| Incident Name: Inaja Fire | Incident Date & Time: 11/25/1956 @ 20:10 | |
|---|---|--|
| Incident Location: | Incident Size: | |
| Inaja Reservation near Julian in East San Diego County and the | 43,611 acres final size | |
| Cleveland National Forest, California | 25,000 acres estimated at time of burnover | |
| Types of resources involved: | # of Fatalities/injuries: | |
| Viejas Honor Camp inmate crew | 11 Fatalities - 7 Viejas Honor Camp crewmembers, | |
| US Forest Service firefighters (Shasta-Trinity NF & Cleveland NF) | 3 Forest Service firefighters, and 1 Correctional Officer | |
| Reasons this fire was selected for the 100 Fires list: | | |
| Fire is historically significant | | |
| 3 or more firefighter fatalities by entrapment | | |
| Conditions leading up to the event: | | |
| would burn." The fire was quickly spotted by lookouts at 09:15 an | resources were dispatched. The Inaja Fire burned under Santa Ana to spread to the southwest. By 17:00 that evening, the fire had | |
| Brief descript | ion of the event: | |
| During the November 25 night shift on Sector G of the Inaja fire, there were two operations going on. One was a firing operation along the tractor-built line on the canyon rim and down the handline. The other operation was to complete the unfinished line down to the river. Day shift was having issues burning due to the adverse weather conditions. The personnel that were cutting and scraping the line down to the river consisted of three crew bosses, the correctional officer, and 13 inmates. The scraper Crew Boss lined out his personnel and then hiked back up to see how the burn was going as directed by the Sector Boss. Once he got close to the rim, he noticed that the main fire was flaring up on a side ridge approximately 1000 feet below the men. It made a short run toward the same main ridge the men were working. He called to warn the men below to come out and one of the other bosses answered him. They all started up the hill and the furthest men down were approximately 1100 feet from the rim. It was reported by survivors that there was main. Some of the men were even wondering why they were coming out. About two minutes after the initial warning the fire gained momentum and now was a real threat to the men. The scraper Crew Boss yelled again to hurry and this time the men dropped their tools, but 11 of the men got cut off below a bluff which was just below the rim and did not make it. All victims were found in an area with a radius of 45 feet and the lower-most victim was only 300 feet from the tractor line at the top of the canyon rim. | | |
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| with a radius of 45 feet and the lower-most victim was only 300 fee | et from the tractor line at the top of the canyon rim. | |
| with a radius of 45 feet and the lower-most victim was only 300 fee Fire behavior factors that w | | |
| with a radius of 45 feet and the lower-most victim was only 300 fee Fire behavior factors that w Santa Ana wind event. | et from the tractor line at the top of the canyon rim. | |
| with a radius of 45 feet and the lower-most victim was only 300 fee Fire behavior factors that w | et from the tractor line at the top of the canyon rim. | |

Multiple spot fires.

Up-slope / up-canyon winds.

Operational lessons available for learning from this incident:

The following lessons were derived from the investigation team conclusions.

Crew location in canyon:

The men were taken down the line into the canyon owing to a lack of information to show possible danger from the fire in the canyon below. The contributing factors were:

- Absence of specific information on the fire status in San Diego Canyon available for the briefing at the base camp, due to poor conditions for aerial reconnaissance.
- Emphasis placed on the danger of the burning-out fire rather than on the main fire in the canyon below when the day Division Boss briefed the night overhead personnel.
- > Quiet appearance of the fire as viewed from the rim.
- > The night overhead personnel had not seen the terrain in daylight.
- > Lack of detailed scouting of the canyon on Sector G during the day.
- Absence of contact with the bosses of the division across the canyon who had a different vantage point for viewing the situation.

Trail (Line) location:

The location of the fire trail on the specific ridge where it was built instead of the spur ridge up the canyon was questionable. The previous behavior of the fire and the position above and alongside a precipitous chimney made the chosen location hazardous.

Lookout:

The crew cutting line into the canyon received warning to come out when the Crew Boss on the upper part of the line saw the fire heating up at a point below the men. It is uncertain in the Inaja Fire disaster that a specifically designated lookout would have given warning any sooner. However, it is vital that a lookout be designated when crews are in a potentially dangerous location.

Notable impact or historical significance for the wildland fire service from this incident:

The Inaja Fire was the last in a series of nine major tragedy fires that had occurred in just a 23 year span prior to 1956. As a result of this fire, the Chief of the Forest Service chartered the *Task Force to Recommend Action to Reduce the Chances of Men Being Killed by Burning While Fighting Fire*. Their report, issued in 1957, produced several significant outcomes and recommendations. First and foremost, the initial draft for the "10 Standard Firefighting Orders" can be found in this report. Some more notable recommendations included:

- Fire Behavior Research: better knowledge of fire behavior must be developed as an essential means of preventing future fire tragedies. Assemble and compile existing knowledge of fire behavior and prepare material for lesson plans and training aids.
- Training Center: establish a service-wide Fire Control Training Center. The purpose of this Center is primarily to provide a high level of training for fire behavior specialists, and a nucleus of fire bosses.
- Career Development: government salary and wage rates make it difficult to obtain and hold competent fire control personnel. Controlling mass forest fires is a difficult and highly technical job. The specifications for these positions should be further reviewed with appropriate Department and Civil Service Commission officials.

Other recommendations included:

- > Standardize large fire suppression organizations and terminology.
- Standardize the fire training and qualification system.
- > Develop training for Crew Bosses on safe practices under blow-up conditions.
- Establish a uniform Fire Danger Rating System.
- > Work closely with the Weather Bureau to improve fire weather forecast capability.
- > Give increased attention to communication on campaign fires.
- > Explore the use of transistor-type receivers.
- Begin a project to investigate protective gear for firefighters.
- Encourage field units to write-up "Near-miss" situations for continued training purposes.

The report from this Task Force in 1957 guided progress in the wildland fire service for decades to come. Many of the tools we have today were envisioned by these individuals. The Task Force even gave early notice to the current wildland-urban interface problem by noting "As resource values increase, and as more structures are built within the forests, the pressures to keep fires small or to fight them at disadvantageous places will become greater and greater."

Every career firefighter should read this report!

Links to more information on this incident:

https://lessons.wildfire.gov/incident/inaja-fire-entrapment-fatalities-1956 https://wlfalwaysremember.net/1956/11/25/inaja-fire/ https://www.fs.usda.gov/psw/publications/documents/psw_rn183/psw_rn183.pdf https://www.nafri.gov/sites/nafri/public/files/attachments/Report of Fire Task Force 1957.pdf

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Incident Summary Page for the 100 Fires Project



Inaja Memorial on Highway 78 near Julian, California.

Incident Summary Page for the 100 Fires Project

INAJA FIRE DISASTER FIRE BEHAVIOR 1930 TO 2015 HOURS NOV. 25, 1956 - SAN DIEGO RIVER CANYON



