

# Task Force Casualty Evacuation

by Captain Dan Brant

*“The only certain result of your plan will be casualties — mainly the enemy if it is a good plan, yours if it’s not. Either way, foremost in your supporting plans must be the medical plan.”*

— MG Rupert Smith

We all like to say, “we’ll train as we fight,” and for the most part, that’s how we train. But one glaring shortfall is casualty evacuation (CASEVAC), where we do not train as we would fight. In fact, it appears that we find it acceptable not to train CASEVAC at all.

Given the myriad training tasks required, coupled with the constraints that training CASEVAC places on training other combat skills, it is not surprising that this area is overlooked; training for CASEVAC is not easy. This article is primer on the training that can be done to improve CASEVAC. It does not have all of the answers or techniques, but does cover some basic tenets often overlooked.

## Combat Training Centers

The one bright light of CASEVAC training, or perhaps its darkest hour depending on your perspective, occurs at the three combat training centers (CTCs). If CASEVAC training is not trained at home station, it will be at the CTCs. There will be MILES casualties and they will have to be evacuated from the battlefield, either as casualties or as bodies and, in some cases, could be a personnel loss up to 24 hours. Faced with these options, we should put more effort into CASEVAC and instill confidence in soldiers and their ability to survive the modern battlefield.

For most organizations in today’s Army, CASEVAC is probably the least trained, worst executed event. This is reflected during rotations to the CTCs by the historically enormous percentage of soldiers classified as died of wounds (DOW). While these DOW statistics may not tell the entire story due to many variables — the level of training on specific missions for a unit, unexpected enemy actions during a fight, or just bad luck — they are a tool to ana-

lyze the ability to plan, prepare, and execute CASEVAC. While we all understand that units on CTC rotations are honing their warfighting skills and are expected to make mistakes, we should all agree that the shortfall in CASEVAC is both unacceptable and reversible.

There are three causes of DOW casualties at the CTCs:

- Improper treatment.
- Improper transportation — moving a litter patient without any type of litter, or overloading the vehicle used.
- Failure to evacuate casualties within the prescribed timelines of the rules of engagement.

At the CMTC, the typical task force DOW rate is between 50 to 80 percent for every battle. The vast majority of DOW casualties fall into the categories of failure to evacuate in time or failure to evacuate at all. While there is no fail-safe way to ensure that no casualty dies of wounds, there are many things that can be done to lower DOW rates. Following the logical movement of casualties within the task force, we will look at common shortfalls and tips to overcome them.

## Troop/Company/Team

The critical first steps in the CASEVAC chain begin at the company/team level. If we fail to execute at this level, there is simply no way to prevent a large number of DOWs. The shortfalls at this level are probably the most obvious to identify and the most difficult to fix. You must find the balance between incorporating CASEVAC into training plans and training warfighting skills. We certainly do not want to see you come to the CTCs and perform excellent CASEVAC but be unable to conduct an attack or defend. Herein lies the major problem with CASEVAC at this level; it is not planned, prepared, or trained proficiently.

In keeping with the mantra of “train as you fight” and with our own doctrinal literature, it is clear that we are failing at a key warfighting task. The importance of CASEVAC as a warfighting

skill cannot be understated. Clearly, once we have casualties in the medical evacuation channels, the chance of them becoming a DOW significantly decreases. Our primary weakness as an Army seems to be the ability to get casualties from their point of injury to the battalion aid station (BAS).

So, what can be done at the company level to reverse this trend? We can look to the medical platoon leader and say, “fix it,” or we can take proactive steps as a team to work through the task of CASEVAC. Let’s face it, the one ambulance and crew that is attached to our company during tactical operations is not going to get it done alone. And by doctrine, the ambulance’s primary purpose is transportation from the company area to the BAS. The responsibility for CASEVAC in our company area falls squarely on the shoulders of every soldier.

There are several ways that a company/team can work through CASEVAC. A couple of ways to remedy the CASEVAC problem are:

- Make somebody responsible, and hold that person accountable for CASEVAC. Hopefully, all other logistics tasks have been completed prior to the fight, so what task is more important for the 1SG besides CASEVAC? Task-organize a logistics team under the 1SG’s control, with the responsibility to clear the battlefield. An effective technique is to install litter chains and litters in the 1SG’s M113 and the maintenance team’s M113 so that they have the ability to move casualties to a company casualty collection point (CCP). The medical team, who will triage, treat, and evacuate from that point to the BAS, can man the CCP.

