



Coffee Can Saddle Tree Strike Learning Review Narrative

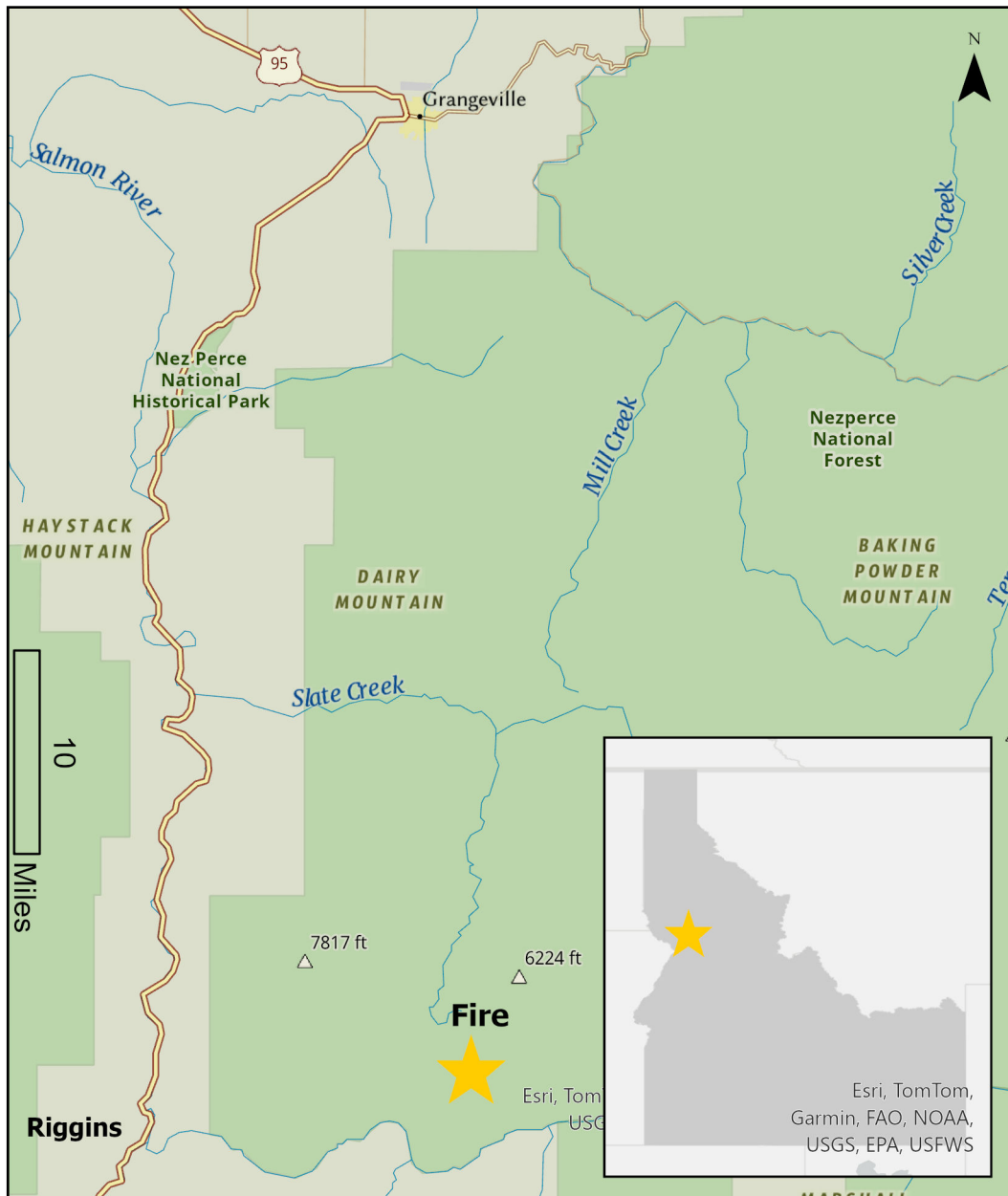
August 2024

A note from the Learning Review team

The intent of this narrative is to provide a series of events, as recalled by participants, along with initial reflections/lessons learned from those who were involved. We understand that the timeliness of this information is critical for learning but, importantly, this narrative does not represent all of what can be learned from this event. Reflections and sensemaking contained within this narrative are initial and field focused. The Learning Review team will continue to pursue learning from this event, expanding the scope of inquiry utilizing Learning Review processes such as convening focus groups and engaging academic and industry subject matter experts (SME). These processes, though time consuming, are vital for deeper learning.

Summary

On August 10, 2024, during initial attack on the Coffee Can Saddle fire, eight firefighters were in the process of engaging the fire when one of the firefighters (the Incident Commander) was struck by a tree. Initial medical care was provided on scene and firefighters transported the injured firefighter via Type 6 engine to a ground ambulance. There they worked with advanced medical personnel to stabilize the patient for transport via air ambulance to St. Joseph's Regional Medical Center in Lewiston, Idaho. The patient was moved the following day to Sacred Heart Medical Center in Spokane, Washington for continued treatment. The patient sustained multiple injuries, including skull fractures, fractured ribs, and a collapsed lung.



Map of the general area surrounding the Coffee Can Saddle fire. The fire was located about 4,000 vertical feet above, and 3 miles north of the Main Salmon River.

Narrative

Responding to the Coffee Can Saddle fire

On the afternoon of August 10, 2024, a thunderstorm brought lightning and some wetting rain through the central mountains of Idaho. Just after 1700, Oregon Butte Lookout called in a new smoke report to dispatch. The location of this new smoke was difficult to pinpoint but was thought to be in or near the Gospel Hump Wilderness. Since there were already two active fires in the wilderness, the district Duty Officer (DO) decided to suppress this fire and ordered a load of jumpers out of Grangeville to respond. At 1734, as the jump plane searched without success for the smoke called in by Oregon Butte Lookout, Chair Point Lookout reported a smoke in the area of Little Slate Creek Saddle. Believing the first smoke report was likely a communication or plotting error, the DO requested that the jumpers check out the new smoke near Little Slate Creek Saddle. It didn't take long for the jump plane to find the new smoke, plotting it just northwest of Coffee Can Saddle. Just before 1800, the DO, believing this was at least one of the fires reported by the lookouts, confirmed he wanted smokejumpers on the newly named Coffee Can Saddle fire, and jump operations began. Down below on the Salmon River, E-611 rolled out of their guard station at Slate Creek to begin a patrol at 1830.

