Naval Safety Command

SAFETY AWARENESS DISPATCH

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FORCE ON FORCE TRAINING

Force on force is one of the most valuable training methods at the military's disposal. There is no better way to impose realism than with a thinking and moving opponent that forces those executing to react in real time. This type of training comes with an inherent risk though, one which is all too often overlooked, that of fratricide. With force on force training, we may be lulled into a false sense of security because live ammunition is not involved. We must take into account, however, that in this training we are essentially violating one of our core weapons safety rules, that of not pointing a weapon at something we do not intent to shoot. This hazard is accepted because we impose stringent mitigations to ensure the safety of those involved. The following are examples of where we failed to effectively impose these mitigations and our Marines and Sailors suffered the consequences.

Force on force training can be conducted utilizing blank rounds, no rounds on a condition 4 weapon (no magazine inserted and no round in chamber), or with Ultimate Training Munitions (UTM) or Special Effects Small Arms Marking System (SESAM) rounds, which are paint rounds fired through a standard service rifle/carbine. These incident narratives involve use of each of these training methods.

- Blank-Fire Training. This incident miraculously did not result in injury, but all too easily could have as a corpsman participating in the blank-fire force on force training mistakenly used a weapon loaded with live rounds. This debacle started when the Officer in Charge (OIC) for the event departed the range to conduct an administrative task at the unit headquarters (T*hat's one link in the error chain, see how many more you can find*). He instructed the Range Safety Officer (RSO) to prepare the unit for the training evolution. While he was gone, the safety corpsman asked if he could join the training. His squad leader gave him permission, but the corpsman did not have his personal weapon with him, because he was originally told he would not need one. His squad leader told him to borrow an additional weapon that was stored with the headquarters element, so the corpsman went to the trailer where he was told the weapon would be. At this trailer was the ammo guard, who had a security weapon loaded with live rounds. This ammo guard was also tasked as the radio watch. At the same time the corpsman was coming to collect the extra weapon, the ammo/radio watch needed help with a problem with the radio and stepped away from his post, leaving his security weapon there. When the corpsman arrived at the trailer he did not see anybody present, but saw the security weapon and took it, assuming it was the one he was supposed to utilize and not realizing it was loaded with live rounds. He noted the weapon did not have a Blank Firing Adaptor (BFA), and attached one. One of the corpsman's squad members gave him a magazine of blank ammunition, but the corpsman put this in his magazine pouch, because the weapon already had a magazine loaded. Shortly after this, the OIC returned and the platoon began the blank-fire force on force training, but no magazine check or line out was conducted to ensure the absence of live rounds. The units made contact and began firing. After the significantly louder M240 jammed, the RSO noted the distinctly different gunshot sound from the other shots being fired. He immediately called cease fire, cleared out the weapons, and identified

the corpsman had a weapon with live rounds and that the BFA was shot off. After counting the remaining rounds in the magazine, it was determined the corpsman had fired 15 live rounds before the cease fire was called. *At first glance this incident may appear to be a simple case of unfortunate timing as the corpsman grabbed the wrong rifle just as its owner coincidently stepped away, but in reality there were* ***so*** *many missed steps that could have prevented this near mishap. The corpsman should have been trained to clear the weapon before taking it. The ammo watch should never have been additionally tasked as the radio watch. This clearly split his attention between his duties. Additionally, he should not have left his weapon unattended. The evolution should not have started without a detailed magazine and weapons check for live ammunition. Finally, the OIC should never have tasked out the preparation of the range. Certain facilities permit the OIC to depart the range, but that doesn't absolve them of the responsibility to ensure safety procedures are adequately adhered to.*

• Ultimate Training Munitions (UTM) Training. During training using UTM rounds, a Sailor was struck in the eye by one of the projectiles, due to improper Personal Protective Equipment (PPE). During this training the Sailor was wearing protective glasses, but training with UTM or SESAMs rounds requires either full face mask or ballistic goggles that prevent any gaps to the eyes. Additionally, the Standard Operating Procedures (SOP) for this training area also stated intentional head shots were prohibited; however, this requirement was not briefed before the exercise. When the training began, one Sailor engaged another from an elevated position, firing several rounds, one which struck the other Sailor in the face. Due to the elevated position, this round stuck behind a gap in the protective glasses, hitting the Sailor's eye. *This mishap had the fewest factors and should have been the easiest to avoid. Simply wearing the right PPE could have preserved this Sailor's eyesight.*

