## Ortega Fire After Action Report ORC- 74734 November 16 – 18, 2009

## Introduction

On November 16, 2009, at 11:37 hrs, the OCFA Emergency Command Center dispatched a high watershed to a reported vegetation fire at 32502 Ortega Highway near Verdugo Canyon Rd. (33 31' 14" X 117 33' 21") approximately seven miles from the I-5 freeway. The Cleveland National Forest augmented the initial dispatch with one Battalion Chief, five engines, one hand crew and one water tender. Weather stations near the incident were reporting temperature of 78 degrees, relative humidity at 10–13% and winds N/NE at 5–10 mph. The first unit on scene reported ¼ acre burning up hill with a moderate rate of spread. The Ortega Fire was declared controlled on November 18<sup>th</sup> after consuming 145 acres.

The objectives for this incident were to keep the fire North of Gabino Canyon Road, East of South 40 Road, South of Ortega Highway, and West of San Juan Truck Trail. These objectives were met throughout the entire incident. Throughout the first operational period, additional overhead, engines, hand crews, water tenders and both fixed-wing and rotor-wing aircraft were ordered to meet these objectives. At 13:58 hrs, OCFA Type 3 Incident Management Team III was requested to assist with management of the incident and provide logistical support for resources assigned. Fire Camp was established at Casper Regional Park approximately one mile from the incident's location.

Containment of the fire proceeded as follows:

- The fire was declared 75% contained the morning of November 17<sup>th</sup>
- The fire was declared 95% contained at 1800 hrs on November 17<sup>th</sup>
- The fire was declared controlled at 1800 hrs on November 18<sup>th</sup>

At the peak of the incident, approximately 295 private, local, State and Federal resources were assigned, and four injuries had been reported. One injury required hospitalization at Mission Hospital for three days due to dehydration.

Three areas that were successful:

- 1. Well established control objectives and trigger points
- 2. Effective transition/blending of OCFA IMT within existing ICS Organization
- 3. Positive working relations with CALFIRE and USFS

Ortega Fire After Action Report ORC-74734 Page 2

## Three areas of improvement:

- 1. Initial attack division designators (Division A right flank, and Division Z left flank)
- 2. Fireline injuries not communicated to ICP
- 3. Inability to advance wildland hoselay due to amount of damaged hose

Increased familiarity by OCFA personnel on the use of Bendix King Radios, but did not eliminate all radio communication issues on VHF frequencies

- ECC is continuing to provide the initial attack units with VHF frequencies during the first operational period which has aided OCFA personnel to become accustomed to this radio system.
- Initially, there were some issues with the repeater tone on Command 2. This issue was identified and corrected.
- The rapid utilization of *OCACESS* allowed two different radio systems (800 MHz and VHF) utilized by different fire agencies (OCFA, CALFIRE, USFS) to communicate during the initial response and deployment on the incident.

Incorrect Divisional identifiers confused initial attack resources on their assignment

- At the beginning of the incident, the left flank was identified as "Division Z" and the right flank as "Division A". This caused some additional radio traffic for clarification by arriving resources to verify their assignment and reporting location.
- This was corrected with the formal transition to the IMT and the enhancement from three to four Divisions.

Confirming that all injuries that impact the incident and/or require medical treatment are communicated up the chain of command and acknowledged at the highest level necessary

- A total of four reportable injuries occurred on this incident. The Command and General Staff were only aware of three, and were notified hours after the injuries had occurred. One non-OCFA employee was admitted to the hospital for dehydration.
- With continuous radio traffic and distractions on an incident, it is not only
  necessary to report an injury, but to also verbally confirm that each level of
  supervision is aware of the injury, i.e., Division Supervisor, Operations Chief,
  Safety Officer, Medical Unit Leader, and Incident Commander.

Ortega Fire After Action Report ORC-74734 Page 3

Challenges in advancing the progressive hose lay due to the numerous damaged hoses by hot material and required pump pressure

- This fire burned in steep terrain with heavy aerial and ground fuels.
- This type of vegetation provided a thick ground fuel bed with a considerable amount of residual heat and snags after the main fire front passed. The heated ground fuel and snags, on or next to the hose, caused multiply hose failures due to the lack of cool ground to place the hose on within the burn or adjacent hot snag.
- At the conclusion of the incident, 2,900 feet of wildland hose had been destroyed. The total fire line perimeter for this incident was 12,087' (Division A/B 5,709', Division Y 1,801' and Division Z 4,577').

Timely response of the land owner representative assisted the Incident Commander in providing local knowledge, additional access points to the fire perimeter and assistance in developing incident objectives

- The quick response of the Rancho Mission Viejo representative assisted the Incident Commander by providing information on access routes, hazards in the area and approval of mechanized equipment to meet the fire control objectives and expectations of the ranch.
- The safest and most timely access to the perimeter of a wildland incident is always challenging without local knowledge.
- There is a need to provide current and consistent quad maps to all vehicles and team members.

Response and smooth transition of newly formed OCFA Incident Management Team III assisted in continued support of incident objectives

- IMT III was ordered three hours into the incident, which provided an early response of team members for transition and blending of initial attack overhead into the team.
- The arrival of the team during daylight hours assisted the initial attack I.C. and the team I.C. to develop and implement a plan before dark. This provided newly arriving Operations personnel the ability to see the terrain prior to darkness.
- As a result of the early response of the team, valuable logistical support was established at Casper Park. This enabled the Logistics Section to begin the ordering of needed resources for not only that first operational period, but for the entire length of the incident.

- Due to the excellent tracking of resources during the first operational period, the Plans Section was able to conduct a planning meeting early in the evening which helped identify additional resources needs, and identified resources that could be released from the incident. This assisted the department's DOC in providing continuity of coverage. The Planning Section was able to produce a complete Incident Action Plan for the next operational period.
- Currently, the OCFA IMT does not have a Finance Section Chief which creates the potential for reimbursement issues on some incidents within the county. Financial concerns with this incident were addressed the next day at the Incident Command Post between OCFA Finance and CALFIRE.

## Other observations and learning points:

- Challenges with all radio communications due to terrain and coverage issues
- Crews responding directly to the incident on Type 1 engine and not returning to their station to staff their Type 3 engine
- Lack of hand crew support early in the incident hindered overall suppression abilities
- Early ordering of specialized resources, i.e., dozers and hand crews, to meet objectives
- Reluctance to order aircraft early in the incident
- Blending of Staff Captains into key functional positions
- Early activation and staffing of department DOC allowed staff to assist the incident in a timely manner with resource requests that were placed, i.e., Fire Command 2, Logs/Communication Trailer, wildland cache, and Service Support needs
- Utilization in the DOC of AVL to determine exact location of incident and equipment
- Meals need to arrive earlier to the line; some folks were not feed until 2100 hrs
- Possible challenges in having to contact DOC to complete the ICS 209 twice daily
- Pre-identify all outstanding issues when transition from team to local Incident Commander
- Excellent cooperation from other outside agencies (CALFIRE and USFS)
- Identify the learning opportunities for in-county incidents