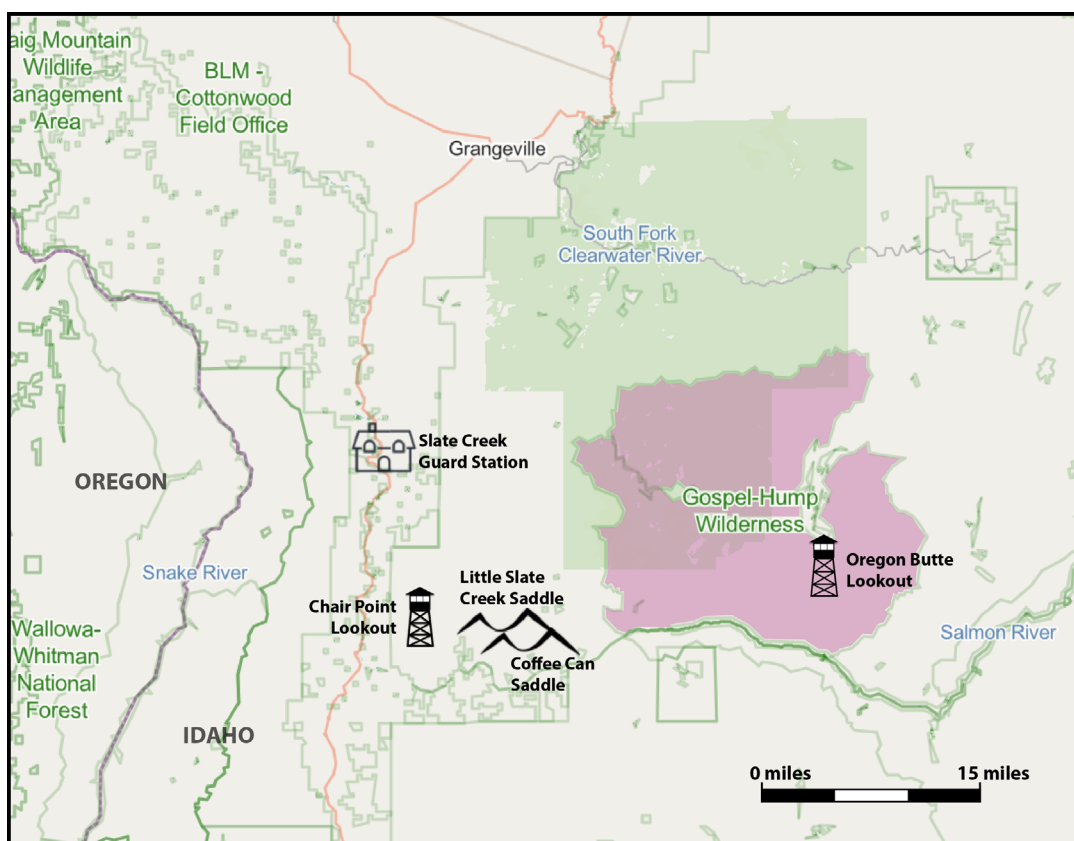


Figure 1.—Map showing the Gospel Hump Wilderness boundary; Grangeville, ID; Slate Creek Guard Station; Oregon Butte and Chair Point Lookouts; and Little Slate Creek Saddle and Coffee Can Saddle.

By 1834, four smokejumpers and cargo were safely on the ground. Smokejumper paracargo was delivered onto a ridge above the jump spot, and after a short but steep hike—0.4 miles and 500+ vertical feet—the jumpers gathered their supplies and began hiking to the fire, which was another 0.8 miles up the ridge. Three jumpers (SMJ-1, SMJ-2, and SMJ-3) left the cargo spot. The remaining jumper, SMJ-4, was behind them assembling the chainsaw and packing supplies. Around 1843, the DO, still unsure of the total number of actual fires, requested E-611 to respond to the area of the Coffee Can Saddle fire. For the next couple of hours, both the jumpers and E-611 made their way towards the same fire—the jumpers following a lat/long provided by the jump ship, and the engine following a legal description provided by the lookout. Shortly after 2000, the group of three jumpers (SMJ-1, SMJ-2, and SMJ-3) tied in with two E-611 module members (ENG-2 and ENG-4) walking on the 9916 road below the fire. The engine module members explained that their engine with one additional person, ENG-3, was farther along the same road. The three jumpers and two engine module members made their way to the engine where they tied in with ENG-3 and learned that their module leader, ENG-1, was above the road still scouting for the fire.

The jumpers continued along the 9916 road following the lat/long from the jump ship. At 2023, as the jumpers left the road and headed up the hill, they heard ENG-1 calling in the initial size-up, providing a lat/long and estimated size (0.25 acres) to dispatch. The jumpers plugged in this new lat/long and it became clear that both the jumpers and the engine module were looking for the same fire. ENG-1, having located the fire first, assumed the incident commander (IC) role and provided a training opportunity for ENG-2, a Type 5 incident commander (ICT5) trainee. ENG-1 returned to the engine to gather the rest of his module and lead them back to the fire.

Engaging the fire

At approximately 2050, jumpers SMJ-1, SMJ-2, and SMJ-3 arrived at the skid road just below the fire. They took a few minutes to grab a bite of food, drink some water, and put on headlamps, before starting to construct line. It was dark, and though the crescent moon was visible it did not provide enough light to work without headlamps. The fire had crept through rocks and over the edge of the cutbank, so the three jumpers anchored off the road, bringing line up through the rocks to the top of the cutbank. The bulk of the fire was on a relatively flat knob, with less than a 20-percent slope, which was a welcome exception

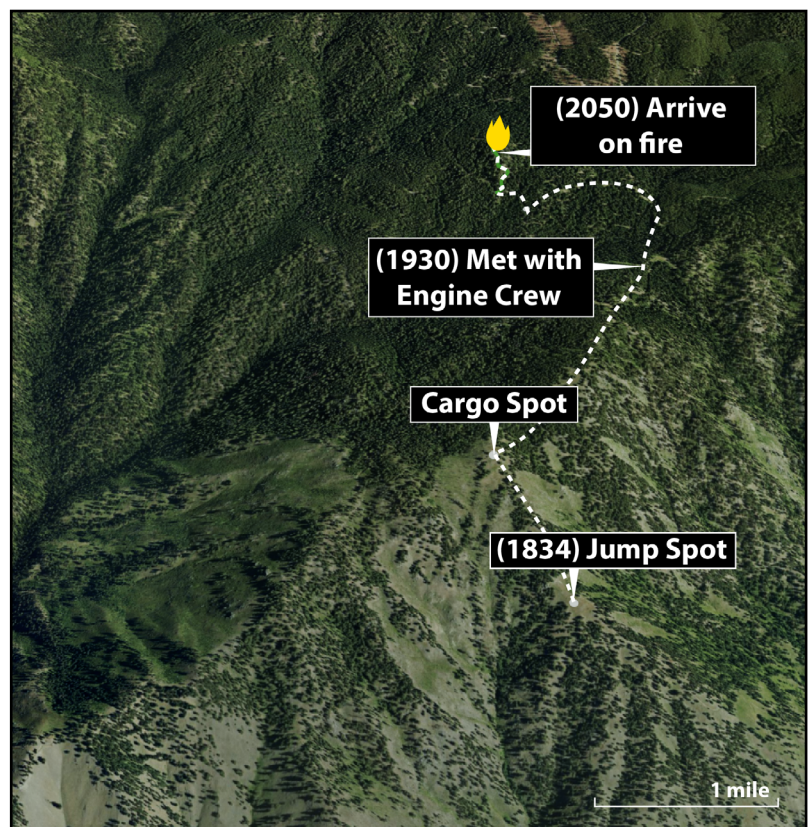


Figure 2.—Approximate route the smokejumpers followed to the Coffee Can Saddle fire.

from typical Salmon River Breaks terrain. Initially, SMJ-3 started on the left flank, as SMJ-1 and SMJ-2 started working on the right. SMJ-3 radioed the fourth jumper, SMJ-4, to check on his status. SMJ-4 thought he would be to the fire shortly. SMJ-2 began constructing line with a Pulaski and a Silky saw while SMJ-1, bumping by SMJ-2, worked his way around to the head of the fire where he saw some increased fire behavior as it got into a jackpot of fuel.

