



Event Type: Response to Helicopter Crash

Date: August 7, 2026

Location: Widemouth 2 Fire, Utah

The Story and Lessons from this Entrapment Incident During an Attempt to Access a Helicopter Crash Site

Introduction

This Rapid Lesson Sharing (RLS) report describes the events surrounding the attempted rescue operation following the fatal helicopter crash on the Widemouth 2 Fire in Utah. It does not address the crash itself.

We extend our condolences for the loss of helicopter pilots Chris Anderson and Miles Elliot to their families, friends, coworkers, and the entire wildland fire community.

Four in a Meadow

Four firefighters were in a meadow awaiting helicopter extraction with a large “solid wall” of fire rapidly approaching.

The operational events that are described and documented in the RLS occurred during an approximate two-hour time span.

How Did They get There?

Like most things in wildland fire, they got there by decisions made with the best of intentions, decades of experience, and a passionate desire to help—followed by changing conditions, earlier-than-normal very active fire behavior, a new fire start from the helicopter crash, as well as a series of unplanned events.

All of these events led to these four firefighters being located in this meadow, waiting for that helicopter extraction—with fire rapidly approaching.

The Morning of August 7th

The assignment this day for the Division’s resources was to begin prepping Road 106 for a potential burn out operation to keep the fire west of the road. That morning, the main fire was paralleling the road approximately one-quarter mile away. While fire activity was somewhat moderate, it began to increase as temperatures rose and the west-northwest winds set in.

A Type 2 Initial Attack (IA) “Regulars” Crew, assembled from five fire protection districts, was assigned to this Division. This crew got an early start working on the fireline that day. After being on this fire for more than one week, their Crew Boss Trainee (CRWB (t)) believed that the Division was finally “*getting into a rhythm.*” He also noted that for several shifts, they had been the only crew on the Division—and, every day, they were getting pushed back by the fire.

The Division Supervisor Trainee (DIVS (t)), located at a nearby Drop Point (DP94), requested a Type 1 helicopter (Helicopter 1) to “slow spread” of the fire along the fire’s edge to provide additional time for the road prep and the anticipated firing operation.

Helicopter 1 had been working for approximately 30 minutes when the DIVS (t) requested, through Air Attack, a second Type 1 helicopter to continue support while Helicopter 1 went to refuel.

This second helicopter order was filled by Helicopter 2 which arrived on scene from the northwest as the DIVS (t) began lining them out on targets and overall objectives.

Helicopter 2 acknowledged and said he would swing around for another pass to make the drop. Just out of sight and behind a knoll west of DP94, over the radio (A/G Primary), Helicopter 2 transmitted that he had a problem, followed by a second transmission: “*Mayday-Mayday-Mayday.*”

Crash Notification and Initial Actions

DIVS (t) and Operations Branch Director (OPBD) were located at DP94 when this accident happened. The DIVS (t) overheard the “*Mayday*” transmission and quickly informed OPBD—who was briefing other resources—saying: “*We just had a ship go down.*” They contacted Air Attack and requested they fly over the area to confirm what had happened.

Very quickly, Air Attack located the crash site and transmitted an estimated GPS location from the air that placed Helicopter 2 in the Birch Creek drainage area. Air Attack also reported that the crash had started a new fire. The crash of Helicopter 2 was reported from Air Attack to Dispatch at 1044 hours.

OPBD, who became the Incident Within an Incident (IWI) Commander, began working through Air Attack to order additional helicopters: an air ambulance, a recon ship, and an additional Type 1 helicopter to suppress the new fire at the crash site.

This sequence of resource requests then occurred:

- ❖ A Type 3 helicopter with medical personnel was requested through Helibase at 1045 hours.
- ❖ An air ambulance was requested through Dispatch at 1047 hours.
- ❖ A Type 1 helicopter for buckets was requested through Helibase at approximately 1050 hours.
- ❖ Relief Air Attack was ordered at 1054 hours.
- ❖ The Helibase Manager asked Air Attack to report the incident over Command at approximately 1055.
- ❖ Widemouth 2 Communications was notified of the incident over Command via Helibase at 1100 hours.
- ❖ The Type 3 Helicopter (8BH) was enroute from Helibase at 1102 hours.

