ORLEANS TREE STRIKE

LEARNING REVIEW NARRATIVE

April 14, 2026

This Learning Review Narrative represents the initial phase of a Chief's-level review concerning the July 18, 2025, incident on the Butler Fire of the Orleans Complex. The review was initiated by the Chief due to the seriousness of an incident that injured multiple firefighters. Utilizing the Facilitated Learning Analysis (FLA) process, this phase focuses on information gathering and sharing perspectives of the event, facilitating sensemaking for both employees and agency leadership. Upon approval of this narrative, leadership will determine necessary next steps; any further investigation will require a new delegation of authority to define scope and intent.

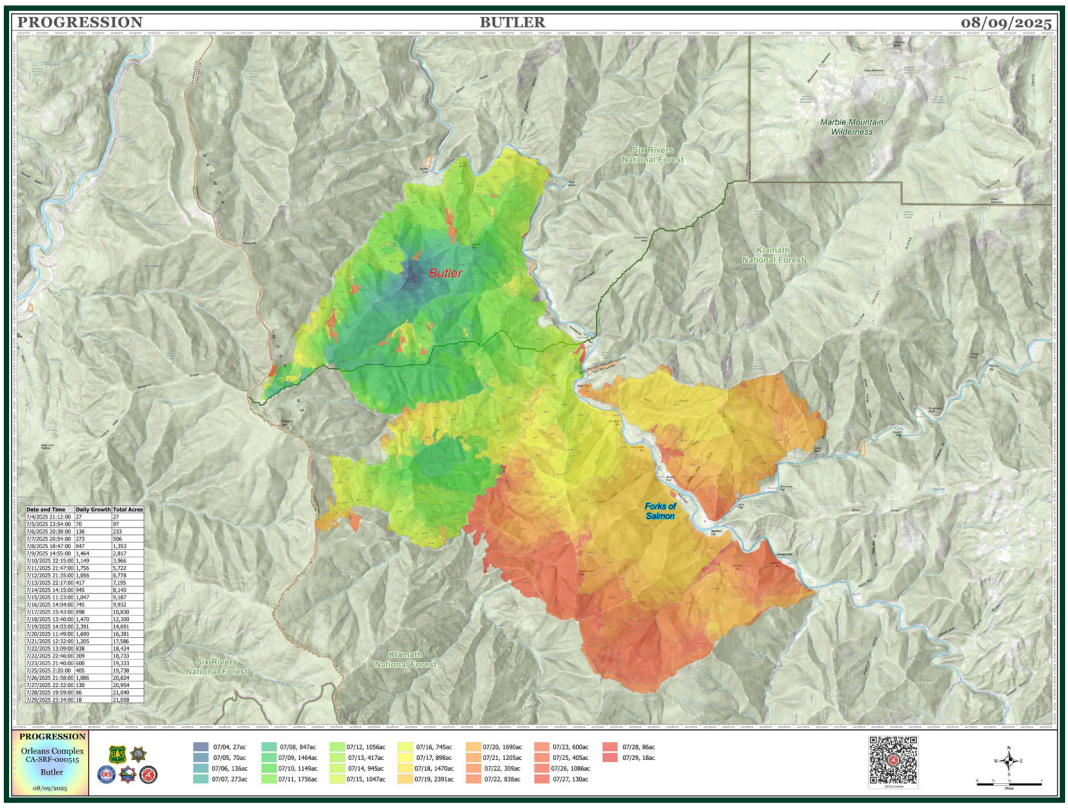
This narrative was completed without feedback from the most injured firefighter (Firefighter Three) who is focused on healing. It does not capture his perspectives or insights. When he is ready, his perspective will be captured and added to the story of the event.

Specific names of patients and responders have been changed by request.

THE BUTLER FIRE

Aircraft detected the Butler Fire on July 3, 2025, at 6:12 p.m. about ten miles east of Orleans, California, on the Six Rivers National Forest. After several days of management by a Type 4, then a Type 3 Incident Management Organization (IMO), a Complex Incident Management Team (CIMT) assumed management of the Butler Fire as part of the Orleans Complex (Butler and Red Fires) on July 11, 2025.

