

JBJECT: Synopsis of Logwood Fire Fatality
Los Padres National Forest
Monterey County

FACTS:

At 2420, Sunday morning, a 12-man CDF Ecology Crew was sent to the indicated fire. The crew had put in a full eight-hour work day constructing a fuel break, in addition to hiking a total of $3\frac{1}{4}$ miles to and from the job site on Saturday. At 1745 Saturday the crew also was dispatched to a fire but was stopped and taken back to camp. The arrival time in camp was 1945. The crew went to bed some time between 2230 and 2300. The victim retired at 2300, but did not sleep. The foreman, In summary, had had no sleep and the crew only $1\frac{1}{2}$ hours since about 0800 Saturday.

Arriving at the fire, the decision was made that the crew would build line from the creek up the north flank of the fire--see attached sketch-- in cooperation with an eight-man U.S. Forest Service crew that would do the same on the south flank. The two crews were to tie together at the top of the fire. There was no radio contact between the ~~two~~ crews or with fire management. The fire weather danger was rated "low".

The CDF crew began line construction at about 0230. By 0430 the crew had built about 125 yards of line up about a 70% slope. The terrain consisted of Redwood with loamy soil for the first 50 yards, then changed to chamise brush in loose and extremely rocky ground.

At this point, they took a lunch break while firing out their line. The chamise was about five feet high.

After their break, they continued building line up to the spur ridge. They arrived at the ridge at about 0630 ($11\frac{1}{2}$ chains to the top of the ridge) and observed the fire had slopped over in two fingers. Visibility was good.

While the crew took another break, the foreman reconed the area. He held a short strategy session with his crew and decided to encircle the slopover to the north and return to the ridge and then to tie in with the U.S. Forest Service crew.

After the danger of the steepness of the area was discussed, they proceeded to build line over the ridge into a swale 320 feet above a drop-off of 82% slope. The crew was working about 5 to 10 feet above the drop-off in loose litter and rock. Because of rolling material, trenching was required. Several small fires had already started below the drop-off from rolling material.

At this time, a corpsman slipped but caught himself before falling over the cliff. A short time later the victim slipped and barely caught himself, whereupon the foreman told him to slam the rake end of his McLeod into the ground to hold himself and build footholds on which to climb out. The foreman saw him build two steps when he was distracted by a U.S. Forest Service foreman (not the one heading the eight-man crew) who wanted to talk to him.

The victim had his feet slip out from under him and without a word slid on his stomach down ^{INTO} the canyon. The time was about 0705. At about 1715 he was found by a U.S. Forest Service man and two corpsmen face down in about 12 inches of water. The corpsmen rendered mouth to mouth resuscitation to no avail. When the crew foreman arrived, he checked the victim's pulse and pupils and found no indication of life.

The coroner stated the official cause of death was drowning; however, he also said that even if he had landed out of the water he would have died within 15 minutes because of his internal injuries.

ANALYSIS:

Access into this area was hazardous under the best of conditions, although attacking the fire at night was considered necessary to keep it from spreading.

The quality and quantity of fireline construction up to the ridge was excellent. This along with the fact that no injuries had occurred during this phase indicated that the crew was well trained, in good physical condition and disciplined. The crew was rested regularly, took a lunch break, and held a strategy session, including a safety discussion. The foreman was concerned about the fire getting under his crew so he had fired out his line before continuing on up to the ridge.

There appears to be two main actions that contributed to this accident:

1. Even though the fire danger was low, the decision was made to man steep, dangerous slopes at night. This was apparently due to fire training and policy to contain fires as soon as possible. If this operation had waited until daylight, the crew would have been less tired and fatigue would not have been as great a factor.
2. The decision to continue building line after reaching this ridge must be questioned. With the slopovers on one side of the line and spotting on the other, it would seem logical that the crew should have been pulled off the line. This, in light of the extremely hazardous situation of slipping and falling over the cliff or having rolling material hit someone, makes the decision even more questionable. In addition to this, the crew had had only $1\frac{1}{2}$ hours sleep ^{ABOUT} in the last 24 hours of, for the most part, hard physical work and therefore were ^{SO} fatigued. Finally, one man had already slipped. This should have caused the foreman to realize the inherent dangers and move the crew out.

This decision, however, was made by a foreman who had been without any sleep for 24 hours prior to the accident. This could easily have fogged his reasoning ability. Also, he had no way of communicating his situation to fire management for consultation and advice. No one contacted him to see how things were going for $4\frac{1}{2}$ hours.

RECOMMENDATIONS:

1. Fire fighting strategy must depend on many factors: weather conditions, fire danger to property, terrain, and the physical condition of fire fighters. Too often the physical condition of fire fighters and job hazards are overlooked for the sake of saving a few acres of brush. The lives of people are too sacred not to be given a high priority consideration in any fire control action.
2. All fire management people should be required to review this accident and be encouraged by their supervisors to make "employee safety" a high priority in fire fighting strategy.

3. Communications for the purpose of fire control is absolutely necessary.
This means providing foremen with portable radios or requiring fire supervisors to maintain close periodic contact with crew foreman.
4. Strong light weight ropes should be provided all crews working in hazardous areas for possible use in rescue operations.

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