2011

Participant Guide

Prepared by Gabriel Donaldson and Craig Cunningham

[SADLER FIRE STAFF RIDE]
Pre-Work:

Prior to participating in the Sadler Fire Staff Ride, students should read the Sadler Fire Investigation and Incident Action Plan which can be found at:


Please read and review the 6 Minutes for Safety from August 9th, 2010:

http://www.wildfirelessons.net/uploads/6mfs/home.html

Students are also encouraged to read the “Ghosts of Storm King” in John Maclean’s Book Fire and Ashes to gain a different perspective of the events surrounding the Sadler Fire Entrapment. Please bring a copy of the Incident Action Plan, Incident Response Pocket Guide and Sadler Fire Investigation with this Participant Guide to the Staff Ride.

Please pack a lunch, dress appropriate for the weather conditions and anticipate about a 2.5 mile round trip hike over moderately level terrain. Participants should plan to carpool in order to reduce traffic to and from the Sadler site.

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Outline:

0700-0715: Introductions (Elko District Office Conference Room)
0715-0900: Sadler Fire Summary PowerPoint (Conference Room)
RHA’s (Conference Room)
Stand #1 (Conference Room)
Pre-Mortem (Conference Room)
0900-1015: Travel to the “Big Safety Zone”
1025-1230: Travel to the “Y” (Stand #2)
Hike Stands #2-#5
1230-1345: Travel from the “Y” to Elko
1345-1500: Stand #6 (Classroom)
AAR
Lessons Learned/Integration
Acknowledgments/Credits:

Gabriel Donaldson: Facilitator/ participant guide formatting, PowerPoint presentation preparation; stand outlines/formats, facilitation and integration

William (Craig) Cunningham: Participant guide formatting, map formatting, facilitation and integration

Shane McDonald: Research, interviews, site preservation, document preservation

Tom Warren: Site preservation

Steve Dondero: Air Attack Summary, aerial organization information, general command overview, VHS footage.

Jeff Arnberger: Networking, command overview

Dylan Rader: General assistance, command and situation information

Matt Murphy: Maps

Gerry Beddow: Pictures, unit logs

Ruby Mountain Hotshot Staff: Setting up field stands, welding stand displays (Alex Lemelin)

Tom Turk: VHS Footage


All contributor’s to the Investigations Report, John Maclean and his authorship of the “Ghosts of Storm King” (Fire and Ashes).
Map of Focus Area/ Dozer Line and Entrapment Site (In Black):
Stand #1: “ORGANIZATION: THE CREW AND THE COMMAND STRUCTURE”

Crew Summary: Golden Gate National Park #3 (GNP #3) is assembled in San Francisco, CA to respond to an incident in Elko County near Jiggs, NV. Comprised of 21 individuals, the crew participates in one training hike prior to a late afternoon departure for the Elko area. The GNP #3 is a mixed bunch of individuals who do not regularly work with each other (a regular crew or ad hoc crew). The CRWB and Trainee disagree on a plan to travel to the fire, with the two being separated by nearly a day. The Crew Boss does not honor his plan to rest overnight in Winnemucca, NV but pushes all the way through to the incident, leaving his trainee in doubt as he and a different driver stay in Winnemucca as initially planned.

Upon arrival at the fire the Crew Boss, Horton, goes on a scouting mission; Naar (CRWB-T) arrives and through consistently poor communication a “search party” request is put in to find Horton; a helicopter announces Horton as “missing” over an A-G frequency; when Horton is retrieved Naar and Horton have a heated exchange.

Command Summary: The fires in Northern Nevada were growing fast and combining. The activity, size and complexity of the fires prompted the birth of the “Sadler Complex”. August 9th did not start off well; the organization was disjointed and due to a number of factors, including a recent team transition, resources were confused about their assignments. Many resources didn’t receive an Incident Action Plan and many missed out on some very important information, including a critical weather update for the fire area, “The minimum RH was expected to be 6 to 12 percent, and a Haines Index of 6 was forecast. Fine fuel moisture was expected to be 3 percent.” The morning briefing in Jiggs was announced by Dan Huter and many resources didn’t hear or know that the meeting was occurring; missing critical pieces of information. The Incident Action Plan indicated a lack of adequate fire line supervisors, displayed by Tom Shepard being listed as the Division Q and Division O supervisor. There was an obvious disconnect between planning and operations, as Branch Directors were tasked with creating their own Branch plans, not to mention the fact that Branch II’s organization had become vague: “In the IAP, the northeast part of the fire was shown as two divisions - O, under Shepard, and Q, under Mike Head. At some point, that was changed to one division - - Q - - with Shepard as division supervisor. There was confusion throughout the day on Branch II over division locations, assignments, and chain of command.”
You have been tasked with mobilizing a crew in San Francisco, California, travelling to Nevada and working on a fire in Jiggs, Nevada. You’re crew is comprised of regular employees with an eclectic set of backgrounds, some of whom have never fought a fire. You have been assigned a Crew Boss Trainee, and it has been requested that you leave as soon as possible.