Near the head of the fire, SMJ-1 noticed two snags close to the edge, a few feet into the black, and leaning interior and back towards the right flank. At least one of the snags appeared to have substantial fire damage and he thought it could fall soon. SMJ-1 radioed the other jumpers on the smokejumper crew frequency to let them know about the snags, and that they had potential to fall before long. SMJ-2 later recalled that, "Upon hearing that traffic, I stopped digging line and moved up the right flank, taking note of both snags while making my way towards the head." SMJ-2 tied in with SMJ-1 and, once again, began to build line near the head of the fire, away from where the snags were leaning.

At this point, the three jumpers on scene were on the left flank. The fourth jumper, SMJ-4, carrying a chainsaw, arrived on scene via a different route, one that did not bring him past the engine parked on the road below. SMJ-4 joined the other three jumpers on the left flank and began cutting brush and smaller fuels to assist with line construction.

E-611 Arrives on the fire

At about this time—approximately 2100—the four members of E-611 arrived at the skid road just below the fire. They had moved their engine to the intersection of the skid road and the 9916 road, and donned

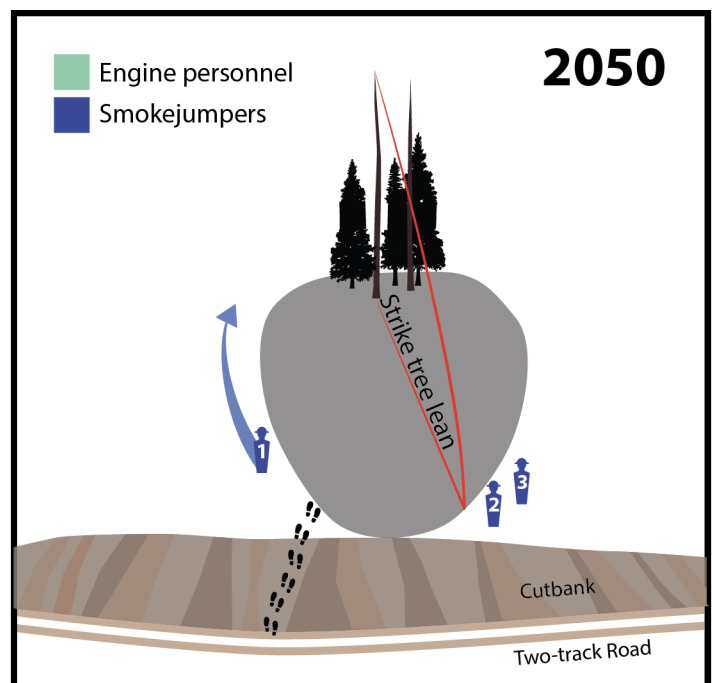


Figure 3.—At approximately 2050, three smokejumpers arrived at the fire. SMJ-4 was still making their way to the fire. At this time, ENG-1 had found the fire, given dispatch a size up, and was returning to the engine to gather the rest of the crew.

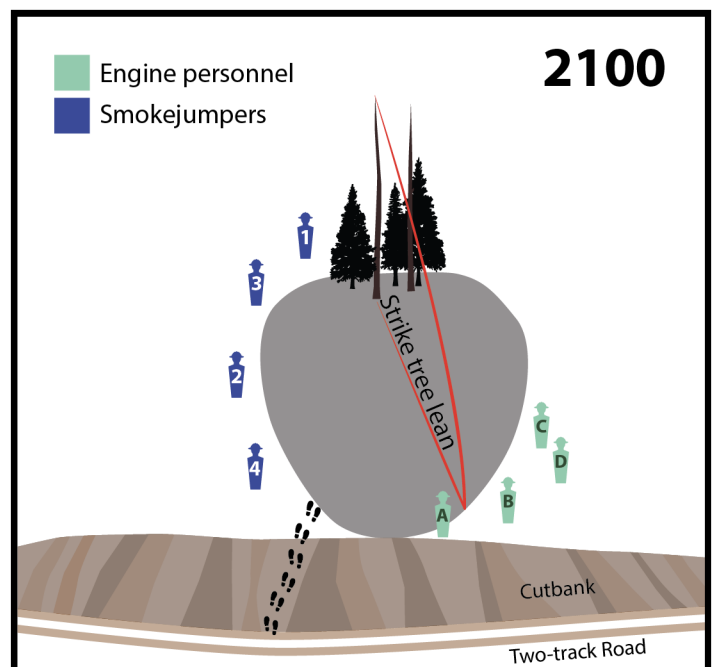


Figure 4.—At approximately 2100, all smokejumpers were on scene, with one smokejumper at the head of the fire who noticed two snags burning. The engine crew also arrived and were establishing a game plan to suppress the fire with the smokejumpers. The engine crew was to anchor to the right, with jumpers to the left.

headlamps before beginning their hike up. As the module crested the cutbank they saw the jumpers working on the left flank of the fire. ENG-3 and ENG-4 paused at the heel to prepare to work as a saw team while ENG-1 and ENG-2 made their way across the black and tied in with SMJ-1 (SMJ-1 does not recall ENG-2 being there during this exchange).

SMJ-1 remembered having a brief and casual exchange with ENG-1 (though ENG-2 recalls being a part of this conversation too). SMJ-1 recognized ENG-1's role as IC, mentioned the snag hazards, and identified their lean as interior, towards the heel and right flank. SMJ-1 remembered expressing his opinion that the snags "would need to be addressed sooner rather than later." He was unsure if he pointed to the snags specifically, but noted that they were only about 5 feet away and that they were burning at the base. SMJ-1 believed they had a shared—although perhaps not explicitly stated—plan to get in, secure the fire, and get out. E-611 would take the open line on the right flank, jumpers were already working the left flank, and they had an understanding that mop up would begin in the morning.

After the conversation ended, ENG-1 walked back across the black towards his saw team, while ENG-2 continued around the fire

What influences how we phrase hazard communications in the wildland fire environment?