The fire had spread from the Six Rivers National Forest and was burning on the Klamath National Forest; both forests were included in the Delegation of Authority to the CIMT. On July 17, 2025, a slopover occurred across the Salmon River; and crews used direct tactics to contain it. On July 18, 2025, around 2:30 p.m., a tree strike injured three members of an Interagency Hotshot Crew (IHC -1).



Butler Fire Progression Map, August 9, 2025

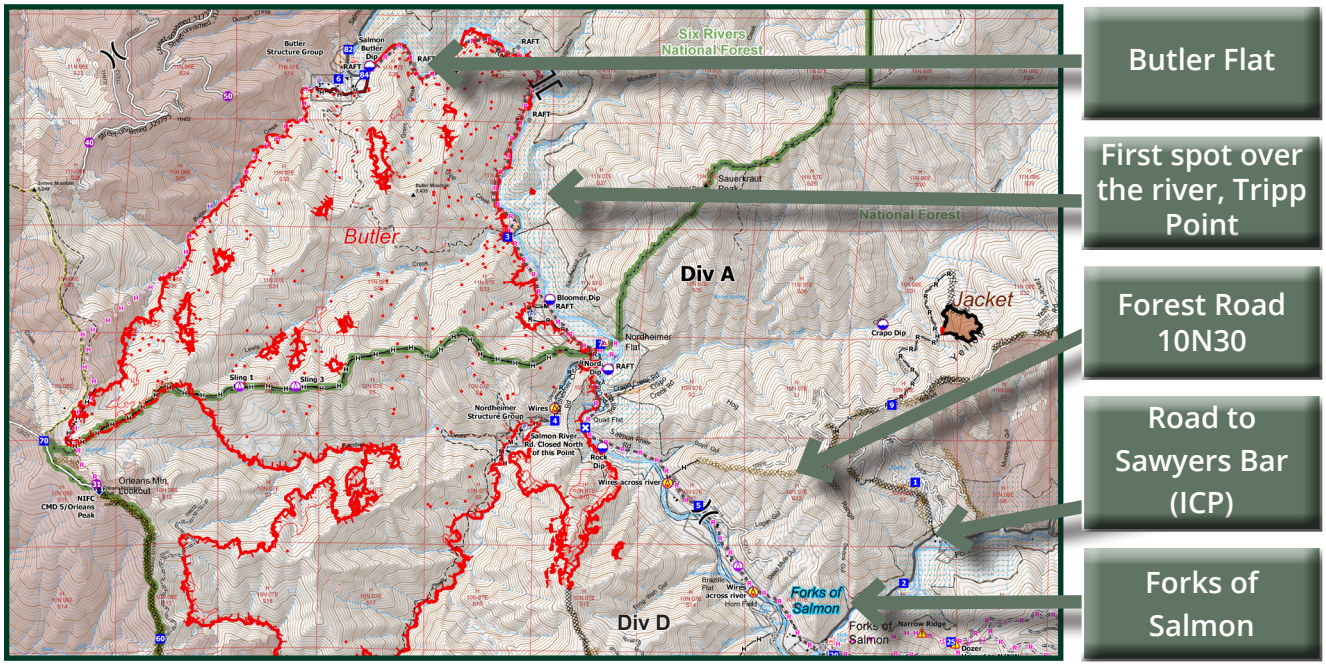
THE SCENE

IHC-1 had been assigned to the Butler Fire early on in the incident, under the command of a Type 3 Incident Management Organization. Now on day twelve of their assignment, with a CIMT in place, the fire was actively burning on the Klamath as well as on the Six Rivers National Forest.

IHC-1 had been working to keep the fire on the west side of the Salmon River. Although the fire had been holding for several days, a first small spot on the east side of the river north of Nordheimer Creek across from Tripp Point had been detected, and contained. But it was not good news.

If fire got established on the east side of the river, the small communities of Forks of Salmon and Sawyers Bar would be directly in the fire's path. Plus, with minimal fire history in 40+ years and the nearest place to stop it approximately 17 miles away "...we'd be fighting fire there 'til next November," said a forest fire chief. This would potentially "...quadruple the risk to responders."

