian Grayshield, Natural Resource Specialist, U.S. Wildland Fire Service

Joseph Harris, Risk Management Officer, U.S. Forest Service

Logan Blankenship, Fire Management Specialist, U.S. Wildland Fire Service

Samual Jamie Rogers, Safety Training Coordinator, Utah Dept. of Natural Resources

Thomas (Micah) Suwyn, Deputy Fire Management Officer, U.S. Wildland Fire Service

Special thanks to Alton Pickup, Uintah & Ouray Acting FMO, for assistance to the LLR Team.