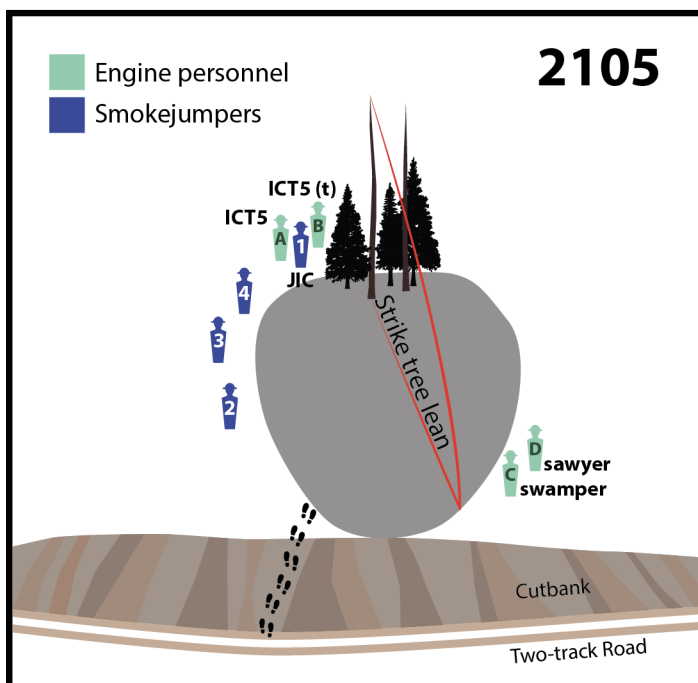


Figure 5.—At approximately 2105, the engine crew had a sawyer and swamper cutting on the right flank. ENG-1 walked around to the head of the fire with ENG-2 to tie in with the JIC (jumper in charge). Hazard tree information was communicated between one another, and a plan was made to suppress the fire.

perimeter to see the rest of it before calling in the size up report to dispatch. On his way past the clump of trees—he thought there could be anywhere from 2–5 trees in the clump, some alive and some dead—ENG-2 noted a larger dead snag that was burning at the base. With the aid of his headlamp, ENG-2 got an idea of its height. His overall impression was, "there were snags on this fire, just like every fire we are on," and the snag burning at the base, "still had some meat to it." After finishing his lap around the fire, ENG-2 tied in with ENG-1 on the right flank, near the heel, to go over the size up information that would be provided to dispatch. ENG-2 briefly talked with the saw team to confirm that they were responsible for putting line in towards the head on the right flank.

After meeting with ENG-2 about the size-up, ENG-1 turned to ENG-3 and ENG-4 to brief them on the plan to cut line. ENG-3 did not recall ENG-1 or ENG-2 mentioning snags

in their briefing. ENG-2 then stepped out into the green, a short distance off the right flank, where it was a bit quieter, and called dispatch. This transmission was officially received at 2117.

SMJ-4 tied in with SMJ-2 near the head, where the fire was burning more actively, and began brushing back towards the heel on the left flank, eventually tying in with SMJ-3. ENG-3 and ENG-4—the E-611 saw team—began cutting, limbing, and brushing fuels along the right flank. SMJ-1, still at the head of the fire, saw the headlamps of the four members of E-611 on the right flank, and was not alarmed by their position. He did not definitively know how tall the snags were in the darkness, but from his read on their condition—buck-skinned, subalpine fir—and interior lean, he didn't feel they were tall enough to reach the other side of the fire.

The Tree Strike

After providing the full size-up report, ENG-2 began walking back to join the others from his module. ENG-1 asked his saw team to bump back to his location to buck up a log. As SMJ-2 was improving the line

When you hear, "snags leaning interior," what does it mean to you? Does it mean the same thing on a 1,000-acre fire as it does on one that is one-tenth of an acre?

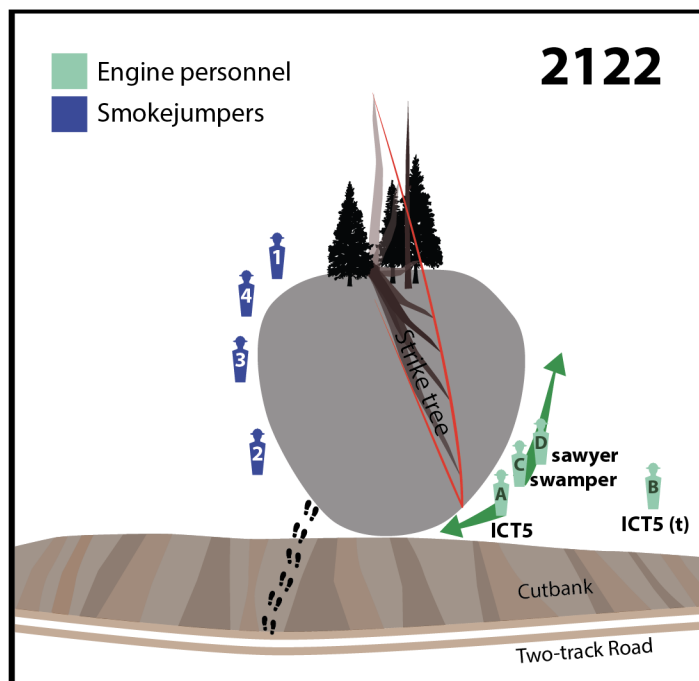


Figure 6.—ENG-1 made their way through the black to tie in with the engine crew's saw team. ENG-2 walked around the head, towards the right flank, then went away from the fire to call dispatch. A jumper heard the tree starting to crack and yelled out. The sawyer and swamper moved to the right, while ENG-1 moved to the left and was hit by the tree.

near the head, he heard the burned-out snag "starting to crack and groan." He saw the tree falling towards four headlamps on the right flank, and began yelling as loud as he could, "TREE COMING DOWN! LOOKOUT!"

ENG-2, walking back from talking with dispatch, was 10–15 feet from ENG-3, ENG-4, and ENG-1, when he heard yelling and saw the tree coming down. He immediately called out for everyone to "WATCH OUT!" ENG-3 looked up and saw the tree falling at them. He recalled, "ENG-4 and I went right, and ENG-1 went left."

SMJ-3, on the left flank, was swamping a log that SMJ-4 had cut when he heard the yelling. He recalled that the yelling was "like you always hear when a tree is coming down, but then the yelling kept going."

ENG-2 saw ENG-3 and ENG-4 moving quickly to their right, up the right flank towards the head, and ENG-1 moving to his left, towards the heel. ENG-1 took a few steps and turned

slightly to look up at the falling snag as it struck him, at 2122, just five minutes after the full size up was given to dispatch.

“When the tree struck him, it hit his head and shoulder, causing him to get folded over, and then shoved him headfirst into another tree.” —ENG-2

The strike tree was a standing, dead (snag) subalpine fir that was approximately 70–80 feet tall, and approximately 15 inches diameter at breast height (DBH). ENG-1 (IC) was struck by the top 1/3 of the tree, where the diameter was approximately 6–7 inches.