So, a plan was communicated from the CIMT to Operations: Check the fire as it flanked along the west side of the river. A strategic firing plan had been written for areas that needed to be burned out promptly if they were going to contain the fire, and the majority of the Division Delta resources were working on that plan. The Klamath NF felt that the implementation of this strategic firing plan was urgent, and that the focus on protection needed to shift from the area around Butler Creek to the more southern areas.



Butler Fire Operations Map, July 17, 2025

4

On July 17, before lines had been completely prepped or burned, a second spot over the river was detected, this time much closer to the community of Forks of Salmon.

That second spot grew rapidly, spreading to almost 1,000 acres. The urgency was clear and everyone understood the mission: It was going to be a firefight, but the alternative was the big box-- more exposure, more time, more crews committed to the Orleans Complex. For the past several years, fires in the same area had been suppressed with good success through direct attack.

As with most of the Klamath, the ground on the Butler Fire was steep, remote, and unforgiving. Resources on Division Alpha were working on a handline with a plan to tie into constructed dozer line along the 10N30 Road. The vegetation was thick through there – a mix of evergreen pines and firs, with some broad leaf trees like black oak and Pacific madrone.

On the morning of July 18, IHC-1 was shuttled to a landing above the line. As they drove up the steep switchbacks, they were aware that they wouldn't be going back out the same way, that the road was likely going to be impacted by fire during their shift. They knew that four other IHCs were also working in the immediate area.

The hotshot superintendents discussed the hazards and adjusted their operations accordingly. IHC-1 tied in with another IHC and agreed to pick up where they had been while the other crew bumped up the line. They were glad to see them; IHC-1 Captain stated "[they]...needed more horsepower." They got to work – one foot in the black – cutting snags and constructing line. They could hear trees falling. There were standing dead trees visible, but they did not feel it was a snag patch. Much of the forest was green, with brushy clumps of undergrowth concealing the bottoms of the mature trees.

And then it happened.

The IHC-1 Captain stepped back and surveyed the scene. He stayed in the black, listening to the radio and monitoring the situation, while Firefighters Two and Three hauled dolmars and water up the handline.

"I'm worried about today. I'm scared for what's going to happen. The times [for extrication] that I gave you before...double them for today."

–CIMT speaking to ground resources at morning breakouts, July 18, 2025.

They were standing shoulder to shoulder when the Captain caught sight of only the merest shadow moving above him. There was no time to say anything. Instinct kicked in and he tried to dive out of the way. Another hotshot working above saw what was happening and yelled **"TREE!"** but the burning madrone had failed at the base and silently toppled from the black, aiming straight at the crew.

Pacific madrone tree *(Arbutus menziesii)* that fell, injuring three firefighters on the Butler Fire on July 18, 2025. The tree was later burned over in the fire. Photo by crewmember, IHC-1.

6

THE INCIDENT

In all, three IHC-1 crew members were struck by the falling madrone snag. And Firefighter Three was pinned. For a minute chaos reigned, then muscle memory kicked in.

IHC-1 had pre-identified their roles: Med Team, Cut Team, Move Team. M-C-M. Everyone on the crew had a pre-identified role, practiced over and over again during training. They swung into action. An IHC-1 squad boss reported the Incident Within an Incident (IWI), then relayed requests for assistance to the Helicopter Coordinator (HLCO) circling above. Limited information was overheard on the radio: Two Reds and one Yellow patient.

The crew acted fast. The Captain had been grazed by a branch as the tree fell and was mostly unhurt, but a bit stunned. Crewmembers moved Firefighter 2, who could walk, away from further danger and starting patient assessment on him. He was quickly downgraded to Yellow: his arm was splinted and he was able to begin walking back up the line under his own power. Since Firefighter Three's injuries appeared more significant, the majority of EMS care was focused on him. The call came to cut Firefighter Three out. He was pinned face up under the trunk of the tree, with his head visible in between two forks. "We have to get you out!"

The crew began to cut the tree off, but with concerns that it would increase pressure on Firefighter Three, it was slow going. Carefully, they cut branches, wedging their packs underneath the trunk as they went.

