



NAVAL SAFETY COMMAND

SAFETY AWARENESS DISPATCH



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Casualty Evacuation Failures

Operational planning aims to fix the problems “left of the bang” (before a casualty happens). As part of that planning, the goal is to eliminate or mitigate hazards to prevent mishaps. With the focus left of the bang, though, we don’t always dedicate the necessary thought toward what happens “right of the bang” (when a casualty happens). Some of us will inevitably have to deal with a situation right of the bang at some point.

Military operations and training come with inherent risks that can never be eliminated. We train with deadly weapons, in combat vehicles, aircraft and in austere environments. This training is challenging and dangerous and must be that way to increase our lethality. Statistics prove, though, that under these conditions, some of our units will encounter a mishap and some will be severe. It is vital, then, that in addition to the effort we put into mitigating the risk left of the bang, we must also dedicate the time and resources needed for effective mishap action and Casualty Evacuation (CasEvac) plans. There are incidents where these plans fell well short of the bar and our Marines and Sailors paid the price. Have a read and see how not having a solid plan or not knowing it can make a bad situation even worse. A good news story at the end shows what happens when we get it right.



- A decent plan, but poorly executed. A recruiting company at a Marine Corps boot camp was conducting a six-kilometer night hike when one of the recruits fell back and passed out. The Range Safety Officer (RSO), company commander, and two hospital corpsmen immediately began treatment, determining the recruit had a core temperature of more than 102 degrees. The recruit depot had a well-established emergency plan for heat cases, which called for the RSO to contact range control and coordinate a CasEvac using one of the predesignated ambulance Pickup Points (PUP). The company commander, however, decided to take control of the scene and instructed the RSO to return to the hike column, which had halted further ahead, to keep track of the rest of the unit. He didn’t realize that in sending the RSO away, he sent the radio programmed for range control away. The recruit’s condition quickly deteriorated and he stopped breathing. The corpsmen retrieved the Automatic Emergency Defibrillator (AED) and began CPR. After CPR began, the company commander started contacting range control. Without the radio, the primary reporting mechanism for an emergency, the company commander called range control via cell phone. He erroneously called the non-emergency line instead of the two published medical emergency lines. He could not correctly identify their location and gave an incorrect ambulance PUP, followed by an incorrect grid location of the mishap victim. As he tried to clarify his position and changed the PUP, emergency dispatch told him to hang up and call 911 so the dispatch could determine and relay his location using his cell phone GPS. Emergency Medical Services (EMS) eventually reached the PUP, but the company had no link-up team, and EMS could not locate the injured Marine. They had to request the unit begin honking a horn from their safety vehicles before they could finally find the scene and take custody of the recruit. The investigation determined there was more than a 12-minute delay in getting the recruit to a higher echelon of care caused by not immediately contacting range control, the confusion caused by not correctly identifying the incident location, and the hindered link-up with EMS. —*An emergency action plan is only as effective as a unit’s ability to execute it. This example validates why rehearsals are so important. The middle of a crisis is not the time to figure out there are kinks in the plan. Test everyone that may be involved in a CasEvac.*

Casualty Evacuation Failures



- Not Tracking Medical Support Assets. A ship was deployed and passed through different areas of operation. The vessel had completed night flight quarters, and as a Sailor was departing the flight deck along the 0-2 level catwalk, he fell down a ladder to the 0-1 Level, striking his head and suffering a severe skull fracture. The ship's medical officer and team provided urgent care, but the Sailor required a level-one trauma center to receive the necessary treatment. When the incident occurred, the ship did not know the location of the nearest facilities. The crew made every effort to expedite the CasEvac process, but time was lost identifying the nearest hospital and

coordinating the transfer of the Sailor to the facility. — *All other aspects of a CasEvac plan are useless if you don't know where to send a casualty. Stabilizing a patient does nothing for them if there is no follow-on care. Don't get caught off guard. Units should work with their operational commanders to update and train to their CasEvac plans for the areas they will be operating.*