As the Crew Boss for the GNP #3 crew, conduct a pre-mortem which addresses mobilization, travel, suppression, demobilization and return travel to San Francisco.

What tools are available to us to aid in a safe, timely and effective mobilization and departure?

Is two way communication flow necessary for a Crew Boss and Crew Boss Trainee to effectively interact with each other? How could you, as a Crew Boss Trainee, effectively communicate concerns/issues to your Crew Boss without inviting conflict? What could Naar and Horton have done to ensure that they were on the same page concerning travel to the incident and all future engagements?

The Incident Response Pocket Guide was not a tool that was available to firefighters in 1999. What parts of the IRPG do we use on a day to day basis?

It is 0600 on August 9th of 1999 in Jiggs, NV. You are the Crew Boss for GNP #3, who has driven all night to arrive at an incident and are without your entire crew due to a miscommunication or lack of communication. You have worked a shift of the fire and are eager to become more involved in suppressing the incident. While attending the morning briefing you did not receive an Incident Action Plan, but hear talk of Red Flag Warnings and extreme fire behavior.

Assuming that you want to work on the fire, what information needs to be clarified prior to engaging or even traveling to your division assignment?

Considering the Incident Command Structure and interface of elements within it, what areas of the ICS are failing at this point in the incident? How might a Branch Director, Division Supervisor, Operations Section Chief or even an Incident Commander mitigate and/or draw attention to these failures? What strong reaction would you take (as a fire line supervisor) to a seemingly weak signal that the organization is crumbling?

As the Crew Boss do you feel that you could safely engage a division of the fire at this time? Why? Why not?

What other tool do we have to consider while trying to safely and reliably organize, manage and engage all aspects of wildland fire? Are there “small failures” which need to be addressed/tracked, prior to arrival at the Incident Command Post which has already occurred?
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Stand #2: “FIRING PLANS AND THE ‘Y’”

**Summary:** Shepard (DIVS) briefed crews at the “Big Safety Zone” approximately 2 miles from the “Y” regarding a plan to burnout out a series of roads and dozer lines. Shepard had developed this plan with Huter (Branch Director), but it had not been fully developed. The “Y” was located about 2 miles north from the “Big Safety Zone” and from the “Y” a dozer line was being completed and tying in with the “Big Black”, an recently burned area which would have sufficed as an anchor point or tie in point. The original plan was to burn from the “Big Safety Zone” to the “Y” and from the “Y” to the “Big Black” utilizing the two hotshot crews (Smokey Bear and Dalton) with GNP #3 in support. The Hotshot Crews were “…reluctant to initiate that plan until the eastern flank south of the Big Safety Zone was secured.” Superintendents Rich Dolphin (Smokey Bear) and Neil Metcalf (Dalton) continued to scout options in and around the “Big Safety Zone” while more resources arrived on Division Q, “Shepard reported being swamped at this time by radio traffic, the number of resources reporting, the number of resources just turning up, and problems with dozer fueling. Operations were delayed in part by the heavy workload he faced.” (From page 9-10 of the Investigation Report)

Shepard had Dozers improving safety zones and creating new ones. The northern dozer line had been put in the evening of August 8th. There were, all told, 6 safety zones of approximate equal spacing between the “Y” and tie in point to the west (the investigation notes spacing of 1370 feet. Our maps and research shows the “Y” as a safety zone plus 4 between the “Y” and CP-11. CP-11 abuts the “Big Black” which is in and of itself a large safety zone). The proposed tie in point was an old burn referred to as the “Big Black” While the "Big Black" was going to be utilized as a potential tie in point, "The 'Big Black' was an old burn not recent, or not from Sadler anyway." The proposed burn spanned a distance of approximately 1.3 miles.

