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

San Diego Unit

Fire Crew Member Collapse

October 2nd, 2011

Chihuahua3 Fire

11CAMVU011073

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.

Lookout **C**ommunications **E**scape Routes **S**afety Zones

SUMMARY

On October 2nd, 2011, Puerta La Cruz Crew 3 (PLC 3) was engaged in mop-up and overhaul operations on the Chihuahua3 Fire in northeastern San Diego County. In addition to performing mop-up operations, the crew members were assisting engine company personnel with removing fire hose from the fire line. After approximately two hours on the fire line, one Fire Crew Member (FCM) collapsed on the fire line presenting an altered level of consciousness to first responders. The crew member was subsequently transported to the hospital via air ambulance and released to CDCR custody later the same day.

CONDITIONS

Weather
Weather information was provided from the Oak Grove RAWS at October 2, 2011 at 1200 hrs. Temperature: 92 degrees; relative humidity: 23%; wind speed and direction: WNW at 6 mph. The RAWS site is located approximately 4 miles north of the incident site.
Fire suppression personnel reported that "a cooling breeze" had been blowing during the work period.

Terrain
Moderate to steep topography; rocky terrain; on both sides of a southwest facing drainage; on north and south aspects. On-site slopes were determined to be approximately 25%.

Fuels
The fire had burned in medium brush comparable to NFFL fuel model 5.

Fire Behavior
The fire was in containment status approaching control. The crew was involved in mop-up and overhaul, including the removal of hose-lays.

Lighting
Lighting, or lack thereof, did not contribute to the cause of this accident.

Personal Protective Equipment (PPE)
All appropriate wildland PPE was in use and in serviceable condition.

Equipment
Neither equipment nor equipment failure contributed to the cause of this incident.

Crew (crew member) Experience
The injured FCM has been assigned to the camp program for approximately two (2) months. The FCM in question is normally assigned to another fire crew and thought that she was not going to be working on the day of the event. The FCM failed to disclose to her supervisor that she was being treated for a previous exposure to Poison Oak via hypodermic injection – earlier that week – and through the oral administration of Benadryl® - earlier that morning.

SEQUENCE OF EVENTS

October 2nd, 2011 PLC Crew 3 assigned to day shift on Chihuahua 3 fire. After a couple hours of work, at approximately 1220 hours, the FCM collapsed with heat related symptoms (initially mistaken by her crew members as a heart attack). Patient care was initiated by PLC 3 crew members then followed-up by CAL FIRE engine personnel.

The FCM was transported by air ambulance (Mercy Air) to Palomar Medical Center in Escondido, California. Air transport was initiated as a precautionary move given the initial uncertainty associated with her condition. Hospital care involved her receiving IV fluids and monitoring by hospital staff.

Follow-up discussions with the FCM revealed contributory factors to her collapse on the fire line. She stated she was receiving treatment for exposure to Poison Oak, which she had encountered on a previous work assignment. This treatment included both over the counter (OTC) medicine (administered orally through the Camp) and prescription medication (administered intravenously – through the Institution). The FCM also stated that established pre-incident hydration protocols were not followed prior to her responding with the crew to the fire. Additionally, her pre-incident meals (dinner the evening before and breakfast the day of the event) had been 'light". Her explanation was that she did not think that she was going to be working that weekend.

The FCM was released from Palomar Medical Center to CDCR's California Institute of Women.

INJURY / DAMAGE

The FCM was transported to and treated at a local hospital for mild heat stress.

SAFETY ISSUES FOR REVIEW

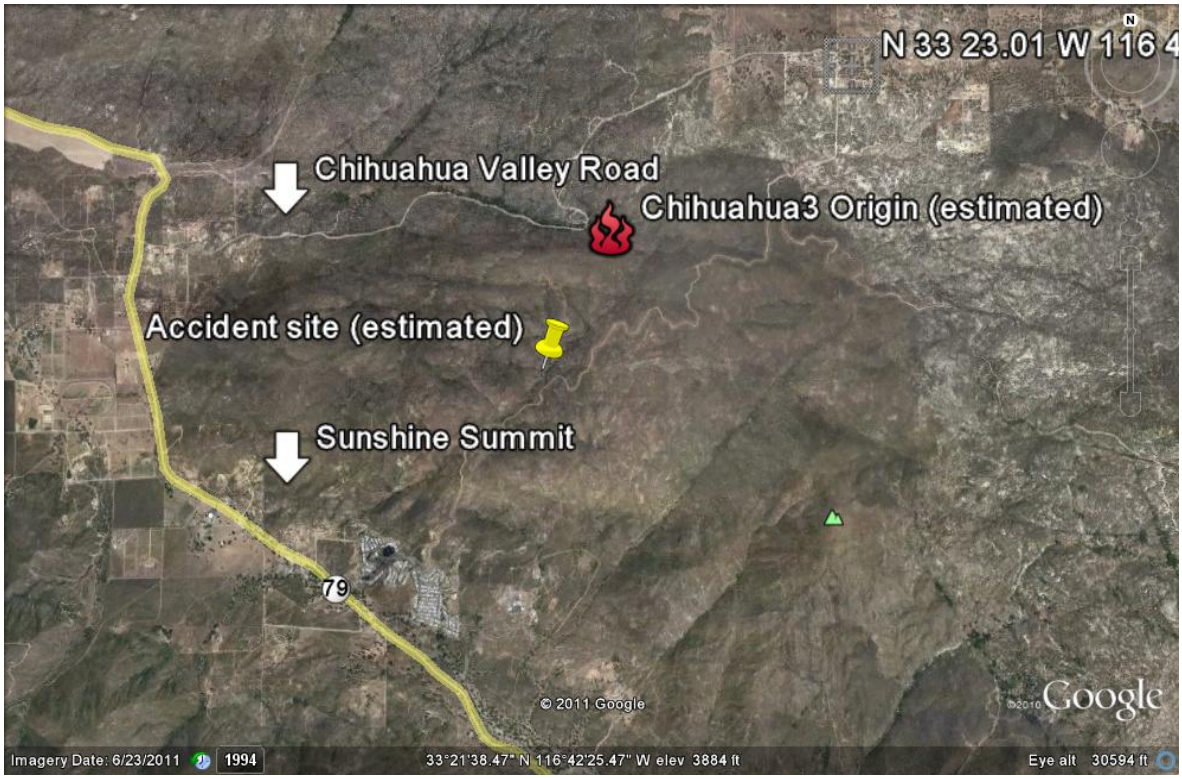
- Fire Fighters need to physically prepared to respond to emergency assignments at all times; this preparation includes adequate rest, proper nutrition and pre-response hydration.
- Consider effects of prescription and over the counter (OTC) medications on fitness.
- Ensure all fire fighting personnel are trained on recognition and treatment of heat illnesses and injuries, as well as, those associated with more severe medical emergencies.

INCIDENTAL ISSUES/LESSONS LEARNED

- CDCR staff and Cal Fire personnel assigned to conservation camps need to ensure coordination with and share information regarding inmate health and medical status with each other prior to and/or during crew check-out procedures.

- Ensure that first responders are performing a truly independent size-up and full patient evaluation prior to ministering to the needs of a patient. Factoring-in erroneous information can result in unnecessary medical interventions.

Precipitation accumulated since midnight: 0.00", in 24 hours: 0.00"



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