- The Perfect Storm of Poor Planning and Bad Decisions. A support battalion was slated to conduct a deployment for training (DFT), during which one of their companies was to conduct small boat training with Combat Rubber Reconnaissance Craft (CRRC). This company's training plan was run by a 1st lieutenant, serving as acting company commander, who also designated himself the OIC for the CRRC training. This role is usually filled by other leadership in the company so that the company commander can monitor concurrent training. This lieutenant also designated himself as the safety medical provider for the training because he had been to Tactical Combat Casualty Care (TCCC) training. This role should have been assigned to a Navy corpsman. Still, the last-minute changes to the battalion footprint for the DFT resulted in the battalion failing to identify the lapse in safety corpsman coverage. Two days into training, two CRRCs collided, causing a Marine to bounce backward, striking his neck on the craft and fracturing a vertebra. With no corpsman in the safety boat, the Marines had to transport the injured Marine ashore before beginning assessment or treatment. When they got him to shore, a corpsman from an adjacent company rushed over to assist. He applied a rigid C-collar (something the mishap company did not bring) and began an assessment. At this point, the company commander arrived. In an everyday mishap, the training OIC would allow the safety corpsman to treat the injured while coordinating CasEvac procedures. The process typically starts by reporting the injury to range control, who will often determine the fastest CasEvac platform. However, in this situation, the lieutenant, serving as OIC and safety medical provider, forgot all his required duties. All he could focus on was getting the Marine evacuated, and he did not take a moment to think of the best way to do so. Instead, he halted the corpsman's assessment and placed the Marine (with a neck injury) back in a CRRC to transport him to a link-up point with the battalion. Rather than calling the situation into the battalion himself, again something the training OIC would typically do, he told another Marine to do it. At the same time, he led the transportation of the Marine. In the confusion, not all pertinent information was relayed to the battalion COC, so they were not fully aware of the situation and did not have anyone at the link-up point determined by the lieutenant, causing further delay in care until the lieutenant could run to the COC and fully explain the situation. They eventually coordinated a CasEvac vehicle to transport the Marine to an ambulance exchange point where civilian emergency services took over care. The investigation determined the number of times the Marine was lifted and moved may have contributed to the severity of his injuries, and the most effective means of CasEvac would have been to wait for an air evacuation, which would have been coordinated by range control, had they been notified. — *One of the most essential parts of a CasEvac plan is the designation of responsibilities. People must know their roles and be fully prepared to*

Casualty Evacuation Failures

execute those duties. Leaders must put deliberate thought into assigning these duties, then their supervisory leadership must sanity check and rehearse the plan.

- What Right Looks Like. A platoon conducted dive training, completing five dives in 19 feet of seawater. After the fifth dive, all personnel reached the surface with a typical ascent and gave an OK signal to the dive supervisor. Approximately five minutes post-dive, though, one Sailor noticed tingling in his feet and weakness in his hamstring. He immediately notified the dive supervisor, who immediately initiated their emergency action plan. He conducted a neurological exam and decided to put the Sailor on 100% oxygen and transport him to the recompression chamber. The route was already planned for and mapped. The Sailor arrived at the chamber within 30 minutes, at which point the duty master diver and the undersea medical officer took custody of him, conducted further examinations and applied the necessary recompression treatment. The treatment was completed after seven hours, and the Sailor was monitored for another hour with a follow-up the next day showing no residual symptoms. — *This unit recognized the nature of their high-risk training and prepared every facet necessary for an emergency. When an incident occurred, they didn't question how minor it might seem and didn't hesitate to conduct the necessary actions to care for their Sailor. They had a plan, knew the plan and executed the plan flawlessly. Well done!*



Key Takeaways

We may hope to never find ourselves in an emergency where one of our Marines or Sailors must be CasEvaced, but as the saying goes, “hope is not a plan.” We must deliberately plan for the reality that a mishap may eventually occur, especially in high-risk training and operating environments. The Marines and Sailors under our charge have volunteered to put their lives on the line for their country. We owe it to them to ensure they are taken care of if something goes wrong. If you aren't performing (at a minimum) these steps in your CasEvac planning, you aren't doing enough:

1. **Make your emergency action plan make sense.** Don't just copy and paste a slide deck from some previous exercise. Ask yourself, “What's different this time?” Consider the type of training, locations, personnel, environment, etc. and plan your EAP for every step along the way. Ensure specific duties are assigned, vehicles are designated, equipment is on hand and critical locations are identified. These details are too important to figure out on the fly.
2. **Rehearse the plan.** Make your team prove they know the plan, including their assignments. **Do** regular “talk-throughs” with key personnel. **Do** knowledge checks on tasks and actions. **Do** planned and surprise rehearsals. **Do not** become complacent.
3. **Provide the proper oversight and coordination.** Just like all the other elements of an exercise plan, the Emergency Action and Casualty Evacuation plan must be verified and approved by higher echelons of the command. This approval cannot just be a check in the box. Commanders must confirm their subordinates understand the plan and must make sure that the plan is supported. A perfect plan from a supervisor is useless if it doesn't have the necessary support from a higher authority.

And remember, “Let's be careful out there”