

Rapid Lesson Sharing

Event Type: Chainsaw Cut

Date: July 22, 2025

Location: Payette National Forest
Idaho

The Story and Lessons from this Chainsaw Brush Clearing Incident

Summary of Events

On July 22, 2025, the Vegas Valley Hand Crew was conducting project work clearing brush with chainsaws along trails on the McCall Ranger District of the Payette National Forest. The crew had been working approximately two hours down the 315 Trail.

Three individuals were working together in a saw team to cut and swamp the brush. A more experienced sawyer was demonstrating chainsaw cutting techniques to the other two personnel.

During this demonstration, one of the swampers held a small piece of brush while the sawyer cut it using the bottom of the chainsaw bar. Upon completing the cut, the tip of the bar struck an unseen object, causing the chainsaw to kick back.

The top of the bar made contact with the swamper who was holding the brush, impacting the protective chaps, cutting through one of the buckle straps and shifting the chaps, enabling the chain to contact their left shin, causing the laceration injury.

The sawyer immediately called a “medical” incident over the radio. The injured individual initially attempted to render self-aid, including preparing to apply a tourniquet—however, medical personnel arrived quickly. An Incident Within an Incident (IWI) Incident Commander was established while the remaining personnel on the crew began constructing a helispot.

Medical Response

At 1310 hours, medical responders on the crew received the call of a Red medical and arrived at 1311 hours. Upon assessment, the injured individual was sitting upright attempting to apply a tourniquet. After determining that the injury was a ½-inch deep, 3-inch-wide laceration with no arterial bleeding, only steady blood flow, the crew Emergency Medical Technician (EMT) stopped the tourniquet application.

Once the bleeding was stopped, providers downgraded the medical to a Yellow.

Medical treatment included:

- ❖ Direct pressure with hemostatic quick clot bandage
- ❖ Pressure bandage applied after bleeding was controlled



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- ❖ Circulation, sensation, and movement (CSM) checked and intact
- ❖ Vital signs assessed (not documented)
- ❖ Patient stable, alert, and “Oriented x4” (*a patient's awareness of four things: who they are, where they are, what time it is [time of day, date, year], and what happened to them*)

Evacuation

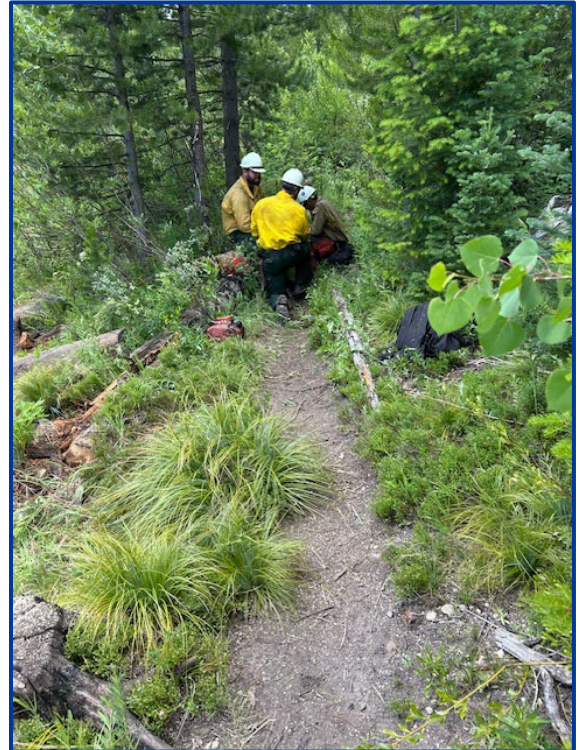
1345 hours: The injured party was transported via two-person under-arm carry to the helispot. (Two rescuers lock arms and form a seat for the injured party to sit on.)

1355 hours: Helicopter landed and patient was transferred to the onboard EMT.

1402 hours: Helicopter departed for transport to St. Luke’s Hospital in McCall, Idaho.

The injured party was stabilized and transported via ambulance.

At the Emergency Room, he was seen and originally told that it would be some quick stitches and an X-ray. The X-ray showed that there was fragmenting of the shin bone. The doctor decided on surgery to clean and further investigate the bone. The bone ended up losing a one-quarter-inch chunk and having a hairline fracture. The patient was released to limited duty the same day he was released from the hospital. He completed the remainder of the season working aviation radios at the tanker base and dispatch. He was released to full duty in September with the understanding from his doctor that he was being laid off that week and would be able to continue extended recovery.



Treatment of the injured individual at the project site before medevac.

Lessons

- ❖ From the time of the chainsaw strike to the injured party being in a hospital room was under 1.5 hours. This is in part due to the rapid response of crew resources being able to make it to the injured party and begin the IWI protocol.
- ❖ The Vegas Valley Hand Crew was active in updating their medical plan. They regularly train for medical incidents—which aided them in their response and their actions taken on this event. As they progressed down the trail that day, the crew also identified potential helispots for improvement.
- ❖ Upon being notified of this medical incident, the local unit dispatched a Short-Haul capable Type 3 Helicopter as well as an additional Type 2 Helicopter. The intention was to Short-Haul the patient from the remote area and shuttle them to a suitable helispot, where they could transfer the patient into the Type 2 for transport to McCall. The work taken by the Vegas Valley crew to immediately begin improving the helispot near the injury site allowed the Type 2 Helicopter to land near the injury site—not requiring a Short-Haul evacuation.
- ❖ The skill difference between the sawyer and swamper created an uneven balance of pace between them. When operating in this type of work, the tempo should be adjusted to meet the lesser experienced and qualified sawyer, rather than expecting the trainee to match the faster, more experienced sawyer. Additionally, ensure that the swamper is working across from the sawyer instead of behind the chainsaw bar.

This RLS was submitted by:
Nolin Page – Boise BLM
Fire Planner/Chainsaw Coordinator

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Three Similar Incidents Occurred in 2019 and 2020:

[Beeskov Fire Chainsaw Cut and Medevac 2019](#)

[Kootenai National Forest Chainsaw Cut 2019](#)

[Utah Project Work Chainsaw Kickback Cut 2020](#)

These previous events all shared a commonality—chaps pulled out of place
by moving chainsaw teeth and cutting the exposed leg beneath.

Always ensure chainsaw chaps fit properly.