At the “Big Safety Zone” on the morning of the 9th, Smokey Bear IHC, together with Dalton IHC determined that if the burn was to be conducted, burning from the Y going west was not a good option. Smokey Bear IHC had been working the east flank for several days prior to the 9th, observing consistent runs at 1100 each day, and a lack of adequate personnel to conduct a large scale burning operation. If the burn was going to be conducted, it would need to be started at an anchor point to the south on the east flank: "It was a combination of safety and sound tactics that required the decision to anchor and secure the east side first. We had been losing line for a week due to resources being spread too thin and not being able to secure line behind fast enough or trying to secure things too fast . . . The fuel load on the east flank was high (old growth sagebrush) compared to the dry lake to the north.” Dalton and Smokey Bear IHC’s together with Shepard and Frank finalized a plan to anchor and burn from a finger which had hit the Crane Spring road roughly 1.5 miles south of the “Big Safety Zone”. Dalton IHC proceeded north towards the “Big Safety Zone” while Smokey Bear IHC burned from the Crane Springs finger to the south for approximately 2 miles: “We began burning the east flank and were already (1100) getting spots across to the east until a more consistent wind and the draw

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of the burn helped reduce spotting. Afternoon runs were of the intensity that being at the head without a solid anchor and line behind tied in, the work would be out flanked to the east.” Smokey Bear IHC Superintendent, Rich Dolphin, tied in with Dalton IHC near the end of the day, to discover that the burning operation on the east flank had been tied into the “Y”, he observed that there was black to the west along the dozer line and S.E.A.T.’s were dropping on fire activity to the west of the “Y”.

Horton arrived at the Big Safety Zone after the meeting of the two Hotshot Crews and Division Supervisor’s. According to Dolphin: “I do not think Horton was clearly informed that the IHCs had done something different and why”, uninformed by Shepard that the IHC’s were burning several miles to the south of the “Big Safety Zone”. Conversely, according to Dolphin, the IHC’s had “no idea the GNP crew was out there burning the dozer line”.

The plan established by Shepard and GNP #3 was for Horton, Deaton, Christensen and Hyde to anchor their burn from the black finger to the west towards the “Y”. After a briefing at 1400, they opted to return to the “Y” and burn to the west due to changing winds. Firing operations began at 1500, with the remainder of the GNP #3 crew staying at the “Big Safety Zone”. Engines 3636 and 3639 would aid in holding operations.

**Stand #2-Firing-Tactical Decision Games (TDGS)**

The Lucky Nugget Subdivision is a resource of concern to the Team managing the Sadler Complex. There is a large portion of unsecured line between the “Big Black” and the “Big Safety Zone” which, if left unchecked could make a run towards the subdivision. The Incident Objectives for the Sadler Complex were: 1) Firefighter and public safety; 2) Protection of structures; 3) Suppression of the fire in the most cost-effective manner; 4) Protection of historic cultural sites; 5) Protect archeological sites in Aiken Canyon and Mineral Hill; 6) Protect livestock.”

As the Crew Boss, do you think there is a feasible method for securing the line between the “Big Black” and the “Big Safety Zone”? Keep in mind the Incident Objectives and that conditions do not warrant a safe direct attack tactic at this time.

As a Crew Boss, what are your concerns with the proposed plans as they stand now?

Keeping in mind that the Incident Response Pocket Guide was not a tool available to firefighters in 1999; what “watch-outs” are you observing? How will you mitigate them?

Lookouts, Communications, Escape Routes and Safety Zones (LCES) are integral components in safely fighting fire. Are they in place? Can you put them in place to safely engage?

What other tool is available when considering risk in the fire environment?

Who has ever had a “hazardous attitude”? How have you been able to mitigate that attitude or how are you mitigating it now?

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Stand #2-Firing-Strategic Talking Points (STPS)

According to local notes and observations by the Air Tactical Group Supervisors and Elko Management there was a priority to protect ranches and structures near the southern end of the Sulfur Springs mountain range (the southernmost part of the Sadler fire). Visibility of divisions O, N and Q from the air was null. The fire’s airspace was being shared by two Air Tactical Group Supervisors due to the size and complexity of the fire, but they were having issues communicating with the provided frequencies. Burning the northernmost part of the Sadler fire (the dozer line) was proposed as a long term strategy only when there was a break in visibility (on the 8th of August). The dozer line was put in the night prior to being burned and there was a forecasted cold front predicted for the 10th of August.