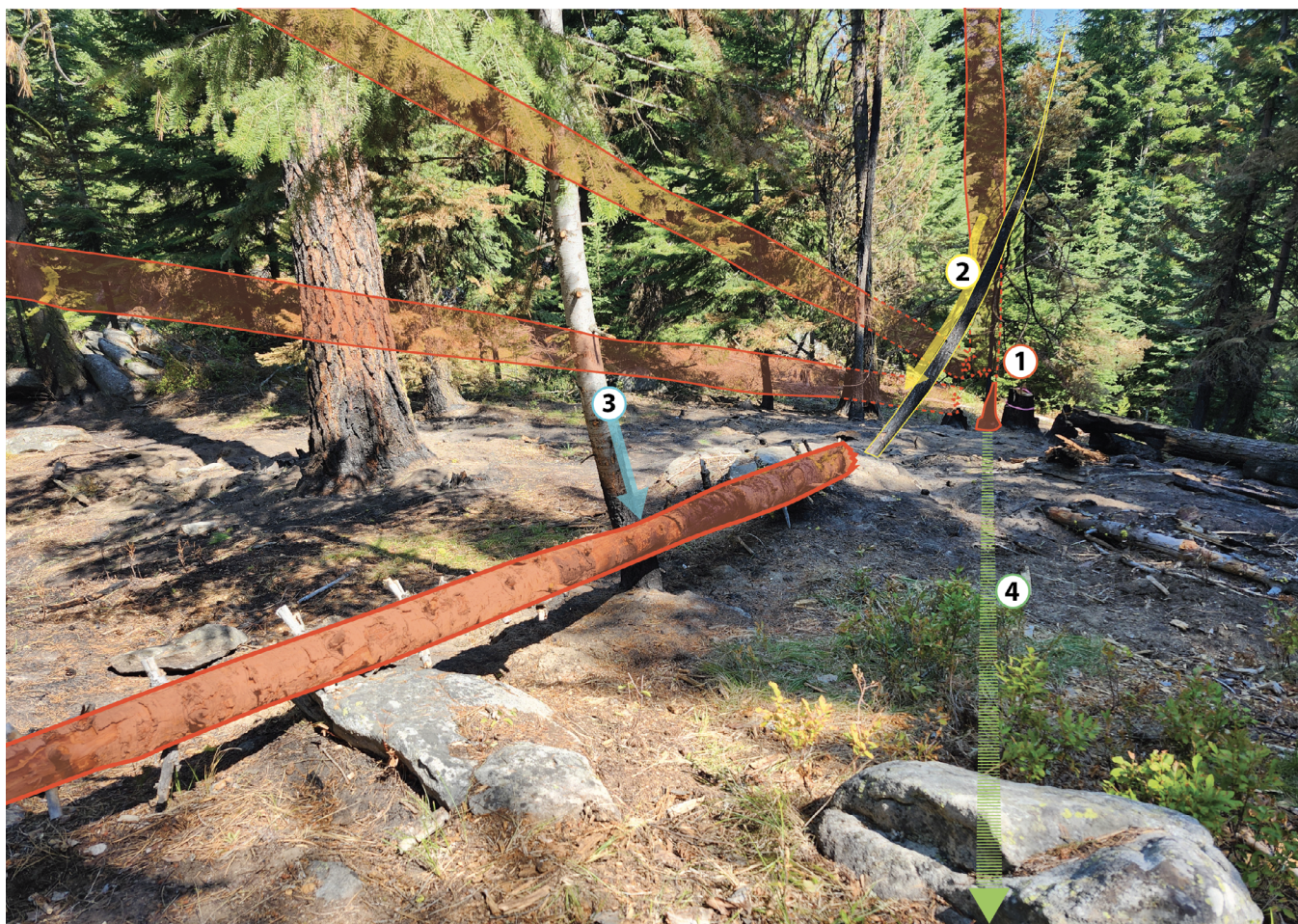


Photo 1.— (1) The strike tree stump and original position. (1a) indicates the lean of the tree. The tree fell and struck a small live tree (2), causing it to pivot to the right. The strike tree came to rest against another live tree (3). (4) indicates approximately where the tree impacted the ICT5. The tree was originally suspended about 5 ft above the ground.

Medical Response

After impact, the upper 1/3 of the strike tree remained suspended in the air, about five feet above the patient. ENG-4 and ENG-2, seeing the patient lying in hot ash, quickly moved him a few feet to a better location. Some personnel on scene didn't immediately realize someone had been struck by the falling snag, but word spread quickly. Within a minute or so, everyone had gathered near the patient and jumped into patient care and Incident Within an Incident (IWI) management.

SMJ-2 arrived on scene and his immediate observations of the patient were that “he was unconscious, blood was coming out of his head, ears, nose, and mouth. There was massive bruising to his face, head lacerations, eyes were both closed due to swelling, and there was sporadic limb movement, moaning, and short and labored breathing.” ENG-4 jumped in to start holding cervical spine (C-spine) stabilization while ENG-2 started an 8-line (Medical Incident Report). ENG-2 contacted dispatch at 2122 stating, “We have a red medical and need [an air ambulance].” SMJ-1 then took over as the IWI IC, and ENG-3 brought over his personal medical kit. ENG-3 and SMJ-2, who were medically trained, started working together leading patient care. One treated the head wounds with gauze and bandages, while the other began a full body trauma assessment, noting significant bruising to the posterior upper spine. While the patient’s shirt was being cut off, the engine module member holding C-spine noticed crepitus¹. With the ambient temperature dropping, and with much of his clothing cut off, ENG-1 was rolled onto a space blanket to help alleviate the initial signs of shock. With the tree still suspended above ENG-1, a decision was made to use the space blanket to move him laterally, about four feet, and clear of the tree. At 2134 SMJ-1, who had taken over as IWI incident commander (IWI IC), called in the full medical incident report to dispatch. Dispatch sensed in the tone of this communication that the IWI team members were beginning to find their stride.

SMJ-4 was sent down the hill to the engine to bring up some medical equipment. He searched, but “after searching through all the compartments, the cab, and the gear stored on top, I was unable to find any of the stuff they wanted.”

