

Rapid Lesson Sharing

Event Type: Limb Strike

Date: September 16, 2025

Location: Garnet Fire
California

The Story and Lessons from this Limb Strike Incident

On September 16, 2025, a falling team of two sawyers assigned to the Garnet Fire was working to fall hazard trees along McKinley Grove Road on the Sierra National Forest. Firefighters were mopping-up on this steep (70% or 35°) slope. The sawyers were identifying and falling trees that posed a risk to these firefighters.

Sometime just after 1300 hours, 250 feet below the road, the falling team identified a large, 45.5-inch-diameter pine tree with a deep cat-face (burned-out cavity) at its base. Due to its uphill lean, they believed this tree posed a risk to firefighters working in the area.

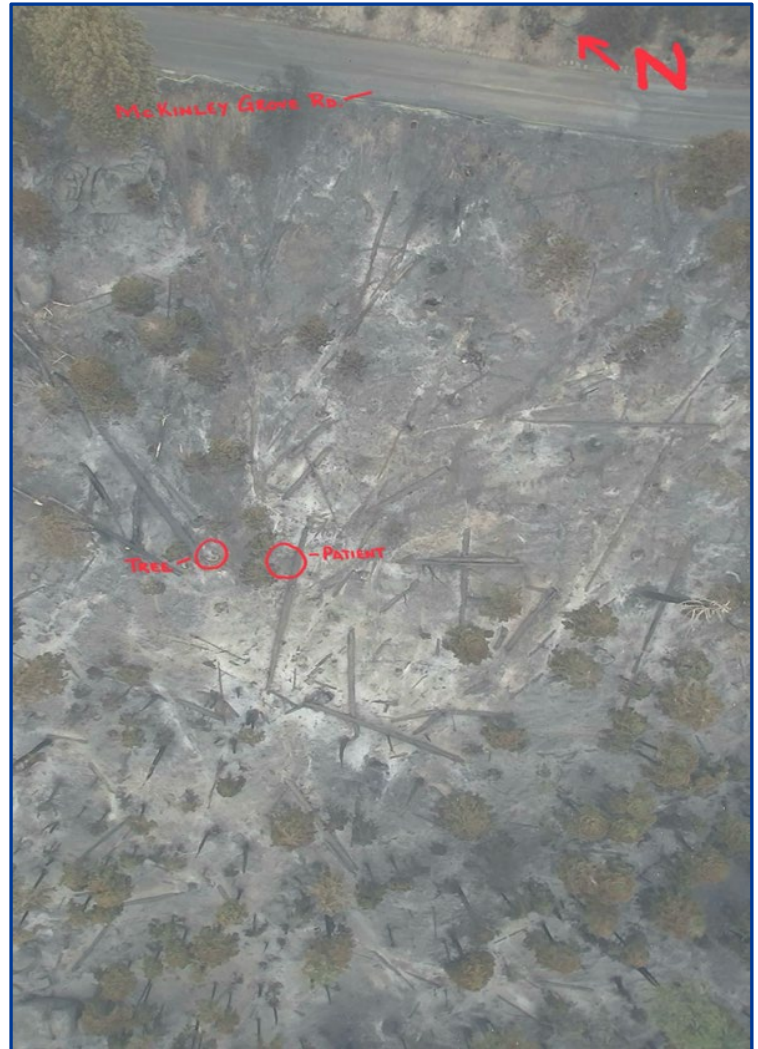
In falling this tree, the more senior faller acted as the spotter, while the less experienced faller would do the cutting. The cutting area was a steep slope of deep ash and dirt (described as “moon dust”) that covered rocks and made walking more difficult. During the tree size-up, the fallers noted large limbs still attached to the tree higher up on the bole. They believed there were no other significant obstacles to potential escape routes, besides the slope and partially obscured rocks.

Limb Strike Knocks Spotter to the Ground

The felling sequence went as planned. As the sawyer completed the backcut, the spotter noticed something falling out of the tree. Both the sawyer and spotter began to utilize their pre-identified escape routes. But after only a few steps, the spotter was struck in the arm by a falling branch. [After the incident, this branch that struck the spotter was determined to be nearly seven-feet long and 10-inches in diameter.]