The IWI Commander directed ground resources, including the Type 2IA crew, two Fireline Emergency Medical Technicians (EMTF), one Fireline Paramedic (EMPF), and the Heavy Equipment Boss (HEQB), to gain access to the crash site.

The HEQB, who had a three-passenger UTV, had scouted this area for potential dozer line the previous day. The HEQB was directed to scout Birch Creek via a small trail that was indicated on the incident map. Even though the HEQB soon discovered this trail was nonexistent, he continued through thick brush and rocky terrain—heading toward the black smoke column rising up from the helicopter crash site.

Type 2IA Crew Personnel Combined into Two Squads

The Type 2IA crew’s four squads were combined into two squads, Alpha and Bravo, who were assigned two primary missions. The configurations and routes of the two squads are shown in Figure 1 on the next page.

Alpha Squad, with 14 personnel, were assigned to rapid access and clear a path for a potential personnel line (P-line) to aid in extinguishing fire around the crash site—if they could reach it.

Bravo Squad, the smaller group, responded with their six-passenger UTV, consisting of: CRWB (t); two crew members; and three medical personnel (an EMPF and two EMTFs); along with a Stokes stretcher, chainsaws, and other equipment. They were to follow the route that the HEQB had taken. However, they could not see a trail or UTV tracks. They did not make it far (see Figure 1 below) before the untraversable trail and terrain stopped them.

At this time, the HEQB was asked to come back to pick up the three medical personnel with the smaller UTV. Upon the HEQB's return, the three medical personnel transferred to the three-passenger UTV—three seated across the front and one hanging off the back.

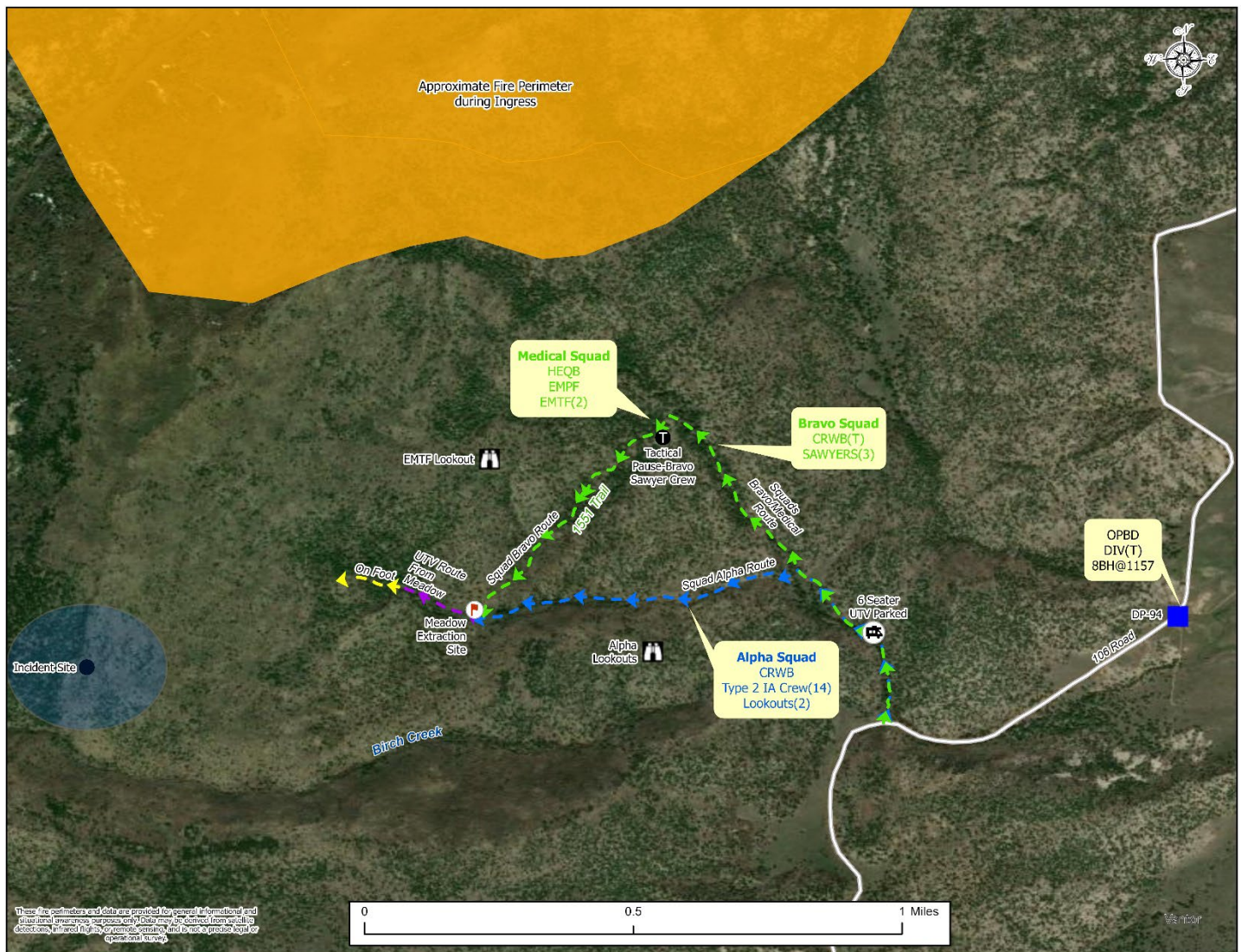


Figure 1. The paths of the two squads as they attempted to gain access to the helicopter crash site.

The crew's six-passenger UTV was left behind near Road 106. The CRWB(t) and three crew members now followed on foot, carrying medical gear, including the Stokes stretcher.

The ride on the small UTV was difficult, with passengers exiting the vehicle and attempting to shift its balance as they slowly navigated challenging terrain—crashing through brush and over rocks.

After reaching a high point en route, the HEQB—noticing that the main fire was increasing in activity—asked if any of the medical personnel had enough fire experience to serve as a Lookout. One of them said “Yes” they would be comfortable doing this—and was dropped off. (The HEQB would later reflect: “I should have given him more direction on when the fire came over the ridge to call out.”)

This EMTF proceeded on foot to a high point to the north, closer to the main fire. The HEQB, EMPF, and other EMTF began heading southwest on the “non-existent” trail.

As they continued, they saw personnel on a ridge above them to the south. Not knowing who they were, they assumed that these personnel were Lookouts. Soon after they saw a previously unknown open meadow and other members of the Type 2IA crew. Resources at this meadow explained that the GPS coordinates from Air Attack put the crash site substantially closer to the meadow than where the crashed helicopter was actually located.

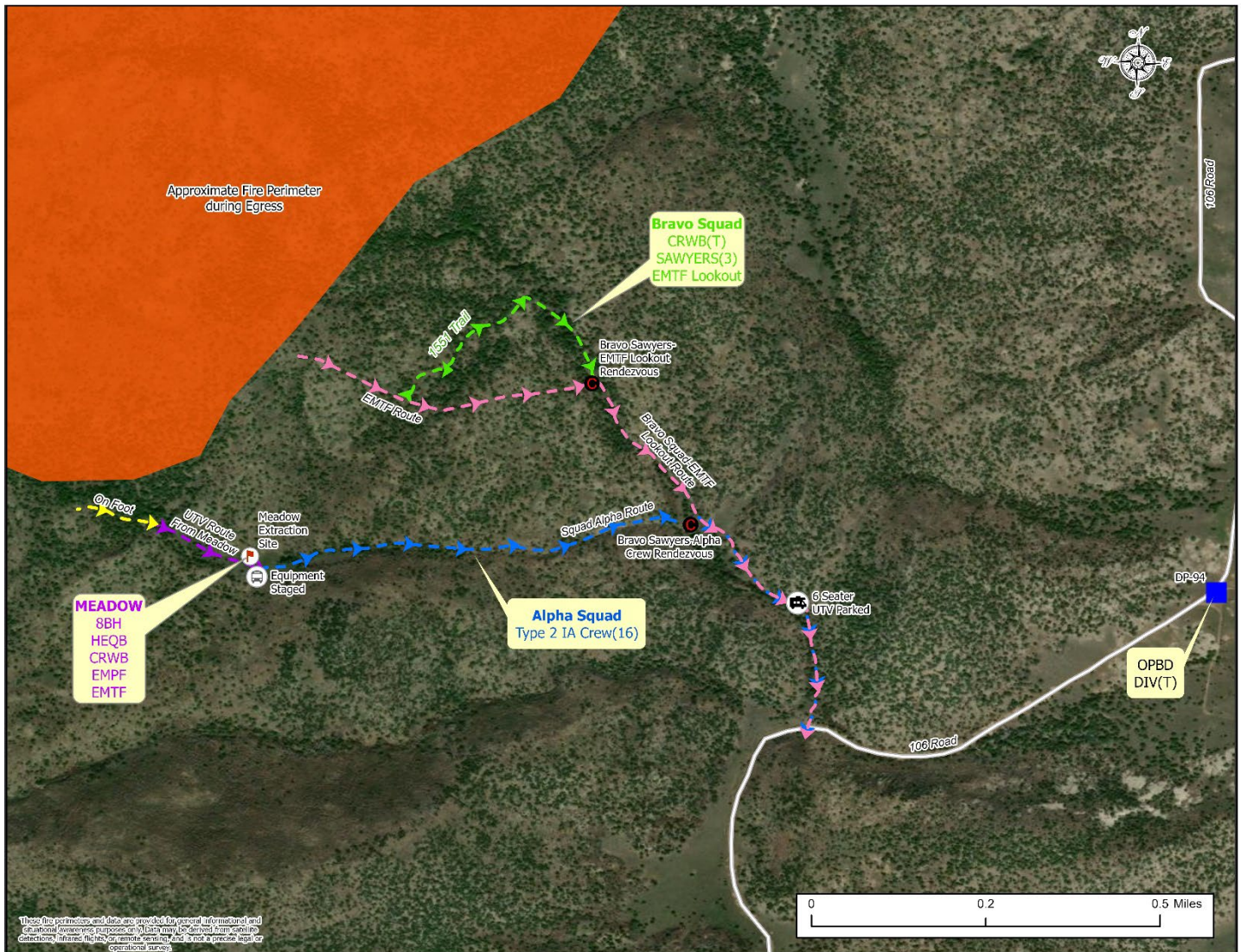


Figure 2. The escape routes from the advancing Widemouth 2 Fire, depicting the egress routes of the EMTF Lookout and sawyers, Alpha Squad, as well as the meadow site.

All Personnel Trying to Access the Crash Site Directed to Disengage

A decision by the HEQB and EMPF was made to continue beyond the meadow in the UTV, utilizing the crew resources at the meadow to help create better access through the dense brush toward the crash site. Shortly after, the HEQB with medical personnel in the UTV came upon rocky terrain that was impassable. Additionally, they discovered that some of the medical equipment and one of the EMTF's pack and fire shelter were missing. At this point, the HEQB directed the EMTF to return to the meadow and tie-in with most of the Type 2IA crew. Reference Figure 2, above, to track the movements of the personnel in their egress from the advancing fire.

Meanwhile, the EMTF, who was acting as the north Lookout, was making rapid egress, running—due to the approaching flame front—from that location in a beeline southeast until eventually joining members of the Type 2IA crew and followed them out.

The HEQB and EMPF continued for a short distance until, at 1149 hours, the IWI Commander—due to a low probability of survival of Helicopter 2's air crew—directed all personnel trying to access the crash to disengage.

Next, they started to make their way back to the meadow.

The Crew Boss (CRWB) ordered the crew to begin making their way back to DP94 from the meadow. He then began discussing with the HEQB what to do with equipment. At this time, the CRWB was informed of the missing fire shelter, to which the CRWB replied: *"That changes things."*

A discussion of options then began. **Option A:** Everyone walk out, including the EMTF without their shelter. **Option B:** Call for a helicopter extraction. **Option C:** Prep for fire shelter deployment with the CRWB and EMTF doubling up in one shelter.

A call was made to IWI Commander to see if helicopter extraction was an option. There was some delay in getting an answer, during which the CRWB asserted that: *"We could walk out—but we need to leave now."* The HEQB was just as convinced that: *"We can't make it."*

Preparing for a Potential Burn Over

The CRWB and HEQB began moving equipment—relocating the UTV, fuel and gear for a potential burn over. (The DIVS (t) would later inform that during this time and throughout the IWI, radio traffic on Command, A/G, and Tac was difficult due to so much radio communication. It was difficult to get a full understanding of the situation and the location of ground personnel in relation to the main fire front, as well as the crash-site's fire spread.)

Eventually, they made contact with the IWI IC. He informed that the helicopter would arrive in four to five minutes. However, the EMTF erroneously heard: *"45 minutes."* During this call, the group in the meadow also passed along their combined flight weight. The helicopter could take 1,100 pounds. The four personnel were well within that allowable weight. Therefore, the expectation was that all four would be picked up in a single load.

When the helicopter landed, the Helicopter Manager (HMGB) jumped out and signaled "2 only." This was decided after the pilot did power checks at this location. The Medic and the EMTF were directed to get on.

After 8BH departed, the remaining two worked on staging the UTV, chainsaws, and other equipment throughout the meadow to limit damage from the main fire.

While waiting for the helicopter, the CRWB left what he thought might be his final message to his wife on a voice memo. He would later explain: *"I kept it as calm as I could—didn't want to scare her."* In addition, after this incident, the Crew Boss informed that he would later receive a message from her saying: *"Love you, too."* *"I must have done a good job staying calm,"* reflected the Crew Boss, *"don't know how."*

8BH remained at full power at DP94 and quickly returned for the remaining two individuals in the meadow. Figure 3, above, was captured during this last flight out of the meadow. (A helicopter "hot landing" is a maneuver in which the



Figure 3. Last flight out of the meadow during helicopter extraction.



main rotor's RPMs remained at high operational speed to ensure that when everyone is secure there is a shorter "run up" to take off.)

The helicopter pilot noted that *"while the fire was close and moving fast, I was more concerned about getting smoked out."* As they began to return to DP94, the CRWB asked for an "overflight" (a reconnaissance mission) to ensure that his crew were all making their way out safely. As they flew over, he noted that: *"They were all out."*

The IWI Commander called comms to inform that: all personnel were back to their trucks headed to DP99; Deputy Ops and sheriff remained on scene; and Helicopter 8BH left DP94.

At 1244 hours, the OPBD/IWI Commander called Incident Communications announcing that all IWI resources were out of the area and accounted for.

Final Note

As seen in the photo above, the UTV was basically undamaged after the fire passed through the meadow—with only minor plastic deformation.

With the benefit of hindsight, we know that all three potential plans—hiking out, sheltering in place in the meadow, and helicopter extraction—were viable.

Photos of the aftermath of the fire passing the meadow area indicates it was likely a survivable site, although fire shelters may have been necessary. The Risk Management process used by decisionmakers during this incident produced a good outcome, with no injuries and only minor equipment damage.

Lessons

Lessons Learned by this Incident's Participants

1. "There is very rarely any pre-season simulations or training for our firefighting resource 'responders' to respond to an aviation mishap. We would encourage this to be a part of foundational knowledge as a responder." **CIMT IC**
2. "Leaders have to take tactical pauses, relax, breathe deep, roll your shoulders. This helps to maintain a calm command presence—and that is critical!" **OPBD**
3. "Bring in senior leaders to handle other Branch duties—triage, prioritize and delegating responsibilities. And be prepared to implement alternatives and contingency actions to ensure command and control of the Incident Within an Incident and fire operations." **OPBD**
4. "Develop and practice active listening. Listening to understand—not respond." **OPBD**
5. "Remember: We only risk a lot, to save a lot." **EMPF**
6. "Briefing needs to include radio frequency assignments." **EMPF**
7. "Do an AAR immediately." **Crew Boss Trainee**
8. "**CISM** can't wait 72 hours. It needs to be within 24 hours. I believe this well-done CISM was the reason the crew went back on the line instead of demobbing." **Crew Boss Trainee**

9. “Recognize that people’s ‘lizard brain’ responds differently to adrenaline. Mine slows down. Others’ runs hot. Help each other find that balance that the situation calls for.” **Crew Boss Trainee**
10. “Everybody wants to help—pump the brakes—make a plan—don’t make it worse. Treat IWI’s like you would an initial attack on a fire.” **Helicopter Manager**
11. “Careful comms is critical. The flight info was transmitted as ‘4 to 5’ minutes—heard by one person as ‘45’ minutes, causing unneeded stress. Keep it simple.” **Crew Boss**

A common theme that was reflected by various personnel involved in this incident:

*“The more inexperienced people are, and the more unfamiliar the mission is—
the more detailed the briefing needs to be.”*

The RLS Team’s Points to Consider Summary – Based on the IWI Participants’ Comments and Reflections

Determining Rescue or Recovery

Making the determination of survivability in incidents like this should be “the first priority.” This determination is the crucial component for designing the appropriate response plan and the subsequent risk management process.

Communication Challenges Require a Clear Comm Plan with Redundancy and Strict Comm Discipline

Radio traffic on Command, Air-to-Ground, and Tactical channels became congested during this Incident Within an Incident. This made it difficult for supervisors and responders to understand locations, fire spread, and resource status. Clear communication plans, disciplined radio use, and established contingencies are essential during rapidly-evolving IWIs.

Terrain Assessment Must Be Realistic and Continuous

The Heavy Equipment Boss attempted to access the helicopter crash site along a mapped trail—later found to be nonexistent. Responders encountered steep, brushy, rocky terrain unsuitable for UTV travel or rapid movement. Continual reassessment of terrain, mobility, and route viability is essential to prevent responders from becoming trapped or overextended.

Equipment Accountability Matters Under Stress

Loss of critical gear—including a firefighter’s pack and fire shelter—significantly influenced decisions about whether personnel should attempt to walk out or shelter in place. Regular accountability checks—especially during rapid movements—can prevent critical gaps that alter risk calculations.

Lookouts Need Clear Guidance and Triggers

A Medic serving as an ad hoc Lookout placed in a high-fire activity area was not provided explicit instructions on what indicators should trigger warnings or evacuation. Lookouts, regardless of background, must receive clear direction on expected fire behavior cues and communication expectations.

Rapid Fire Growth Requires Conservative Decision Making

Responders made access attempts to the helicopter crash site as fire activity increased around them. This led to a situation in which four individuals became trapped in a meadow with fire approaching. Conservative triggers for disengagement and cautious assessment of changing conditions help prevent responders from becoming isolated or endangered.

Helicopter Extraction Plans Must Be Explicit and Understood

Miscommunication about extraction timing (hearing “4-5 minutes” on the radio as “45 minutes”) created additional stress for personnel facing entrapment.

Human Factors Have a Major Role in IWI Decision Making

On this IWI, stress, fear, and emotional overload influenced perception and decision making—particularly for personnel who had already struggled with not reaching the pilots and then faced a potential burn over without a fire shelter. Leadership actions such as calm reassurance, clarifying options, and situational grounding proved critical for maintaining functional decision making under pressure.

IMT Support and Aftercare are Vital

Responders consistently reported that IMT support during and after the IWI was practical, consistent, and humane. This support helped personnel process difficult decisions made under extreme conditions. IWIs could benefit from including responder care as a central component of incident management.

Closing from the RLS Team

The RLS Team extends a thank you to everyone who so openly shared their actions during this incident.

The Incident Management Team’s support for those involved—both during the IWI and in the days that followed—was consistent, practical, and humane. That support mattered.

We also want to recognize the ground resources who tried to reach the crash site. They moved through steep, brushy, rocky ground with no real trail, under rising fire activity, carrying medical gear and trying to create access for others. Their decisions were driven by a clear desire to help the two helicopter pilots. When conditions made further progress unsafe, they withdrew as directed, accounted for their people, and got everyone out.

That combination—IMT support for those involved and the determination of the responders who attempted access—was confirmed again and again in the RLS Team interviews.

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