As an outgoing member of the Type 2 organization either demobilizing from the fire or transitioning into another role, how critical is disseminating strategic information from shifts prior? Some people tend to believe that they can start with a fresh slate when organizing an ongoing incident, is there value in re-organizing and omitting previous strategic plans? Was there an imminent need to conduct a burn-out at the northernmost division of the Sadler Fire on this division on August 9th?

The Incident Action Plan for the 8.9.99 day shift shows Dalton IHC, Smokey Bear IHC and GNP #3 assigned to Division “N” (Chuck Frank). Due to a vehicle failure en route to the “Big Safety Zone” Horton (GNP #3) was unaware of the plan which was established by Frank, Shepard, Smokey Bear IHC and Dalton IHC. GNP #3 was assigned an operation on an adjoining Division Q (Shepard). Resources continued to arrive and Shepard was “swamped at this time by radio traffic, the number of resources reporting, the number of resources just turning up . . .”

How could the team have mitigated potential span of control issues?

Contrasting our knowledge of fire operations today what large scale strategic steps could have been taken to effectively manage the influx of resources relative to the fire’s growth?

Stand #2-Firing-High Reliability Organizing

As the Crew Boss originally assigned to a division with 2 IHC’s, how might you “develop skills . . . that will allow for improvisation and action when a failure occurs” (Commitment to Resilience)?

If you knew that there were other crews on this division with you what questions would you ask the Hotshot Superintendents and others on the division to broaden your understanding of what is happening and “defer to expertise”?

It has been noted that there “. . . was a combination of safety and sound tactics that required the decision to anchor and secure the east side first.” As a Division Supervisor, what signal (weak or strong) might prompt you to adjust interim tactics and strategy? What other information would you need and what questions would you ask of your resources to develop a plan?

3 Air Attack information and northern Nevada situation information provided by Steve Dondero (Elko Air Attack during the Sadler Complex) and Jeff Gardetto (Air Support Group Supervisor on Ed Storey’s Type 1 Team); northern Nevada situation information provided by Jeff Arnberger (Fire Operations Specialist during the Sadler Complex)
Safety Zones, “Big Black” and the “Y”:

- The “Big Black”
- CP-11
- Safety Zone #4
- Safety Zone #3
- Safety Zone #2
- Safety Zone #1
- The “Y”
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Stand #3: FIRING FROM THE “Y”

This stand extends from the “Y” to the “Fire Whirl”. For the sake of this Staff Ride [4] “Safety Zone” labels have been added to maps and narratives. Naar’s rendezvous occurred at approximately the second safety zone. For a chronological list of events reference the “Firing Timeline” on Page 18.

Summary: It was about 1400 when GNP #3 began preparation and briefings for the dozer line firing operation. Huter and Shepard together with Horton changed the burning plan to progress from the “Y” towards the “Big Black” (opposite their initial plan). While these plans were being made, Naar and the crewmember Giampaoli were en route from Elko after purchasing a pair of boots. Horton made the decision that only a few of his crewmembers would participate in the burnout as he had concerns regarding fitness levels and experience of some of his crewmembers. Horton selected David (Ty) Deaton, Keren Christensen and David Hyde to conduct the burn out with him. They all travelled in the back of Shepard’s pick-up truck towards the “Y” (Heading back from the “Big Black”). Engine 3636 was going to support the burn out: “Engine 3636 followed to support the firing squad. While driving to the Y, Shepard encountered Bob Hawkins, field observer, and Joe Reyes, an unassigned division supervisor, and asked them to help keep an eye on the burn. Upon reaching the Y intersection at about 3:00 p.m. the firing squad immediately unloaded from the vehicle, lined out, and began moving west backfiring from the dozer line with Engine 3636 supporting them. . .”

There was active fire within the confines of the road and dozer line system which was progressing towards the Dozer Line. GNP #3 utilized a 4 strip firing pattern, but changed tactics when they realized that the fuels were receptive enough to carry fire with one torch. The rolling terrain to the south of the burnout restricted view of the main fire activity. While GNP #3 was burning out, Engine 3636 and Hawkins shot flares to the interior to draw more heat.