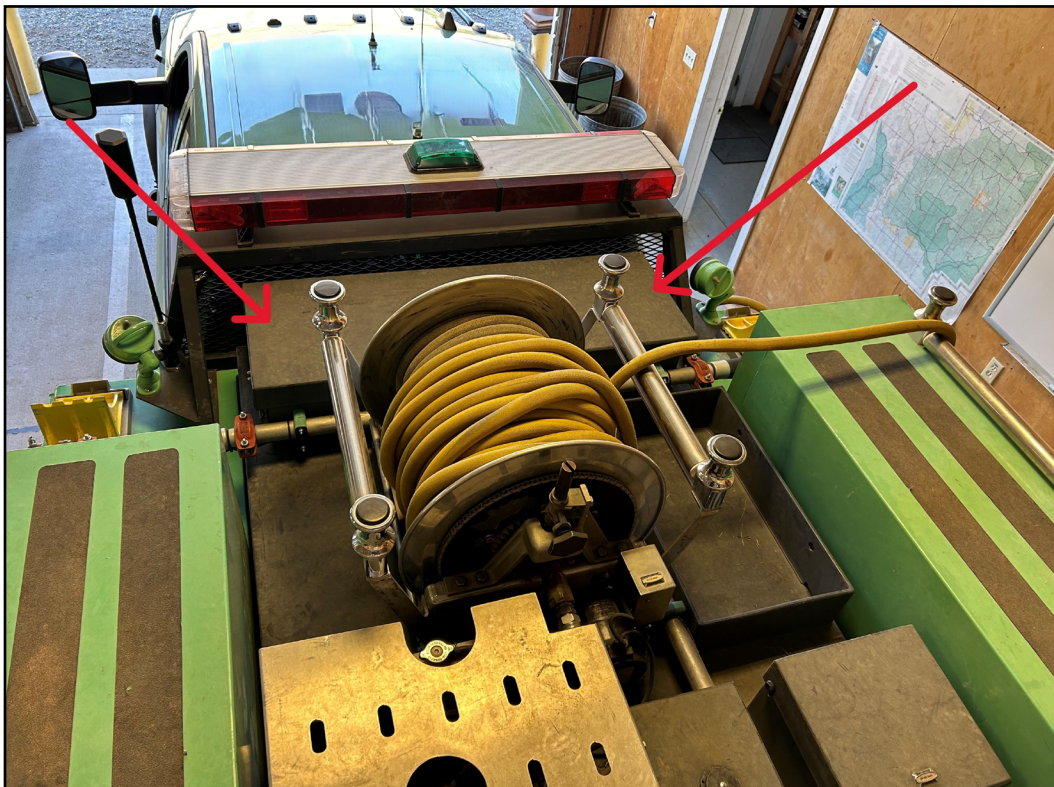


Photo 2.—The red arrows point to the black box where the requested trauma bag was located, there was no SKED. The only way to access the box is to climb on top of the engine.

1 Crepitus—a palpable or audible grating or crunching sensation produced by motion.

SMJ-4 called SMJ-3 on jumper tac to see if he could get some clarification. ENG-3 remembers trying to describe to SMJ-3 where the equipment was so he could relay it on to SMJ-4, but he was still unable to locate the trauma bag or SKED/KED. The trauma bag with oxygen was on the engine but was not in an obvious spot to someone unfamiliar with the engine. It was in what the engine module referred to as “the coffin,” a black box on top of the engine, between the cab and the water tank (see photo 2). The SKED/KED was not on the engine; it had been moved to a chase truck recently during the process of moving equipment to a new Type 6 engine. SMJ-4 was able to find a different bag containing first aid supplies, which he brought back up the hill to the medical providers.

While the firefighters were on the hill providing care, dispatch was buzzing with focused activity. The Forest Fire Management Officer (FFMO) and District Duty Officer (DO) overheard radio traffic and quickly convened at the dispatch center. Together with a compliment of dispatchers and other district and forest leadership, a hospital liaison was arranged and valuable intel was provided, including potential landing zones for the air ambulance. After initial phone calls to his emergency contact went unanswered, Law Enforcement was eventually able to make notification directly to ENG-1’s parents.

Back up on the fire, the individuals providing medical care noticed that ENG-1 was showing signs of needing to vomit. Rolling him onto his side while holding C-spine, they observed dry heaving and that the patient was congested with blood and other fluids. The decision was made to attempt an oropharyngeal “oral” airway (OPA), but it was met with resistance. A nasopharyngeal “nasal” airway (NPA) was attempted but it too was unsuccessful. The patient began showing signs of “agonal breathing” so another attempt at an NPA was made and was successful and breathing improved. Both the OPA and NPA came from the medical kit ENG-3 carried in their pack. With an airway established, they turned their attention to C-spine stabilization. Without an actual cervical collar (C-collar) on scene, one was improvised by using a SAM splint. However, it interfered with airway management and was ineffective for stabilization, so they continued with manual C-spine stabilization. Without oxygen or a Bag-Valve Mask (BVM), manual breaths were given through a pocket mask².



Photo 3.—Examples of a SAM splint (left) and a cervical collar (right).

The module, having recently reviewed the [Dutch Creek](#) Protocols during a Six Minutes for Safety briefing, knew that minimizing the time to higher care was critical. With an airway established, they turned their focus on figuring out a way to get ENG-1 off the hill—without a backboard or SKED/KED. SMJ-2 remembered a training scenario from his previous job in which they constructed an improvised litter using two small trees, chainsaw chaps, and fiber tape. After a quick description, part of the group started

² There was a C-collar, BVM, and oxygen in the trauma bag on the engine, but the bag was unable to be located at the time of the incident.

assembling a makeshift litter. At 2205, ENG-1 was rolled onto the litter and the firefighters began to carry him down to the engine.



Photo 4.—*The actual improvised litter made with 3 pairs of chaps, fiber tape, and small trees cut and limbed.*

They used two or three people on each side of the litter, one holding C-spine and giving breaths, and one scouting the best route to the engine. With the path illuminated only by headlamps and moonlight, they carried the patient down the skid road to where the engine was parked at the intersection of the 9916 road. Stops were made every few minutes to provide rescue breaths, and to give personnel carrying the patient time to switch hands. The pack out to the engine, about half a mile, took 32 minutes. They knew they needed to move the patient somewhere where he could be transferred either to a ground ambulance or to an air ambulance. The firefighters attempted to place the patient onto the back seat of E-611, but the length of the improvised litter poles and the patient's height did not allow the doors to be shut. A hand saw was used to cut the poles. At 2237, ENG-2 jumped into the driver's seat of E-611 and turned the heater on, while SMJ-1 took the passenger seat. ENG-3 was at ENG-1's head, holding C-spine/jaw thrust and continuing to monitor breathing. SMJ-2 stood on the running boards at ENG-1's feet, bracing himself to hold the door open against the brush while they made their way along the narrow 9916 road. At 2241 dispatch notified SMJ-1 that Life Flight was in the area and trying to establish contact. SMJ-1 did not have Life Flight's frequency (EMS2) readily available, and attempted, unsuccessfully, to contact them on Air Guard and an Air-to-Ground frequency. An engine module member handed SMJ-1 his radio with EMS2

queued-up, and communication was established. At 2246 SMJ-1 contacted dispatch to provide a status update, letting them know that they were in communication with Life Flight.

