Rapid Lesson Sharing

Event Type: Medical Extraction Incident

Date: July 29-30, 2025

Location: Nebo Fire; Eagle Cap Wilderness; Wallowa-Whitman National Forest; Oregon

The Story, Lessons, and Insights from Those Involved in this Challenging Injured Firefighter Extraction Incident

"On a personal note, not being able to get the patient off the hill, being told 'No' over and over again, I have never felt so impotent. The folks we put in harm's way on these fires rely on us to be able to get them should things go wrong. In this case—although not our fault—I feel like we broke that trust."

Initial Attack Floor Lead
Blue Mountain Interagency Dispatch Center

Background

The lightning-ignited Nebo Fire was detected at 1207 hours on July 29 by a recon plane.

This fire was located on the southeast corner of the Eagle Cap Wilderness on the southeast edge of the Wallowa-Whitman National Forest. This area is close to the Snake River which is the boundary between the U.S. Forest Service Region 6 and Region 4—and close to the McCall Smokejumper Base on the Payette National Forest.

McCall Smokejumpers were ordered at 1230 hours. Jumper 41, a McCall Smokejumpers jump ship, was over the fire and providing a size up at 1310 hours.

At 1411 hours, eight smokejumpers and cargo were on the ground.

At 1912 hours, the Jumper in Charge (JIC) called in an update to the Blue Mountain Interagency Dispatch Center (BMIDC) informing that the saw line was complete around the 0.75-acre fire and that they were securing the incident. The fire's elevation was 6,890 feet, burning in "grass, timber, and alpine fir."

Resources on scene were going to continue to work on the incident until 2100 hours before heading to their campsite, located below the fire.

The Story

At 1945 hours, one of the jumpers was struck by a tree that hit him in the face, head and neck, knocking him onto the ground—where he then hit his head again.

A few minutes later, this tree strike incident was reported to the Blue Mountain Interagency Dispatch Center, at approximately one hour before darkness. There wasn't enough time to perform the extraction mission of having local aviation resources get the jumper off the fire to definitive care.

Upon notification of the incident from the Initial Attack Floor Lead, the Forest Duty Officer notified the Forest Supervisor—following the Forest's Incident Within an Incident (IWI) protocol.

At that time, the Deputy Fire Staff Officer said he would come into the Blue Mountain Interagency Dispatch Center (located in La Grande, Oregon). The Dispatch Center Manager also informed that he would come in.

A 'Red' Medical Incident

At 1951 hours, the IWI was called into Dispatch by the fire's Incident Commander (Jumper in Charge) as a "Red" Medical. (A "Red" priority, the highest urgency level on a Medical Incident Report [MRI], means a life- or limb-threatening injury or illness requiring immediate evacuation.) Dispatch then went through the IWI protocol and notifications in support of the Incident Commander (who also became the IWI Incident Commander) on the ground.

The only standard category helicopter that was available in nearby La Grande had gone out of service at 1900 hours. The Helibase Manager for the Grande Ronde Rappel Base confirmed that the pilot for the standard category helicopter was not available.

All Aviation Requests are Declined

Following the established emergency request protocols, many other aviation requests were made to remove the injured firefighter from the fire ground before dark. These aviation requests were made to: the air ambulance service Life Flight; a U.S. Forest Service short-haul helicopter from McCall, Idaho; the privately operated Two Bear Air Rescue from Kalispell, Montana; and various military resources.

All declined this mission either due to remaining daylight hours or the weather conditions at the time.

This information was relayed to the IC and, also, to use "VMED 29" for the Air-to-Ground communication. (Oregon, Washington, and Idaho use this VHF radio frequency as a shared regional channel for emergency medical services and air ambulance coordination.)

The IC made it clear not to send ground crews for the extraction as it could lead to an additional medical emergency.

Injured Jumper to Remain on Incident Site Until the Next Morning

After dark, the requests went into the Geographic Area Coordination Center (GACC) to obtain a hoist ship carded for night flying in both Oregon and Idaho. All of these attempts ultimately failed. The injured jumper, therefore, had to remain on the incident until the following morning.

At approximately 2144 hours, after these various aviation resources had declined to respond, the IC requested that the Forest Service short-haul helicopter would be the primary extraction for the patient the next morning. Notifications were made from BMIDC to the Payette Dispatch Center in McCall.

In the early morning after daylight, N38HX, an exclusive use contract helicopter from the Payette National Forest with short-haul capabilities lifted from McCall at approximately 0455 hours MDT enroute to the incident.

This ship was able to land nearby and, at approximately 0615 PDT, lifted off with the patient enroute to a hospital in Enterprise, Oregon, arriving there at 0624 hours.

The patient was then transferred to a Life Flight helicopter from Lewiston, Idaho, and transported to the St. Joseph Regional Medical Center in Lewiston. The patient was treated for head and neck injuries and later released back to their home unit.

The Nebo Fire was contained at approximately 1200 hours on July 30.

Lessons

Lessons for Duty Officers and Agency Administrators

- If an incident occurs or is reported later in the day with daylight diminishing, consider if there is truly a need to staff an incident in the wilderness or backcountry with little to no Values at Risk—or can the incident be staffed in the morning? Understanding that this is contradictory to current national direction of aggressive initial attack, obtaining Forest and Regional support to delay the response due to safety and risk factors would be a consideration.
- If it is determined that there is a need to staff an incident with aerial-delivered firefighters, consider not staffing within an hour or so of "civil twilight." This precaution—due to the limited time before dark—is especially relevant for extracting aerial-delivered firefighters should a medical incident occur. Furthermore, due to their insertion method on an incident, this is particularly applicable for smokejumpers.
- Once wildland firefighters are engaged on an incident—mostly in the wilderness or backcountry, but this could also apply to other locations—consider having these resources disengage from suppression actions and remain in their "campsite" until daylight, the following shift. This same rationale applies should a medical incident occur.
- To aid in rapid extraction if a medical IWI occurs, consider an extension of the daily availability period of local or adjacent aircraft when you have resources on incidents in the wilderness or backcountry.

Insights and Lessons from this Incident's Participants

The Aviation Coordinator/Dispatcher at the Blue Mountain Interagency Dispatch Center

What do you now know that you wish you'd known before this tree strike extraction incident?

I always assumed that the National Guard, the U.S. Navy, etc., would respond when asked (assuming all other options had been exhausted). And they did not. I never realized we would get into a situation where no aviation resources would respond.

Therefore, always consider ground evacuation as a contingency.

What would you share with others who could be in a similar situation?

From the Aircraft Dispatcher perspective, for these remote fires it makes sense to keep standard category helicopters—if available—in service until as late in the day as possible. I don't know if this incident's outcome would have been different. But, for future reference, this is important to note.

What were some successes and challenges?

Successes include the Interagency Incident Emergency Plan that Blue Mountain Interagency Dispatch Center (BMIDC) utilizes for incidents such as this worked as intended. Communication with Payette Dispatch (that hosts the helicopter that completed the extraction) was excellent.

BMIDC Dispatch to the Forest Duty Officer communication was also excellent. There was, however, a delay in direct communication with the District Duty Officer due to limited radio communication and a satellite phone was used to contact BMIDC. There was no delay in getting permission from the Duty Officer or Agency Administrator or making notifications to request various aviation assets.

The two major factors that impacted the aviation response on this incident were the challenges presented by the weather—and limited daylight.

Multiple thunderstorms were occurring in the incident's area and across the northwest which inhibited the travel from Boise, Salem, and Missoula where Life Flight, military, and private hoist capable and night-time-flying-equipped aircraft are stationed.

What actions can be taken moving forward?

Continue to emphasize to medical Incident Commanders that aviation may not be able to respond. Ground evacuation should always be considered. However, due to the remoteness of this incident, the helicopter the next morning may still have been the closest resource.

Is there anything else you would like to add?

This incident was especially challenging for various reasons. Weather, time of day, and remoteness were all major factors. When engaging a fire, firefighters should always consider these factors.

Agency aviation resources rely on weather reports from the Incident Commanders. Weather reports from aerial-delivered firefighters are considered some of the most trustworthy. This is rightfully due to their knowledge and their training of the weather influence on wildfire behavior and how agency aviation resources can mitigate weather hazards.

The IC reported to BMIDC that the weather was suitable for aviation over the incident. Non-agency aviation resources do not rely on weather reports from Incident Commanders. The Life Flight Dispatcher told me that the incident was on the edge of a Convective SIGMET (an hourly aviation weather advisory issued for severe and hazardous thunderstorm activity that poses a threat to all aircraft) and that is why they would not be able to respond to this incident.

The Wallowa-Whitman National Forest Fire Staff Officer

What do you now know that you wish you'd known before this tree strike extraction incident?

More thorough knowledge of the process and the timeframes needed to request nighttime aviation missions through the Air Force Rescue Coordination Center (AFRCC).

What would you share with others who could be in a similar situation?

Don't count on air ambulance aircraft—specifically, in this incident, Life Flight—to retrieve an injured firefighter after dark.

What were some successes and challenges?

Some of these successes were the information process and phone tree notifications set up by the Regional Risk Manager. There was an excellent flow of information in a timely manner between both regions—Region 6, with the Wallowa-Whitman National Forest, and Region 4, with the Payette National Forest—and the affected Line Officers from the Wallowa-Whitman where the incident occurred and the Payette where the injured employee was from.

The IWI and aviation request process followed by the Dispatchers at the Blue Mountain Interagency Dispatch Center was predominantly flawless. However, they were still not able to obtain an aircraft. This underscores one of the challenges that was daylighted during this incident.

The high reliance on Life Flight—as well as all air ambulances with nighttime flying capabilities—after the federally-procured aircraft go off shift for the evening is obvious. The next level of request goes to AFRCC to obtain

a military aircraft capable of night operations. Ultimately, after several hours, this led to an answer of: *"Not accepting the mission."*

The weather was certainly a challenge as both Life Flight and the military aircraft pilots turned down the mission several times throughout the course of this incident. The timeframes (have to wait 45 minutes) for continuing to request Life Flight (after original "No" answer) once the weather had changed within the vicinity of the incident led to those requests being well after dark—but again, ultimately, ended in a "No" answer.

If the patient was not stable and able to remain on the incident overnight, the inability to obtain nighttime-flying-capable aircraft could have led to further complications for the patient and/or their potential death.

This is an obvious issue on more than a local scale when firefighters are engaging fires after dark. I think we have a good process in place locally, regionally, and nationally during daytime hours—whether on incidents managed by teams or the local unit—to retrieve injured firefighters off of incidents.

What we continue to lack is a solid process regarding the ability to obtain aircraft after dark to get our injured firefighter to the next level of care.

What actions can be taken moving forward?

Going forward, some actions that have been talked about would be to ensure better local and regional understanding of the request process for military aircraft. In addition, continuing to understand the true limitations of air ambulances in wilderness or backcountry landing situations—regardless of the time of day, but especially at night.

Establish a local policy that, unless absolutely needed, stops the forward progress of an incident in the backcountry or wilderness situations and have on-the-ground operations cease after dark. These resources will be in their designated camping spot for the night with the understanding that if something were to happen while on the fire ground after dark, we lack the ability to be able to remove them from the incident and get them to definitive care in a timely manner.

Understand this will not be able to happen on every incident. Even so, it needs to be a consideration for local Duty Officers and Line Officers.

The delivery of smokejumpers within a certain timeframe of darkness should likely be avoided by the local unit as there is a higher occurrence of injury during jump operations. And, also, recognize the inability to remove an injured jumper within a couple hours of civil twilight or darkness.

Duty Officers should consider waiting until the following operational period to deliver aerial-delivered firefighters, specifically smokejumpers, to an incident. Furthermore, it may be the correct course of action to have other aerial-delivered resources—such as rappelers—engage that incident.

Is there anything else you would like to add?

There was acknowledgement by the management group (Forest and Regional Line Officers and Staff/Duty Officers) on the phone calls that we (Forest and Regional Line officers, Fire Staff officers, supervisors, and safety and risk personnel from both R6 and R4) had immediately following this incident, that they were truly unaware of our inability to remove an injured firefighter after dark.

That was reinforced on this incident after going through two different state request processes as well as federal and private aircraft—and we still couldn't get it done.

It is important to recognize that, in this incident, if the injured firefighter had not been stable and able to remain on-site overnight, their injury status/situation could have turned out a whole lot worse.

The Initial Attack Floor Lead at the Blue Mountain Interagency Dispatch Center

What do you now know that you wish you'd known before this tree-strike extraction incident?

Going into this I had always believed if everything else fails the military ship would still go. It may take longer, but they would still take the mission. That is not the case

What would you share with others who could be in a similar situation?

Even doing everything right (having multiple contingency plans following procedures in a timely manner) you can still have a medical emergency situation that you cannot do anything about.

What were some successes and challenges?

We (BMIDC dispatchers and managers) worked extremely well as a team. Everyone involved on our end had drilled on medical scenarios and were instantly able to come together and get things done

One of the challenges was that radio comms were very poor so this medical incident was entirely through Sat Phone. While this worked well, it did cause the Dispatcher to have to relay everything twice

What actions can be taken moving forward?

Improve our radio coverage on the fire's radio coverage. This is a tough one. We could have maybe used a Region 4 repeater to enhance radio coverage. This incident was located in sort of a dead spot for the Wallowa-Whitman National Forest's radio coverage. We need to look for other ways to relay the actual weather over the incident.

Is there anything else you would like to add?

If you had come to me and told me that this is going to happen and to pick the team I wanted, who I had that night is exactly who I would have chosen—including our usual night Dispatcher being unable to come in and our former Assistant Dispatch Center Manager coming in for night shift. After his recent retirement, he returned as an AD for Night Dispatcher. He therefore knew the area and the players much more so than a "temporary" Night Dispatcher's knowledge base would have possessed.

On a personal note, not being able to get the patient off the hill, being told "No" over and over again, I have never felt so impotent. The folks we put in harm's way on these fires rely on us to be able to get them if things go wrong. In this case—although not our fault—I feel like we broke that trust.

This RLS was submitted by:

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