At around 1515, there were numerous spot fires, which prompted a request from Engine 3636 for firing to cease. There was no response on the radio and firing continued: “At the same time, two burnout operations and the backfire were being conducted on the same tactical frequency. The tactical channel was heavily overloaded, and the command frequency was clogged with logistics traffic. The GNP3 crew was using its crew frequency for communication, and Horton was using the scan feature on his radio to monitor the tactical frequency”.

At 1530, roughly half way through the burning operation, a NDF Engine arrived on the dozer line with Naar and Giampaoli, back from Elko with fresh boots. GNP #3 continued firing, unable to see or hear the increasing activity from the main fire.
Sadler Entrapment Map 1

Figure 1. *August 9, 1999 at around 3:00 p.m. the backfiring operation begins.*

Sadler Entrapment Map 2

Figure 2. *Location of the firing squad on August 9, 1999 at around 3:30 p.m.*
While conducting this burning operation, it was noted in the Investigation that there was heavy radio traffic on Command and the Tactical Frequency. Horton’s crew was utilizing their own crew net to communicate between each other and those participating in the burning operation couldn’t or didn’t hear any critical radio traffic regarding an increase in fire activity.

As a lookout, field observer or unassigned division supervisor asked to keep “an eye on the burn” what information do you need to convey to Horton? What should Shepard have clarified to his division resources regarding the request for Joe Reyes and Bob Hawkins to be his informal lookouts? What should Shepard have made clear to Joe Reyes and Bob Hawkins?

If you were an assigned lookout in this situation, how would you have mitigated the need to communicate critical information to the resources conducting the burnout? Keep in mind that the radio traffic is heavily clogged.

As the Crew Boss and primary contact for the burning operation what is your task, purpose and end state for this particular project. Assuming you have an adequate anchor point to burn off of, how will you convey your leader’s intent to those who will be burning for you?

As a Crew Boss, identify “trigger points” for stopping your operation.

Referencing the Incident Response Pocket Guide, re-evaluate the:

- Risk Assessment Process
- The 10 and 18
- LCES
- Operational Leadership
- Communication Responsibilities
- Leader’s Intent
- Human Factor Barriers to Situation Awareness

What’s missing? What’s present?

Considering the full spectrum of information and guidance an HRO template provides what is destroying the safety culture, pillars or foundation of an HRO?

Is everybody on this division operating under a “reporting culture?” What barriers are preventing this from occurring?
Stand #4: FIRING UNTIL ENTRAPMENT

Summary: The GNP #3 crew is at the apex of the time wedge with each member of the firing operation immersed in their respective duty. Communication is failing and fire behavior is extreme: “At about 3:40 p.m. Huter, dozer bosses Jim Allen and Gerry Beddow were watching the backfire operation from about three tenths of a mile to the west of the squad. As the main fire became visible near the firing squad, these three people saw a fast moving ‘river of fire’ take off down from the hills toward the dozer line and squad.” Despite the efforts of Dan Huter (Branch Director) to contact the crew, he still had no response. The fire sent a fire whirl across the fire line which cut Engine 3636 off from the crew; the engine retreated to a safety zone. Several spot fire were formed, the crew discussed trying to put the spot fires out, Horton urged them to “. . .go, go, go!” The squad continued firing, cut off from Engine 3636 and the previous safety zones identified on the dozer line, at 1540, the order was given by Horton to “Go, go, go run!”

Figure 3. Location of the firing squad on August 9, 1999 at around 3:40 p.m. when they were overrun by the main fire.
Stand #4: ENTRAPMENT/ CHECKPOINTS 1-11

Checkpoints 1-11 highlight the area from where the firing squad was overrun to the consequent burn over. The fire whirl is marked as CP 1a and isn’t identified as a Checkpoint in the investigation. The “Big Black” is located at the fence line to the west. Please reference figure 4 and the correlating checkpoint legend and distances. Pictures #1 through Picture #4 show the fire advancing towards the dozer line and were taken from around the “Big Black” and/or Checkpoint 11. The Branch Director is pictured with the Chevrolet.