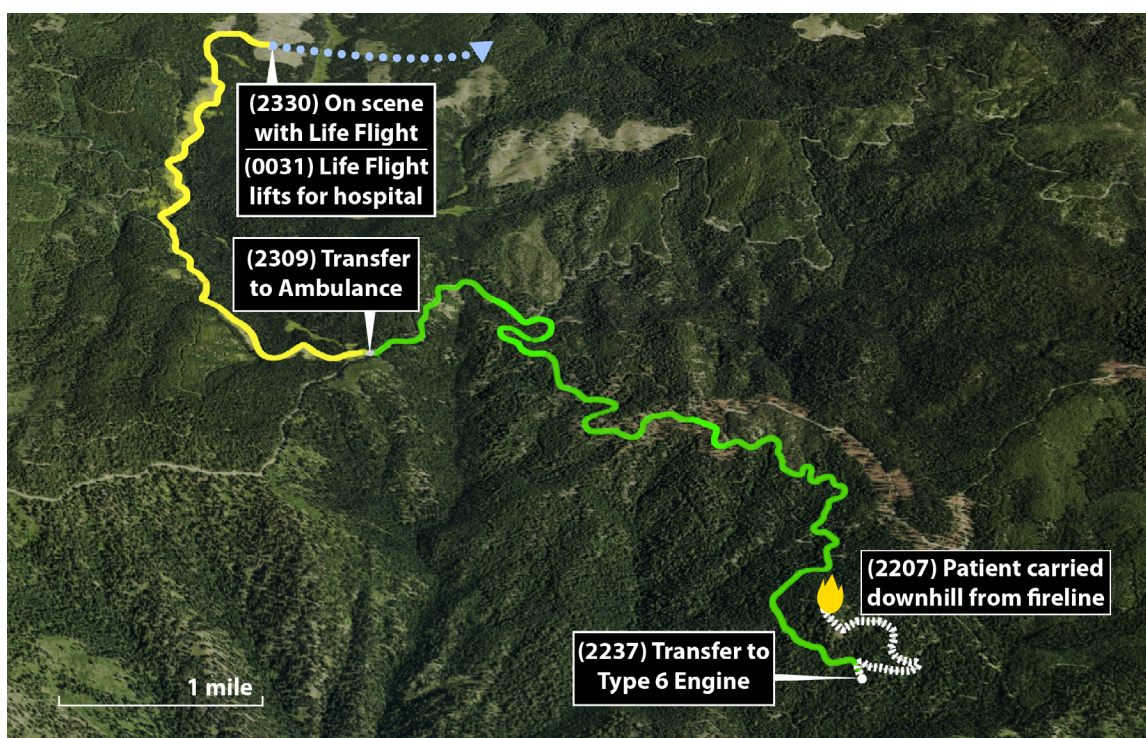


Figure 7.—Evacuation route from the fireline to Life Flight location with timestamps.

After driving the patient in the engine for 3.4 miles, they met the ground ambulance at the junction of the 221 and 394 roads, near Little Slate Creek Saddle. ENG-1 was transferred to the ambulance at 2309, where he was fitted with a C-collar and supplemental oxygen. He was accompanied by ENG-3, who continued to assist with breathing and administration of supplemental oxygen. At one point, while in the ambulance, ENG-1's pulse was no longer detected, and chest compressions were performed. The ambulance drove for a little over two miles to where the Life Flight helicopter was to land. Once on the ground, Life Flight medics joined the others in the ambulance and, for nearly an hour, worked to stabilize ENG-1 for flight. ENG-1 was loaded onto the air ambulance helicopter, and they departed for St. Joseph Regional Medical Center in Lewiston, Idaho at 0031 (on August 11). The patient arrived at the Level 2 trauma center in Lewiston at 0110 and was transferred to a Level 1 trauma center in Spokane, Washington later that day.

Learning From Those Involved

The learning opportunities highlighted in this section were developed as a first installment in the Learning Review process. It is important for you, the reader, to understand the framing the Learning Review team and the participants adopted while reflecting on this event. The instructions from the team to participants were that “we are not trying to fix what happened, rather we are trying to learn from what happened. How do we set the next group of folks up for success?” The reflections listed below are not meant as after-the-fact judgements of right or wrong. Instead they are meant to explore opportunities for learning. This framing

tends to draw learning opportunities away from “fixes” and towards questions that support reflection. Some of the reflections captured below will be the foundations for future learning products. Please read this section with this framing in mind to support your own reflection and learning.

Category: Initial Attack / Taking Action

When the tree strike occurred, the Coffee Can Saddle responders had only been on the fire for a half hour or less and it was dark enough that everyone was wearing headlamps. Naturally, reflections focused on the risk trade-off associated with taking action on the fire that night, but themes of hazard identification training also surfaced.

Lessons from Participants

1. Risk Trade-Offs

- During initial attack late in the day or in low light conditions, consider fuels conditions, recent weather, and expected spread potential in the risk-risk trade-off assessment.

Questions to Support Reflection

- What are the trade-offs in delaying suppression actions until daylight?
- How do physical, social, and cultural environmental factors influence risk-risk decisions?
- What are the pressure—real or perceived—influencing decisions to act ASAP after being dispatched to a fire? Is urgency assumed?
- How might this event influence the way you consider the trade-offs between risk vs. gain on future incidents?

2. LCES is about preventing burn-overs, not tree strikes

There is a lot of focus on entrapment avoidance in NWCG S-courses and refresher training. Much of the 10 & 18s and LCES is focused on preventing entrapments and burn-overs. But according to the [Forest Service Wildland Fire Histomap Project](#), it is more common for someone to get hit by something than to be burned over.

- Check out this WFSTAR video on [Identifying Hazard Trees and their Target Zones](#).

Questions to Support Reflection

- Are we emphasizing the right hazards when teaching new firefighters about the fire environment?
- What should a hazard tree equivalent to LCES look like?

Category: Incident with an Incident—Extraction

Naturally because of the emotional intensity and the proportion of time committed to the events after the tree strike occurred, the participants' learning was focused on the Incident within an Incident (IWI), which included the medical response and the extraction.

Lessons from Participants

1. Learning from past incidents

- The engine module cited their recent discussion of Andy Palmer and the [Dutch Creek](#) protocol as influential to their decisions and actions. The Dutch Creek protocol emphasizes the importance of getting a patient to higher-level care as quickly as possible. The responders all shared an understanding to “take care of ABCs then get the patient moving.”
- According to one of the jumpers, the improvised extraction device made from poles, chainsaw chaps, and fiber tape was first conceived during a scenario training in which the litter was improvised. The jumper shared the basic concept with the other responders and the litter quickly materialized.

Questions to Support Reflection

- How do you train for an IWI response? Does your training reflect real-world “curve balls” that require improvisation and time-critical problem solving?

2. Red Medical = Immediate call for air and ground transport

- Though an air ambulance was ordered during the initial call to dispatch, one responder expressed the sentiment that they wished they would have spoken up when the discussion of what resources to order (ground ambulance, air ambulance, etc.) was happening.
- It was suggested that when a “Red Medical” is communicated (to dispatch or incident communications) it should automatically trigger an air and ground ambulance response. Additional information, environmental conditions, etc. might alter the response downstream, but an automatic two-pronged response keeps options open.
- The local unit is looking into imbedding this trigger into dispatch protocol on a trial basis to explore if it meets the desired intent.

Questions to Support Reflection

- What is the protocol on your unit when a “Red Medical” occurs? Is there an automatic response portion of the plan?
- Because time is often critical, where can your unit/module gain efficiencies?

3. Communications with Life Flight

- There were challenges communicating with the air ambulance for some of the responders on the ground. The correct frequency—EMS2 in this case—was presumably cloned into all the handheld radios on scene. However, in a high-stress situation, having to change groups and find frequencies can be burdensome and can take critical time and attention away from on-scene actions.
- The 2024 Interagency Standards for Fire and Fire Aviation Operations ([Red Book](#)) Chapter 15 states that “Continuous monitoring of Air Guard (168.6250) frequency is mandatory by agency dispatch centers and aircraft.” This requirement extends to all interagency aircraft (including contracted aircraft). However, this policy may not apply to cooperating aircraft you might need to communicate with (e.g., an air ambulance).
- Anticipate non-Agency-contracted aircraft (e.g., an air ambulance) to be unable to program frequencies while in flight.