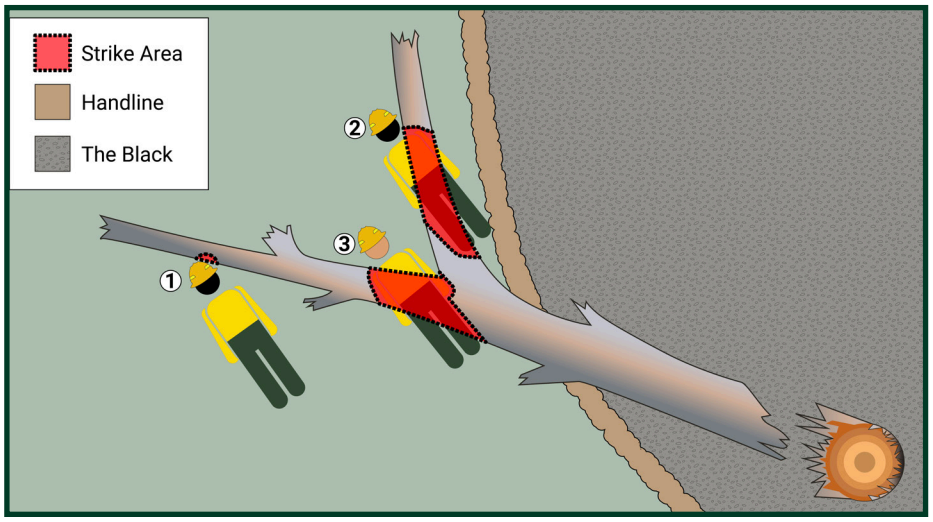


Illustration of position of three injured hotshots:

1. Captain: **Initial Yellow,** downgraded to Green.

2. Firefighter Two: **Yellow,** extricated via ground in short-haul capable helicopter.

3. Firefighter Three: **Red,** extricated via hoist.

In the end, it was primarily brute force that lifted the fallen snag off Firefighter Three. An IHC-1 Emergency Medical Technician (EMT) hoisted Firefighter Three onto his chest, dragging him out from underneath the tree, and began patient assessment. He appeared to be conscious but had obvious injuries to his leg and chest. They bandaged the openly fractured leg to control bleeding, got it splinted, and implemented cervical spine motion restriction.

Other crews arrived at the scene quickly. A second crew's (IHC-2) EMT and Advanced Emergency Medical Technician (AEMT) arrived with a full-body vacuum splint and started IVs. The four hotshot crews on scene assisted with care and got to work preparing for extrication and hoist, cutting trees and clearing a pathway. **Advanced care on the line was critical here:** medics recognized life-threatening conditions and took appropriate action.

Within 25 minutes, despite the fact that ground access was being impacted by active fire behavior, additional medical staff had arrived, coordinated by the Division Supervisor (DIVS(t)) and the field Medical Unit Leader (MEDL), additional medical resources arrived on scene: line EMTs, line medics, Rapid Extraction Module Support (REMS) Teams.

By the time the hoist helicopter lifted the patient, "90% of the patient care was complete*."