![Figure 4. Location of firing squad during the entrapment. Also see the legend and distances table.](image)

**Legend:**
- CP1: Firing squad location when fire whirl crossed line to the east of them.
- CP2: Firing squad stopped lighting, began running, dropping tools.
- CP3: Dozer push-out.
- CP4: Gear dropped and scattered.
  - CP4a: 8 unburned fusees
  - CP4b: 1 burned fusee
  - CP4c: 1 burned headlamp
- CP5: Burned remains of Christensen’s line pack.
- CP6: Christensen unfolds shelter, shields herself with it, calls for help.
- CP7: Melted vinyl shelter cover.
- CP8: Deaton’s approximate location when Christensen saw him when smoke shifted.
- CP9: Naar, Horton, Deaton fall to ground.
- CP10: 1 canteen
- CP11: 5 unburned fusees
- CP12: Vinyl package and pull tab for shelter
- CP13: Safety zone

**Distances:**
- Fire whirl to CP 1: 340 ft. (approximate)
- CP1 to CP2: 90 ft.
- CP2 to CP3: 242 ft.
- CP3 to CP4: 70 ft.
- CP4 to CP5: 38 ft.
- CP5 to CP6: 14 ft.
- CP6 to CP7: 35 ft.
- CP6 to CP8: 90 ft. (approximate)
- CP3 to CP9: 85 ft.
- CP9 to CP11: 216 ft.
- CP11 to Branch Director’s truck: 500 ft.
- CP2 to CP9: 365 ft.
- CP2 to CP11: 581 ft.
*Pictures complements of Gerry Beddow.

Notes:
Within this Division or in cooperation with other Divisions, what are some other tactical changes that could have taken place to address this part of the fire?

Would changing the lighting technique or pattern have made any difference in the success or failure of this burning operation? How?

What of the 10 Standard Firefighting Order and 18 Watch-Out Situations should be mitigated by the time Horton yells, “Go, go, go, run!”

It is good practice to find alternative options to plans in the Risk Management Process. Taking into account your knowledge of the Division, how could the general strategy have been adjusted in the IAP to safely address the values at risk?

By adjusting strategy, how could Division resources have been organized to address the values at risk without compromising firefighter and public safety?

Included in the Principles of High Reliability Organizations is (1) preoccupation with failure (2) reluctance to oversimplify and (3) sensitivity to operations.

What failures could have been corrected during the firing operation?

Was there an attempt to simplify this operation? What were the errors in oversimplifying?

What “strong response” could have been made to the increased fire behavior, lack of communication, negligence of LCES?
1100: Dolphin and Metcalf Return from Reconnaissance.

1300: Huter and Shepard decide on firing from the "Big Black" to the "Y".

1400: GNP#3 Safety Briefing at the "Big Black".

1430: Horton, Deaton, Christensen and Hyde change their starting point to the "Y".

1500: Backfiring begins from the "Y" heading west.

1515: Spot fires across line, E3636 request that firing stop.

1530: Naar and Giampaoli are dropped off with firing squad by NDF Engine near Safety Zone #2.

1540: Huter and 2 Dozer Bosses watching backfiring operation "river of fire".

1540: Events and conditions have aligned for the entrapment.
It was evident that an entrapment had occurred, and it has also been noted that if it weren’t for a sudden wind shift the chances of survival would have been greatly diminished. Following the entrapment, the involved parties gathered at the “Big Black”: “The six crew members, feeling the safety zone was too small, ran down the dozer line to Huter’s location. Huter inquired about injuries and finding that Naar was an EMT, he instructed Naar to take charge of EMT duties and to administer oxygen from his trauma kit. Some of the crew members were coughing severely.

Huter gave his vehicle to Horton to drive himself and the five crew members to the west end of the dozer line, where they joined the 15 other crew members of the GNP3 crew. About 4:00 p.m., Huter called for a helicopter medical transport of the crew . . . Christensen and Giampaoli were flown by helicopter directly from the line to the ICP for initial treatment. From there they were taken by ambulance to the hospital in Elko where they were treated for second-degree burns and smoke inhalation. The other 19 crew members were flown by helicopter to Indian Well and then to Jiggs camp. From Jiggs, they were taken by bus to the Elko hospital where Horton, Naar, Hyde, and Deaton were examined and treated for smoke inhalation.

Christensen, Giampaoli, and Naar were kept overnight in the hospital for observation while the rest were released and billeted in a motel. Storey notified the Elko BLM Agency Administrator of the hospitalizations about 8:00 p.m.

Christensen, Giampaoli, and Naar were released from the hospital on August 10, 1999, and were expected to recover fully. They rejoined the rest of the crew at the motel in Elko to await a critical incident stress debriefing session.”