Questions to Support Reflection

- Do you know what frequency to use to communicate with partnering resources during an IWI that isn’t on your home unit?

4. Lessons from dispatch

- Having dispatchers and unit leadership physically convene in the dispatch center to facilitate a “War Room” approach helped with coordination, communication, and support to the field. Additionally, participants expressed concern about the impending dispatch consolidation. Specifically, participants noted that:
 - These additional resources provided support for dispatch and hoped it helped the folks in the field too.
 - Forest fire leadership couldn’t image not being able to engage that way.
 - It is their belief that moving and consolidating dispatch would not support the approach that was successful in this instance.
- Participants noted having two night dispatchers on duty was very helpful in this case. Because the Coffee Can Saddle fire was one of multiple incidents dispatch was concurrently managing, it would have been extremely difficult for one dispatcher to manage alone. The unit is planning a new SOP to have two dispatchers on duty at night during peak fire season.

Questions to Support Reflection

- How is your unit’s dispatch center set up for managing multiple or complex incidents at night?

Category: Medical Equipment and Training

The participant's lessons in this category were primarily focused on equipment and training. There were the obvious lessons focused on having and labeling the necessary equipment on the engine, but the participants also brought up underlying lessons about the sustainability and direction of the EMT training program.

Lessons from Participants

1. Equipment

- The obvious lesson from this incident for the participants was the importance of knowing the location of medical equipment on vehicles, especially when someone from another module is asked to retrieve gear. Compartment doors should be marked with First Aid/Medical decals that clearly display their location.
 - The engine module has remedied this by labeling the locations of medical equipment on all their vehicles.
- Standardizing the location of medical equipment on crew vehicles emerged as a possible lesson in both the interviews and in the facilitated dialogue. It was felt that while this might work well at a unit/district level, it is unrealistic at the larger interagency levels. Since standardization was not seen by this group as viable, they came back to the importance of labeling the location of medical equipment as the principal lesson.
- Participants noted that module members, and specifically medically trained members, are carrying specialized equipment above and beyond what is required (standard cache first aid kits). This led to a question of whether there is a need to revisit the contents of a standard medical kit.
- Having a pocket mask available was imperative to saving the patient's life in this instance. A pocket mask should be in every first aid/trauma kit.
- Finally, participants recognized the close tie between medical equipment and medical training stating, "having equipment ready to treat 'Red' medicals is good. But if you don't have people trained to use it, it is useless."

Questions to Support Reflection

- Is your module "Red Medical" ready?
 - Does every module/truck have a full complement of medical resources, including an extraction device (e.g., SKED Kit), backboard, trauma kit, oxygen, etc.?
 - Is inventorying your medical equipment a part of daily checks?

2. Training

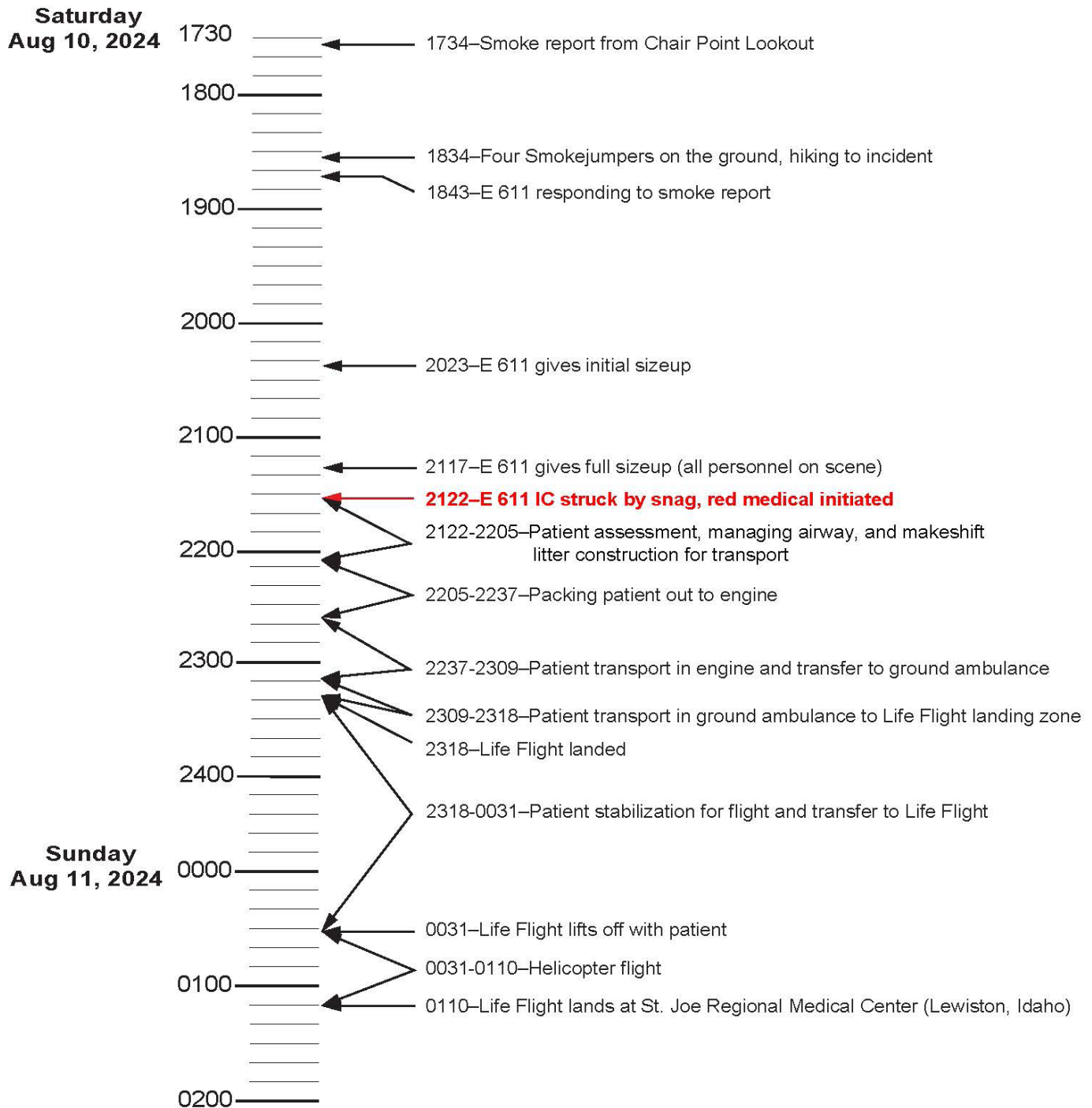
- Participants emphasized that having two EMTs on this IWI was critically important and, from their perspective, saved the patient's life.
- Participants recognized the importance of the EMT skillset, yet identified that there remain obstacles for hiring, training, and retaining EMTs.

Questions to Support Reflection

- What is the right balance of medically qualified personnel on a unit? What are the factors that influence needing more/less?

Appendix A: Timeline

Coffee Can Saddle Fire Incident Aug 10, 2024



Time from tree strike to arrival at hospital: 3 hours 48 minutes