The limb strike knocked the spotter to the ground. He immediately recovered his senses and made his own Incident Within an Incident (IWI) “emergency traffic” call over the radio. On the road above him, he noticed a red pickup truck and signaled for the driver to stop.

The truck stopped. Its driver was a Fire Behavior Analyst (FBAN) who was out collecting situational awareness of the fire environment. The FBAN, a former paramedic, immediately began rendering aid. The FBAN also took over IWI radio communications with the Communications Unit at the Incident Command Post until more resources arrived to assist.



Overhead photo of the accident site.



Top Photo – The stump and bole of the hazard tree. Arrow points to the limb that struck the spotter.

Bottom Photo – The hazard tree stump showing the face cut, backcut, and two "posts" of hinge wood on either side of the cat-face.

Timeline

- 13:30:** Emergency Traffic, tree strike.
- 13:34:** Division M Safety, a Norcal IHC, Ambulance, and Paramedic-Fireline (EMPF) on scene.
- 13:36:** IWI declared, 8-Line and IC established over Command frequency.
- 13:42:** REMS1 on scene, patient stabilized, packaged for extraction.
- 14:06:** Patient extracted and transferring to Ambulance.
- 14:09:** Ambulance at DP30 awaiting hoist helicopter (Army UH-60 "Guard 892").

14:15: Guard 892 on scene, evaluated and changing LZ to Helispot 10.

14:29: Ambulance and Guard 892 at Helispot 10.

14:37: Patient loaded onto Guard 892 and enroute to Fresno Community Medical Center with 17-minute estimated flight time.

At the hospital, the patient's injuries were determined to be a fracture of the left forearm near the wrist, the laceration and degloving of the left index finger (when layers of skin are ripped from underlying tissue), and a laceration to the left palm.

Lessons

- ❖ In discussion with the sawyer and spotter after this incident, they could not identify errors in their decision-making or risk management process. This chain of events emphasizes the reality that the best performers can make the best risk-informed decisions, and—in the hazardous wildland fire environment—still experience a negative outcome.
- ❖ The spotter immediately began calling in the IWI using a pre-planned script in his head that he updated as the falling team moved to each new location. He had worked through the script in his mind to anticipate an injury to his saw partner. Suddenly, when he was the injured party, he gave the “patient age” as 40-years-old—the age of his saw partner. Despite this minor error, the rest of the rehearsed IWI call made the medical response that much faster.
- ❖ Through previous IWI medical extractions on the Garnet Fire, the Incident Management Team (IMT) felt well-practiced by this stage of the fire. Previous experiences had led the IMT Safety group to ensure resources knew how to use the Medical Incident Report (“8-Line”) and emphasized proper categorization of patient injury severity (Green-Yellow-Red).
- ❖ The IMT Safety group's standard practice is not to question the medical responders on the ground. This includes the categorization of injury and the requested transportation method (Ground vs. Air).
- ❖ The IMT had developed the practice of staffing their Communications Section with individuals with Dispatch experience, utilizing the Initial Attack Dispatcher (IADP) qualification rather than the more general Radio Operator (RADO) qualification. The IMT views the Communications trailer as a 911 call center and prioritizes staffing it with people who can take emergency calls. Feedback has indicated that the tone of voice and clarity from Communications during IWI events helps bring comfort to the folks on the ground.



The limb that struck the spotter.

- ❖ An IHC and a REMS team showing up at the same IWI scene usually bring different mindsets, skillsets, and tools. IHCs have major horsepower and problem-solving ability, while REMS have technical rescue skills. To reduce friction as extraction plans are developed and implemented on scene, the IMT identified this potential tension as an area of focus in the future.
- ❖ Systems that spatially track resources, such as ATAK, Twisted Kelp, and Tablet Command, greatly increase situational awareness and the ability of an IMT to locate an IWI and coordinate medical response and medevac.

This RLS was submitted by:

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