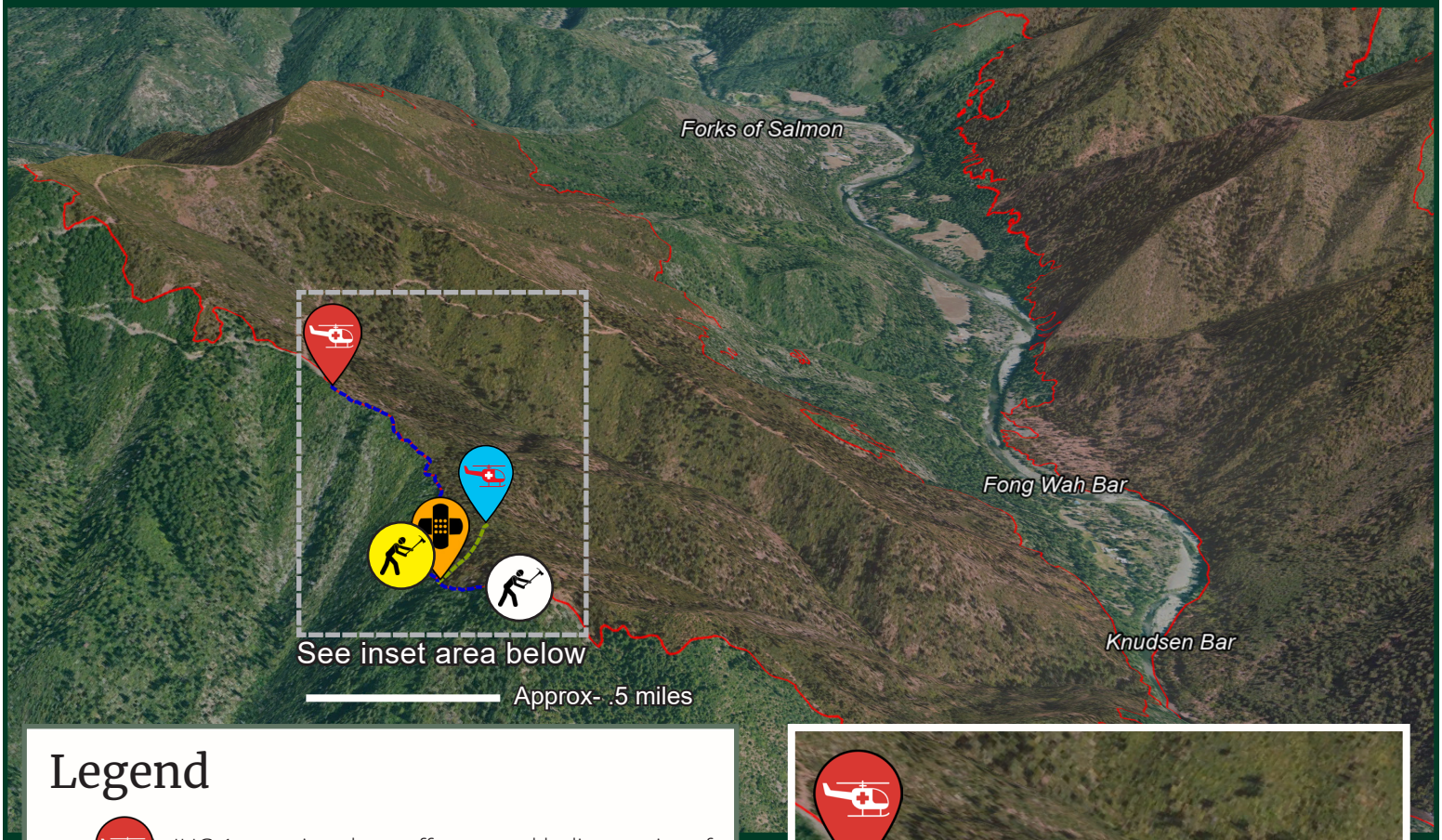
The focus of the medical care was on Firefighter Three. A total of nine EMS resources— three IHC EMTs, two line medics, two REMS Teams, and two paramedics on the hoist ship provided care prior to arriving at the hospital in Redding.

The third patient, the IHC-1 Captain, had been hit in the head by the tree as it came down, and his injuries were originally called in as Yellow. But he was quickly downgraded to a Green and was committed to staying with his crew. But with a call out for three patients, his whereabouts concerned a few people who didn't receive that message. The short-haul helicopter returned to the IWI site after delivering Firefighter 2 to a LifeFlight at the helibase, anticipating that they would also be transporting the Captain. They returned to base when they became concerned about fuel, still unsure of the outcome.

"They did an amazing job and made my job easy."

