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File Code: 1450, 5130 **Date:** October 16, 2001
Route To: District Ranger, Fire Staff, Partnership Council, Files

Subject: M.V.R.D. Fire Staff Comments on the Thirtymile Fire Investigation Report

To: Okanogan-Wenatchee N.F. Administrative Officer

The purpose of this memo is to provide feedback on the Thirtymile Fire Investigation Report. The perspectives contained herein are primarily from Methow Valley Ranger District, Fire Staff who had direct involvement in actions taken during the first 24 hours. Our intent is to be objective, and to provide some clarity to the portions of the report that were ambiguous or inaccurate. The comments range from substantive and pertinent to key points in the report, to clerical or typographical in nature. Toward the end of the memo there are observations and recommendations from the fire group as a whole that are intended to provide additional insights. The format is by page, reference and content as contained in the report.

Page	Reference	Content
Title Page		Winthrop, Washington
Page 3	7	Schmekel arrived, assessed and requested additional support including an IC (he is ICT5 qualified, and an ICT4(T)), and an investigator. He was communicating with the District FDO on fire location, behavior, and potential.
Page 3	8	It was Schmekel not Laughman who communicated the assessment.
Page 6		Forest Management Structure…. Table. The District FDO was Jack Ellinger.
Page 8 Page 31 Page 34 Page 36 Page 81 MER-2	Table #9 5th bullet #13, 2nd bullet #3, 1st bullet last paragraph	To our knowledge there was no assigned IC Trainee. It may be that Kampen operated as an IC Trainee in the mind of some, but he was not assigned as such, nor was he viewed that way by the receiving unit. " " " " " " " " " " " "

Page 13 Page 38	74 #25	E-701 and E-704 checked in with Daniels (not Kampen) upon arrival at the origin. “ “ “
Page 13	75	E-704 held at the origin and E-701 proceeded up the road, turned around near what would be the eventual deployment zone, and headed back down the road looking for and working spots.
Pages 14, 15	83	After foaming the upper spot, E-701 spoke with Daniels for a few minutes then headed back down the road to look for other spots while the crew contained the spot at the upper spot location. E-701 disconnected a length of hose there, with the intent of returning and mopping the spot after the crew had it lined.
Page 15	84	E-704 didn't call for help. They worked spots south of E-701. E-704 proceeded north in response to an E-701 request for a volume pump. E-704 drove to E-701 location then drove back down road to set up the volume pump where the river met the road, and just below the point the escape route was breached.
Page 15 Exec Summary, ii	Paragraph 3 Paragraph 5	E-701 also radioed Daniels to evacuate. Daniels confirmed. “ “ “
Page 23	2nd bullet	While fire behavior was relatively “benign” as described on page 7, during the mid-morning on 7/10/01, fire behavior was not consistently underestimated throughout the incident. Schmekel's initial size-up (pg.3), fire behavior throughout the night at Thirtymile (ref. Pg.24, #17), observations from the previous day on Libby-South, weather indicators, known drought factors throughout the season, and observed fire behavior beginning in the early afternoon all pointed to potential extreme fire behavior. What appears to have been misread was the ability to continue a holding action into a period when torching, running, and spotting exceeded the capabilities of assigned resources.
Page 23	#7	Is not consistent with statements about reading the weather on page 54, paragraph 2. Based on discussions with Okanogan Dispatch, we believe the reality of that situation was that Okanogan Dispatch did read the morning weather for the entire north end of the Forest, but only read the afternoon weather for the Okanogan Valley. The reason they did not transmit the

		p.m. weather to the Methow Valley side was that by that time the fire traffic on the radio was continuous. Fire traffic always takes precedence. (Also see Recommendation #2.)
Page 24	#18	It was actually late-morning to early afternoon (ref. ppg.8-10, 52).
Page 33	#40	E-701 crewmember provided 1st Aid assistance to one of the civilians.
Page 35	#5	The information was passed on to the District FDO.
Page 35	#7	States that Forest FMO requested road closure, while page 7, paragraph 1 attributed this to District FMO. District FMO is correct.
Page 35	#8 & 10	There was no doubt in any of the leadership's mind or actions that we were still in IA on the morning of 7/10/01. It was still the first operational period, containment had not been achieved, and the fire had not escaped IA strategies and tactics at that point. Page 6, last paragraph attributes this knowledge to Kampen and Daniels. MER-6, Strategy, Tactics, and Transition recognizes we were still in IA.
Page 35	#11	The WFSA was initiated on the evening of 7/10/01. It was not done on 7/9/01, nor during the morning hours of 7/10/01, because until the afternoon of 7/10/01 the fire had not escaped IA, and IA had not been unsuccessful to that point (criteria from Wildland and Prescribed Fire Management Policy, Implementation Procedures Reference Guide,8/98). Statements on page 37, numbers 19-22 support the premise that IA had not been unsuccessful until 7/10/01 in the p.m., as well as other locations in the report.
Page 37	1st bullet	There is a clear and consistent process, it just wasn't clearly understood by some key people on 7/10/01.
Page 37	#23	Was the ATGS relaying a request from the IC, or was he actually making the decision and placing the order?
Page 40	#1	The statement under Standard Order #1 may be true for the afternoon operations. It is not true for the morning operations.
Page 42	Watch Out Situations	The first two statements under Watch Out Situation #5 may be true for the afternoon operations. They are not true for the morning operations.
Page 49		Shawn Rambo, crew member on E-701 was interviewed.
Page 49	Gary Reed	Gary Reed was not MVRD FDO. Jack Ellinger was.

Page 49	Gary Reed and Sally Estes	Gary Reed and Sally Estes (Dispatcher and Dispatch Coordinator, resp.) according to our understanding were not interviewed. We understand that they provided copies of dispatch logs, mobilization guides, and other documents, but that no one in Okanogan dispatch was actually interviewed.
Page 52	Appendix: Time Line	Event and Response Actions columns: typographical errors, 11:00 p.m. should read a.m.; same comment further down the page under Events column for 1:00 a.m. (should be p.m.).
Page 79	#1, Geographical Disorientation	Some knew, this according to comments by Furnish at the employee rollout meeting (Wenatchee, 9/26/01). The fact that it was a dead end road is why the escape route identified in the morning was to the road and head south.
Page 80	Medical and Physiological Factors	DFMO: The notion that he was unaware of Schmekel's original assessment and size up had nothing to do with his lack of sleep. It had everything to do with it not having been communicated to him. It's immaterial either way because the DFMO was on site, witnessed the fire behavior from the night before, worked the operational period the day before, saw what fire behavior was then and expected similar again this day (7/10/01). He provided weather information that indicated more of the same. Soderquist provided this information during his first interview with the investigation team, however that among other elements of his statements are not acknowledged in the report. Daniels, Kampen, Brown, Cannon, Thomas, and Soderquist all reviewed, reconned, debriefed, transitioned on-site together that a.m. and agreed we had to get water on it quick before containment (also acknowledged earlier in the report, see page 6, bottom paragraph), and mop-up. That is probably 100 plus years of fire experience with local knowledge, standing together agreeing on strategies, tactics, production, fire weather and behavior. Plans and decisions on that morning were not being made by a single intoxicated individual on their own. It must also be recognized that we were in the first operational period. While 2:1 work to rest ratio is what we strive for, the Interagency Incident Business Management Handbook (Ch. 12.7-1) recognizes that during the first operational period exceptions may need to be made. The final sentence on the DFMO indicates that he was out of the loop for several key hours as events unravel because he was ordered to get some rest. This statement delivers a rather mixed message. Is the point that he should have gone home and rested after the first 16 duty hours, and recommended that

		all similarly worked assigned resources do the same? This would have occurred around 0100 hours on 7/10/01, and to achieve 2:1 would have put him and other key individuals "out of the loop" until 0900 on 7/10/01. This is the period that the WFSA for Libby-South was being prepared as well as numerous other support functions for ongoing operations. Maybe it is that he should have stayed up, and continued to be available to stay in the loop? Was he supposed to get some sleep or not? The reality of the matter is that when he did head home for some rest, it was after 1500 hours. And when he was awakened to return to duty it was sometime after 1700 hours. He was never really out of contact, as he left instructions for him to be called in the event in a significant change, and this is precisely what happened.
Page 83	DFMO Sleep Chart	It's a little tough to reconcile the numbers in the chart with those listed above it. They don't agree. But near as one can ascertain, the numbers above have Soderquist waking up at 0400 hours on Sunday, 7/08/01. Why would he do that?! It was his day off. He also would have gone to bed earlier than 2400 hours on Sunday night, recognizing that the next day was a work day. On Monday, 7/09/01, it shows him having slept from 0430-0500 hours. That actually occurred on 7/10/01. These transcriptions are significant, because the chart has the DFMO in a diminished cognitive state throughout Monday, 7/09/10, apparently because of the erroneous data used for Sunday. Monday in fact, should have the DFMO in as high a state of cognitive effectiveness as a person who has had a full night sleep can be. The trend after that should be downward, but should be higher than indicated in the chart. It appears as though someone set out to prove a point.
Page 94	Map 3	Map numbers don't show all listed numbers.
Page 96	NWR #6 Qualifications	Daniels was assigned as Crew Boss, a position for which he is well qualified. He is, in addition, qualified at the Division Supervisor and ICT3 levels.
Page 97		Methow Valley District Personnel Qualifications. Schmekel is a qualified ICT5 and is a trainee ICT4. His job on initial dispatch was to respond, size up, assess, request appropriate resources, and communicate with the District FDO.
MER-2	5th paragraph	It's a euphemism to write that '…the water handling system

		was ineffective…", the plan was sound for the morning hours, and the equipment was operational.
MER-3	2nd paragraph	E-701 & 704 did check in with the IC.
MER-6	Fatigue Strategy…	Work to rest cycles were not disregarded. It is true that 2:1 guidelines were not adhered to for everyone, but as stated in previous comments, the Thirtymile Incident was in its first operational period. Standard practices acknowledge that 2:1 shall be followed beyond the first operational period. To clarify, it should be noted that the suppression strategy for the a.m. was not appropriate for the p.m. The morning strategy did consider the noted parameters. The report has a tendency to run the morning and afternoon operations together when talking about LCES, strategies, tactics, and adherence to the 10 and 18. There should be a clear distinction in thinking and writing that is separated by the period of disengagement from the east side of the Chewuch River.
MER-7	Failure in Road Closure…	The report classifies this as still being in Initial Attack. The entrapment of the civilians occurred during the afternoon hours, and would more accurately be considered as extended attack. It should also be noted that while the barricade was not in place to block their ingress, or alert them to the hazard, the road was run to the end, and their presence was not determined. They apparently were off road and hidden on one of the numerous "rabbit trails" that take off the main road to the Thirtymile Campground and trail head.
MER-9	Organizational Relationships	If leadership on the incident was unclear, it would be more accurate to portray that from the perspective of whomever was unclear. As far as Forest and District management were concerned, there was no doubt as to who was in charge throughout IA and the associated transitions. While it is generally recognized that the transition period is one in which safety and adherence to standards are violated, it appears as though the most grave oversights and consequences occurred during a period when there was no transition in incident leadership.
MER-13	Endangered Species Act…	What is clear is that we need to communicate the existing relationship between ESA and fire suppression as practiced on this unit.

Additional comments, questions, and observations:

1. The format, style, and content of this report is substantially different from the South Canyon reports. It focuses on a number of factors that weren't addressed in prior reports. The useage of the terms management and leadership is variable and promotes ambiguity. It is often vague as to whether the report is referring to people on site, on the incident, or back at forest/district headquarters. The style varies from that of a technical report, to that of a more creative work. Is that because of different physical, site, human, or political factors? Various sections being authored by an array of people?

2. Recommend that dispatch always check with field IC's when weather is being read to confirm that it's been received. This is done sometimes.

3. The report acknowledges that the Libby-South Fire was a high priority, and that it played a major role in allocating resources. It also needs to be said that the attention between the fires for resources, support, and the response times by dispatch and district personnel was affected in all facets of fire management.

4. In addition to the previous requests for interview transcripts (Soderquist for the OSHA interview, and Laughman and Schmekel for all interviews) we would like transcripts for all interviews sent to the respective interviewees. In other words, each person who was interviewed should receive a copy of all interviews in which they participated. This should occur post haste in view of recent decisions to provide all interviews to Congress, the families, and the media.

In summary, we feel the report addressed all key features of the Thirtymile Incident that led to the catastrophic events of July 10, 2001. We also recognize that we must learn from the findings of the report and management recommendations. Four unique and dearly loved people who were members of the firefighting community perished in the performance of duty. Many of us who were involved will eternally replay the events of the day, the accounts of what happened, and attempt to find our own answers for the tragedy. No one willingly or knowingly acted negligently. To think otherwise, would be a mistake. It is difficult to provide feedback to the report without feeling defensive. As indicated in the opening remarks, our intent has been and will continue to be, to remain objective yet sensitive to the perspectives of others who had direct involvement in the incident. This includes the investigation team who had the challenge of assembling a report that considered many, and we're sure varied points of view of the same events. Our hope is that our comments will facilitate understanding, and as stated in the Prologue of the report, hope that a tragedy of this nature never happens again. This has been a sobering experience for all of us on the Methow. That includes a large network that runs through the community, our families, and well beyond. None of us will be the same as before. That's good and not so good. All of us hope our review comments support the goal of making future actions safer.

Pete Soderquist
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Methow Valley Ranger District