

**Statement of
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Before the Subcommittee on
Public Lands and Forests
Committee on Energy and Natural Resources
United States Senate
Concerning
The Thirtymile Fire Accident Investigation**

November 14, 2001

Mr. Chairman and Subcommittee Members:

Good afternoon. While I appreciate the opportunity to testify today, I regret that we are here because of the Thirtymile Fire accident. Accompanying me today is Jerry Williams, Director, Fire and Aviation Management, who will be responsible for many of the actions arising out of our investigation report's recommendations.

I deeply regret the deaths that occurred on the Thirtymile Fire; my grief and the grief of the entire Forest Service family are deep and genuine. The Thirtymile Fire was a tragic event. The four brave firefighters, who lost their lives, as well as the survivors, truly are heroes. I have immeasurable respect for them and for all of our firefighters who face danger every day protecting our resources and us.

I am confident in the overall conclusions reached in the report, which details the collective conclusions reached by the investigation team. The members of the investigation team are highly skilled, representing many years of experience. The investigation identified a number of interconnected likely causal factors that we must address. Understanding the likely causal factors and taking all possible action to prevent similar happenings in the future is a critical concern for not only the Forest Service, but also for other Federal, State, and local government fire suppression organizations who must learn from these unfortunate and tragic events.

OVERVIEW

The fire, caused by an abandoned picnic cooking fire, was located 30 miles south of Winthrop, Washington, along the Chewuch River. Firefighters were assigned to initial attack; the Entiat Hotshots relieved the initial attack crew and continued the initial attack effort. On July 10, a second crew arrived that subsequently was entrapped. Fire shelters were deployed, but four people lost their lives: Tom Craven, Karen FitzPatrick, Jessica Johnson, and Devin Weaver.

Before I discuss the findings of the report, let me tell you how we respond to incidents when there is a serious accident, such as entrapment and deployment. Within hours, we designate a team of technical experts to meet on-site to make an initial assessment of the

facts. Within 24 hours of any fatalities, an initial report is filed. The work continues and a more detailed report is written, 72 hours after the investigation team meets. We do this because it is critical for us to find out major issues and causal factors so that we can quickly notify other firefighters about any preliminary factual findings, which could affect their procedures or operations.

For the Thirtymile Fire, we chartered an investigation team that held its first meeting on July 11, the day after the tragedy. On July 14, the team issued its report that stated the basic facts about the fire. Although there were no immediate remedial measures called for, many of our fire organizations did stop to review procedures and reinforce basic safety messages. A conference call was held with our Regional Foresters and Station Directors to discuss the fire. The investigation report was completed on September 26. Because there were continuing questions concerning why some of the victims and survivors remained on the rock scree above the road, I asked the Review Board to reexamine the factual report and witness statements relating to this question.

SUMMARY OF THE REPORT FINDINGS

The people on this fire were dedicated people. They intended to do the right things, but they were deceived by the fire and the situation changed on them quickly. The lessons to be learned as a result of the fatalities on the Thirtymile Fire are mostly about what was not done that should have been done. The report concludes that there were many opportunities to prevent these fatalities. Accepted firefighting safety procedures were not followed and, as a result, four firefighters lost their lives. The fatalities and several injuries all occurred during, or shortly after, deployment of fire shelters, but the mistakes that led to this tragedy were made earlier before the entrapment and eventual deployment.

The report states that the entrapment of the firefighters occurred because of a failure to recognize a rapidly deteriorating fire situation, the placement of firefighters in a vulnerable position, the lack of communication about critical information, leadership's ineffective control and command of operations, and, most critically, the failure to adhere to safety procedures and Standard Firefighting Orders—and all firefighters are taught the “Ten Standard Orders” and “Eighteen Situations that Shout Watch Out.” The entrapment of two civilians occurred because of a delayed closure of a potentially hazardous area and failure to successfully evacuate the valley upriver from the fire.

Strategies and decisions made on the fire from initial attack to deployment did not appropriately reflect the extreme fire conditions that existed, nor did those decisions appropriately consider the diversity and complexity of fuel types in the valley bottom. Similarly, features of the valley bottom and the lack of adequate safety zones influenced the final outcome.

Transition fires are our most difficult fires. The Thirtymile Fire was in transition at the time of entrapment and fatalities. Transition refers to a stage of a fire when it exceeds the capability of the initial attack forces to suppress the fire. Transition is usually characterized by rapid growth, spotting across control features and increased intensity. If

firefighters are fatigued and the fire makes a transition to a larger fire, the changed fire conditions may not be recognized and good, quick decisions may not be made. On the Thirtymile Fire, our firefighters exceeded our work/rest guidelines.

There was some confusion about why or how the firefighters ended up deploying shelters in different locations. As I stated, on October 3, I asked the Accident Review Board to conduct a review of the investigation to see what details could be discerned about why some of the victims remained on the rocks. The Board identified two possible scenarios, either of which may describe why the some firefighters appeared to have chosen not to go the road. One possibility is that those firefighters did not hear the incident commander's directive to come to the road. Another possibility is that the five firefighters had heard the directive to come to the road, but their interpretation of the directive was to be "close" to the road and they believed they were close to the road. Probably we will never know, with certainty, precisely what was said, to whom, and at what time. What we do know is that communications were not clear to all the crewmembers.

FUTURE ACTIONS

On October 19, I released an action plan to address the changes recommended by the report. We are taking actions on situational awareness, assessment, and transition, fatigue, incident operations, fire management leadership, personal protective equipment, and safety management and accountability. I have directed Regional Forester Harv Forsgren to initiate an administrative investigation to consider performance and accountability issues related to the actions taken to suppress the Thirtymile Fire. I would be happy to keep the Committee apprised of our progress on these actions, especially those related to accountability.

As I said earlier, I deeply regret the deaths that occurred on the 30-Mile Fire; my grief and the grief of the entire Forest Service family are deep and genuine. I reaffirm to you our commitment to do our level best to improve firefighter safety and processes to reduce risks—we owe it to Tom Craven, Karen FitzPatrick, Jessica Johnson, Devin Weaver, their families and the survivors—and we owe it to the firefighters of the future. I will now answer any questions you may have.