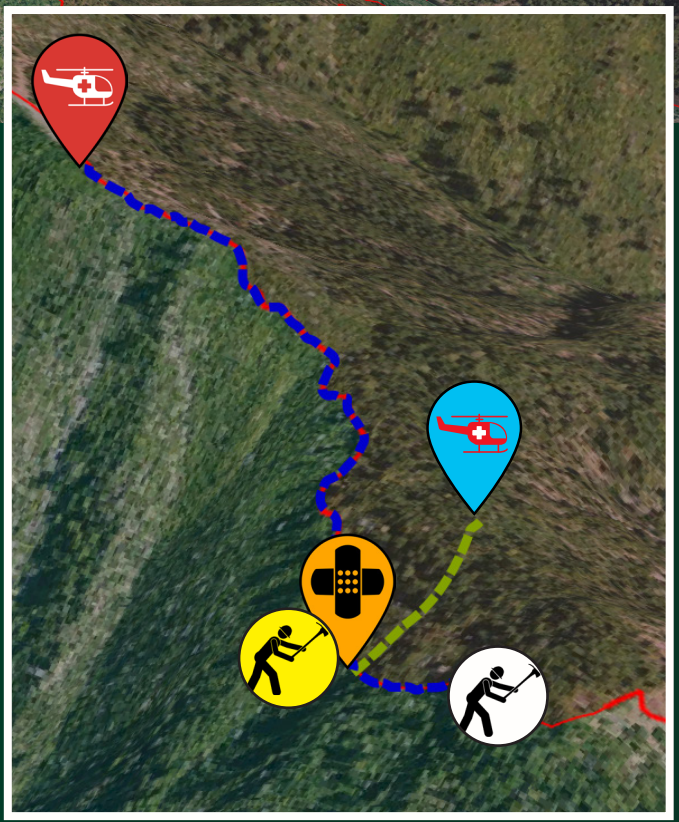
*– *Paramedic, Hoist Helicopter*

INCIDENT SITE MAP*



Legend

- IHC-1 morning drop-off spot and helispot; site of Firefighter Two extrication (via landed helicopter.)
- Hoist site; site of Firefighter Three extrication (via hoist.)
- Site of injury
- IHC-1 work site
- Other IHCs on Division
- Proposed firelines (dozer and handline)
- P-line used for extrication
- Active fire perimeter



*Site map is approximate. Perimeter is based on infrared mapping from July 19, 2025 at 0230.

THE EXTRICATION

Due to the location and the nature of the injuries, extrication by aircraft was clearly the first choice. Although there had been multiple efforts from the local units to secure an extraction-capable helicopter, no extrication helicopters were permanently housed in the area. Fortunately, two helicopters were in the area due to wildfire activity. In the box at the Incident Command Post (ICP), the CIMT called a short-haul helicopter which was assigned to the incident, and was pre-positioned at Scott Valley Helibase/airport. A hoist capable helicopter out of Kern County, which was pre-positioned for Geographic Area response at Mott Airport in Dunsmuir, was also told to spool up.

Near the accident site, the four hotshot crews assembled nine saw teams, working to create a p-line and a hoist site. A dozer and crew worked to make a place for the short-haul capable helicopter to land. Helicopters worked to cool the road for a potential ground transport. If the aviation option was not viable, a painful and grueling 6+ hour ground extrication and transport would be required.

Thankfully, visibility made aerial operations possible on the division, even though it had been socked in with smoke earlier in the day. Thick inversion is common there, sometimes limiting or grounding aircraft use and effectiveness. With clear air, appropriate aerial resources staged and available, and resources on the ground preparing for safe operations, today everything worked.

Hoist site, Klamath NF
Photo by FLA Team

And many others contributed as well.

As the IWI was unfolding, the Butler Fire was by no means dead. In fact, activity was continuing to pick up. By the time the crews returned to the scene after extrication, some of the hotshot and EMT equipment was burned up. The hoist helicopter's tag line had burned as well. The crews that remained on the fireline had to tune out the noise of what had just occurred and get back to fighting fire.

And they were successful. The spot was contained at 1,000 acres. Their work prevented months of future exposure to firefighters on the line, on the roads, away from homes.

For the patients, care didn't stop when they got to the hospital. The Pacific Southwest Region has a robust hospital liaison program to support injured firefighters once they get off the line. In this case, a hospital liaison was staged in Redding to assist injured firefighters once they arrived at the hospital. They had been very busy. There had already been thirteen from one fire and nine from another who had been at the hospital and engaged with liaison support. Having a skilled, compassionate person pre-staged and ready to respond takes a huge burden off patients, families, and the unit.

"We had a job to do."

-Firefighting resources on Division Alpha

Night operations along the Forks of Salmon Road, July 19-20, 2025.

CONCLUSION

When firefighters reflected upon the incident, a common statement emerged: **we saved a life.** But what does it take to save a life when injuries occur in the wildland fire environment?

When the incident occurred, all the firefighters had spent a significant amount of time training to manage an Incident Within an Incident. The IHCs, DIVS, and CIMT had all run scenarios to better prepare for incidents on the fireline. Crews understood what was necessary to get a non-ambulatory firefighter out of the woods. "When the incident happened, we had already planned out roles and duties for a single patient, but I wasn't fully prepared to manage three different patients," DIVS(t) reflected.

Any pre-planning begins with an assessment and acknowledgment of risk. A formal Incident Strategic Alignment Process (ISAP) had been initiated and updated throughout the incident. Risk to responders was continuously identified as a primary value at risk. These conversations continued all the way down to crews working on the ground. Everybody knew that going direct to stop the fire on the ridge was a significant risk to ground resources, but it was the right risk at the right time because it potentially reduced the risk that future responders would need to undertake. When asked if the risk to responders was worth it, one of the IHC captains reflected, "This is a dangerous job. I would make that call again."

Because of the acknowledgment of risk, EMS resources were prepositioned throughout the division. A field MEDL had been assigned to manage the multiple EMTs, paramedics, and REMS teams that were called upon. All of the IHCs had invested in medical training and scenarios. Multiple EMTs were embedded as members of the crew.

Training, discipline, knowledge of alternatives and system workarounds, plenty of available medical staff of varying levels positioned strategically around the fire and multiple aerial extrication options: It was all those things plus comprehensive advanced pre-planning that helped save a life.

Orleans Complex, July 18 2025
Photo by Matt Lynde, HLCO

DISCUSSION POINT

Communication

How much are field resources including coordinating with overhead in their training, and how much discussion does overhead have with the field when planning for IWIs?

As is common in a rapidly evolving scenario, very few communications channels worked flawlessly during the IWI, underscoring issues that had been present throughout the incident. The picture that emerges is of two simultaneous incidents—one with the crews at the site of the injuries, one with the overhead near Drop Point 9.

"There was a lot of duplicate communication going on," remembers one responder. TAC channels, Command, Air to Ground TAC—all were being used simultaneously. Texts and calls (via Starlink) were all being used to confirm information overheard on the radio. Sometimes information was being shared from the ground on Air to Ground TAC straight to Dispatch. However, sometimes pertinent information went through Division over Command to the ICP. As a result, two different IWI ICs identified themselves, and the short haul ship got ordered three different times. The whereabouts of the third injured person also caused concern-- even at the hospital there was expectation that another patient was incoming.

While it all worked in the end, how can we do better?

"It was more like an MCI."
-IWI Responder

DISCUSSION POINT

ALS and Medical Assets on the Fireline

In this incident, Firefighter Three was aided by at least nine medical responders even before extrication, and many of those were members of his own or other IHCs. Most crews have at least one qualified EMT, but do you have Advanced EMTs, or even paramedics on your crew? The specialized knowledge from those folks went a long way to stabilize the patient, and possibly saved his life.

How does your team support EMT training and skills practice, including advanced skills? Many options for this exist—have you explored any?

In addition, a consideration for IMTs: On the IMT that was assigned to this incident, the Medical Unit is treated as a section under ICS. In this arrangement, a MEDL supervises multiple Planning and Field MEDLs. From the MEDLs perspective, the role of the Field MEDL was crucial in this scenario. The presence each day of a MEDL out on the divisions allowed adjustments of medical coverage on the fly, which was key. The Planning MEDL can adjust 204s and 206s as needed, while the lead MEDL can be focused on IC briefings, and communication with other medical resources, allowing for prompt requests for air and ground needs during an IWI or injury. The MEDL briefs crews daily on which medical assets are assigned to their divisions, allowing quick reference rather than requiring a daily to comb through a lists on the 206 while they're under stress.