The IHC’s on this Division had no idea that the burnout of the Dozer Line was being conducted simultaneous with other division operations, and noted that the shelter deployment wasn’t even mentioned in the following days briefing at the Jigg’s Spike Camp4.

Stand #5- The Safety Zone -Tactical Decision Games (TDGS)

You are the Task Force Leader for a Division conducting a burnout operation. You are notified that burn injuries have been incurred by members of a squad from a Type 2 crew, including the crew boss.

What needs to be done to begin patient treatment and what protocol do you need to follow?

As an incoming Task Force Leader arriving on this division of the Sadler Fire, what questions would you be asking of the division supervisor? Of the resources assigned to you? How would effectively integrate yourself into the existing organization and what issues would you address?

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4 Phone interview with Rich Dolphin, Superintendent Smokey Bear IHC on 3.17.11
Shortly following the burnover (20 minutes later) and subsequent burn injuries, a branch director (Huter) and dozer boss (Allen) completed the burnout which had ended a very short distance from the “Big Black”.

As a task force leader assigned to this division and responsible for initial evaluation and treatment of the burned individuals, do you feel that completing the burnout is mission critical?

Would it be appropriate to interface with the Branch Director at this time and how would you go about it?

**Stand #5-The Safety Zone-High Reliability Organizing (HRO)/ Strategic Decision Points (SDPS)**

HRO’s depend on a “reporting culture”; they depend on timely, transparent and accurate information to be conveyed. Sometimes we might wonder if we need to relay certain information and often times we decide that what we’ve observed or noted isn’t worthy of being passed along. In the case of the burn injuries which were incurred during the entrapment, Ed Storey notified Elko BLM Agency Administrator of the hospitalizations at 2000.

When talking about the “Pillars” which support the “Safety Culture”, was the delay in notification due to communication failures? Was the notification made in a timely fashion?

Considering that “just cultures . . . should be accountable for implementing a reliable operating system and managing the workforce,” what needed to occur long before the incident in order to ensure that a “reliable operating system” was in place?
The events which followed the release of GNP #3 have not been chronicled in the same manner as the investigation of the entrapment. Integrating the lessons learned from the Sadler Fire is not a onetime endeavor, but a piece of the continuous learning cycle. With the luxury of hindsight an opportunity exists to look at the events and errors which occurred on August 9th, 1999 outside of Jiggs, NV and make the judgment that “we would not make the same mistakes”. The Sadler Fire was one of many fast moving fires which outran not only the people trying to fight it, but the people trying to organize and manage it. Tools like the IRPG weren’t yet available, Critical Incident Stress Management (CISM) was a fairly new practice, Burn Injury Protocols weren’t necessarily available and organizations (ICS, IMT, Working Groups, etc.) continued (and continue) to evolve. In order to live and work safely we have to accept that we live in an unsafe world, and that we must learn from mistakes.

As students of fire we are obligated to learn from our mistakes and we are obligated to reinforce the practices that result in safe operations. We exist in a learning and competitive culture which fixates on failure in order to breed a safer culture. The After Action Review is a simple and effective tool that is used to develop our knowledge and understanding of events which have occurred. Combined with debriefings, pre-mortems, and briefings the AAR reinforces our “learning culture”.

**Stand #6-The Safety Zone-Integration**

As the Division Supervisor conduct an After Action Review with the resources on your Division:

- What was planned?
- What actually happened?
- Why did it happen?
- What can we do next time?

Would there be any value in submitting a SAFENET after being a part of this incident? If you had to choose one piece of the puzzle which contributed the most to this entrapment, what would it be and why?

How will we apply the knowledge from today’s staff ride into our continued learning in the fire environment?

What can we do during the pre-season to prepare ourselves, our co-workers and our subordinates for a safe fire season?

What actions can we take to reinforce positive action and correct weaknesses?
Evaluation (Please submit to Facilitator's at the completion of today’s Staff Ride):

*Constructive feedback is an integral part of the integration process and improving future facilitation.*

Were the Participant Guides sufficient? Do you have any suggestions on additions, omissions or areas in the guide which can be improved?

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Was the Facilitation of today's Staff Ride appropriate? Did the facilitator's adequately foster a “lessons learned” environment?

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Was the level of pre-course work too difficult? Too easy?

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Did the logistics and overall outline of today’s Staff Ride run smoothly? If not, please provide suggestions.

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Additional Comments: