Incident Summary: On June 12th, 2008, Andy Palmer graduates from high school. He completes Basic Firefighter training June 24th and Wildland Fire Chain Saw training (S-212) June 28th. He is hired as a seasonal firefighter on an engine crew June 29th and completes his A Faller taskbook on July 4th. July 22, 2008, the engine receives a resource order for the Iron Complex, California. The supervision at the park are motivated to see the engine crew obtain an assignment and call the crew in on their day off. The crew suffers a series of complications enroute to the fire including mechanical problems with the engine that lead to the eventual separation of the crew and engine captain after arriving at the incident. The remaining crew members are encouraged to pursue a line assignment as a falling team. The IMT personnel assign the crew as a falling module. During that assignment the crew cuts a tree that is outside their falling qualifications. A class C ponderosa pine is cut, falling downslope into a fire-damaged sugar pine. A portion of the sugar pine breaks off and falls upslope, hitting firefighter Andy Palmer, resulting in multiple severe injuries...and the loss of a firefighters' life. It was Andy’s first fire assignment.


The local Sheriff’s office receives a call from incident command and begins inquiring for a helicopter. Two air medical services decline the mission due to poor visibility from smoke. California Highway Patrol’s helicopter was not available and the US Coast Guard (USCG) had not yet been contacted.

Other firefighters arrive on scene. Nomex shirts are used as pressure bandages on shoulder and leg injuries. The injured firefighter is reported as having severe bleeding and being conscious. The severity of the injuries and the sense of urgency are not communicated to paramedics dispatched in an ambulance to the incident.

As the medics arrive on scene they realize the injuries are much more serious than they had been told and decide to facilitate a rapid evacuation via carryout.

Fifty-five minutes since the accident. The patient is prepared to move and the decision is made to go to the ambulance rather than waiting for the helicopter. The ambulance is approximately 2000 ft down the dozer line.

One hour and 25 minutes since the accident. A third paramedic has arrived on scene and the decision is made to wait for the helicopter. Firefighters start clearing a zone for hoist extraction.

One hour and 50 minutes since the accident. Multiple delays of the USCG helicopter are caused due to poor communications of patient status, potential use of a Forest Service helicopter assigned to the fire, and method of extraction. Once the USCG is enroute, communication about the new extraction location, radio frequencies and patient status is an issue and slows the extrication efforts. While being transferred to the hoist basket, personnel on the ground report profuse bleeding. No patient care can be given while being hoisted.

Two hours and 47 minutes since the accident. During the flight, cardiac arrest treatment protocol is initiated and the helicopter lands at Redding Municipal Airport with CPR in progress.

Three hours and 26 minutes since the accident. An ER Physician pronounced time of death, via radio. The Coroner later determined that Andy Palmer’s death was caused by excessive blood loss.

Lessons Learned Discussion Points
- Identify and discuss a variety of options for medical evacuation (ATV, wheeled litter, etc.) anticipating that a helicopter will not be available.
- If the crewmember sitting beside you were to be seriously injured on the fireline, what would you and your crew do? How thorough is your unit or IMT’s Incident Emergency Plan? Consider doing a mock-up medical evacuation from start to finish. Utilize the new Medical Incident Report in your IRPG to effectively communicate emergency information. Use this 6MFS to learn how to use the MIR. Assess the drill with an AAR.
- Read page 2 in your IRPG.