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• No Rounds Training. The last case involved a unit attempting to conduct a drill using no rounds (condition 4) weapons, but due to a lack of oversight, one of the Marines unknowingly had a chambered round when the drill began. The drill took place at a strategic weapons facility with a higher readiness posture that required Marines to conduct guard duty patrols with their weapons in condition 3 (a loaded magazine inserted, but no round in chamber). They also maintained a section of Marines posted in a Reactionary Force Facility (RFF) that retained control of their individual weapons, but in condition 4. On the day of the incident, Marines conducted guard duty patrols as normal. Due to a unit requirement that fire team leaders on patrol have an M203, and a shortage of this weapon in the unit, Marines often had to trade off weapons when they conducted patrols. During the first guard duty the fire team leader made a condition 1 weapon (loaded magazine inserted and a round in the chamber), based on his misinterpretation of a unit policy stating Marines can increase their readiness posture based on the tactical situation. When he was relieved from his post he removed his magazine and conducted a weapons transfer with the oncoming fire team leader, but neither Marine cleared the chamber of the weapon, which still had a round loaded. When this Marine was relieved, he kept the weapon he received when he started the patrol, removed the magazine, and reported to the RFF. During this process of attempting to transition to condition 4, he did not check the chamber to make sure it was empty. Later that evening, the limited area supervisor in the RFF briefed the Marines on a nightly drill he intended to execute involving force on force training for an active shooter scenario. The unit had formal guidance on the requirements for force on force training and locations where it could be conducted. These specifically included the requirement to conduct a safety brief and inspect

weapons to ensure no live ammunition is present. They also stated the RFF was not an approved area for the drill they were conducting. However, due to ambiguity in these orders and a failure of senior leadership to observe training and ensure these regulations were understood, this guidance was also misinterpreted. The ambiguity and lack of oversight resulted in the supervisor executing the force on force training in an unapproved location without checking the weapons for live ammunition. When the drill started the Marine from the second patrol still unknowingly had the round in his chamber as he aimed in on the door he suspected Opposing Forces (OPFOR) would come from. When a Marine walked through, he took the weapon off safe and attempted to dry fire, shooting the chambered round into the other Marine's abdomen. *This mishap arguably had the most failures occurring at every level. The individual Marine who fired the weapon failed to follow our core weapons safety rules. Force on force training may call for aiming a weapon at someone, but this training did not require him to take the weapon off safe or dry fire. Additionally, both he and the fire team leader on post before him failed to adequately clear their weapons when conducting their hand off and downgrading weapons conditions. The supervisor failed to adequately consider the risks when preparing his Marines for the nightly drill. Finally, the unit at the organizational level failed to adequately state their training policies or to ensure they were sufficiently understood.*

Key Takeaways

There is inherent risk with any type of training, much more with weapons training, and even more when we conduct force on force training where we aim these weapons at our fellow Marines and Sailors. This risk is only acceptable because we are supposed to impose strict mitigations to prevent mishaps. Complacency, a lack of oversight, and misinterpretations resulted in these units failing in their application of these mitigations. We recommend the following to avoid the same mistakes.

1. **Perform actual weapons clearing procedures, don't allow complacency!** Many of us should remember how aggressively weapons clearing was enforced at our entry level schools. This is not a standard that should be isolated to these environments. Every unit, every command, every training location should enforce the same standard of weapons clearing. Many units, though, can probably testify that their Marines and Sailors get complacent in this regard. This complacency must be eliminated. Anytime a weapon is passed off, picked up, or otherwise it must be cleared as condition 4.

2. **Line-outs must be enforced.** Leadership must ensure this is properly executed. Line-outs are the most effective redundancy to make sure the above recommendation is adhered to. Furthermore, while the task of visually lining out participants may be delegated to assistant range safety personnel, the OIC should always be present to ensure this is done effectively. As leaders we must not accept a simple "we're good." The term "trust but verify" is especially applicable here. We must take the risk of fratricide during force on force training seriously.

3. **Wear the right PPE.** Paint rounds like SESAMs or UTMs are particularly useful in imposing realism in training, but they come with their own risk as well. We are expecting these rounds to hit our Marines and Sailors, and while they are non-lethal, they are still high velocity projectiles that pose a hazard to sensitive parts of the body, such as eyes. This means we must adhere to the regulations made to protect these sensitive parts of the body.

And remember, "Let's be careful out there."

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