- Plan for and rehearse CASEVAC. We have identified who is responsible, now let’s plan for it, through the entire operation, just like any other piece of our tactical plan. Where will company CCPs be placed? Where is the BAS? How do we get there? This is certainly not as complex as planning a company defense, but does require some thought about routes, obstacles, and enemy threat. Since we have gone through the

steps to incorporate CASEVAC into our tactical plan, let's go ahead and rehearse it when we rehearse the plan. Ensure our CASEVAC team and medics attend the company rehearsal so that they understand where and when we expect to take casualties. Ensure that our platoon leadership understands how they will contact the ISG when they need to have casualties evacuated, what routes are proposed, and how they mark vehicles with casualties on board.

*“Regardless of the method of evacuation, all scout leaders must have the necessary CSS graphics available, including locations of battalion or troop casualty collection points. Evacuation procedures must be part of the platoon plan and should be rehearsed as part of mission preparation.”*

– FM 17-98, Scout Platoon & FM 17-15, Tank Platoon

Much of this planning can be accomplished long before going to a CTC and can be published in the company TACSOP. Established CASEVAC standards in the company TACSOP should address, at a minimum, the following: how to identify vehicles with casualties, day and night; what assets are dedicated to CASEVAC; who is responsible for the C2 of CASEVAC; how to place CCPs in offensive and defensive operations; who to notify when there are casualties; and what radio net to use.

The most difficult aspect to manage is training CASEVAC at home station. There are a number of reasons for this, but the bottom line is, we just do not do it. Yes, it takes some time away from other training, but is it worth it? Soldiers should be confident that if they become a casualty every effort will be made to ensure their survival.

When we do train CASEVAC, we must avoid the bad habit of: “Jones, Smith, Johnson... you are all casualties. Go stand by that tree and wait for the ambulance to pick you up.” This method robs soldiers of the opportunity to train on their specific area of CASEVAC. The crew missed an opportunity to train on extricating a casualty from a vehicle. The combat lifesaver missed the opportunity to train on med-



ical skills. And, the CASEVAC team missed the opportunity to train on locating, treating, and moving casualties off the battlefield in a timely manner. Train it as a part of the operation.

Finally, get soldiers to combat lifesaver training and ensure they attend annual recertification training. At the CTCs, they may add time for the casualty to arrive at the BAS; in real life, they may save a life.

### **Task Force**

The next step for the casualty is the BAS and into the task force medical evacuation system. Here we see some similarities in shortfalls, as at the company level. Typically, the staff does the planning for evacuation haphazardly, and the preparations and training completed by the task force medical platoon are inadequate. The medical platoon leader does not receive the necessary training to be a productive member of the task force planning staff and lacks the tactical knowledge to fully understand the implications of different types of maneuver operations.

In looking at ways to overcome CASEVAC shortfalls at the task force, examine what the task force commander and staff can do, and what the task force medical platoon leader can do.

### **TF Commander and Staff**

The TF commander and staff have to train the medical platoon leader in the basic fundamentals of tactical operations as a part of his professional development. Knowing how the task force will execute an attack, defense, movement to contact (MTC), or breach will make him a better medical planner for the task force. He will not arrive from the officer basic course with the tactical knowledge required to do his job completely; he has to learn much of

his job at home station, just like any other officer in the unit.

*“To support task force operations, the medical platoon leader or battalion surgeon and medical operations officer must understand the scheme of maneuver as well as the support plan of the FSB medical company.”*

FM 71-2, The Tank and Mechanized Infantry Task Force

At the task force, we need to train medical platoon leaders in the military decisionmaking process. They bring some level of expertise of medical operations to the table and he can be very useful in assisting the S4 with other logistics planning. Medical platoon leaders must become experts. There are plenty of publications and people that can assist. Rehearse CASEVAC thoroughly at the CSS rehearsal and, if practical, it will pay big dividends to also rehearse it during the maneuver rehearsal. Rehearsing CASEVAC with maneuver will pay bigger dividends, as there are more key players involved and CASEVAC should be a logistics function, which occurs in concert with the actual fight. Regardless of how we do it, CASEVAC must be thoroughly rehearsed through all phases of the operation to ensure a clear understanding of how to plan for its accomplishment.

*“Integrating the medical support plan with the tactical scheme of maneuver increases the total plan's effectiveness by synchronizing critical elements of combat power, to include medical assets.”*

CALL Newsletter 89-5, Commander's CASEVAC System

Maximize the number of nonstandard CASEVAC vehicles available for use during tactical operations. Think of nonstandard vehicles in terms of medical combat power, such as one M113 ambulance equals four litter patients, but one 5-ton truck equals 12 litter patients. That is three times the combat power! Every nonstandard vehicle that is not dedicated to a more critical task should be made available to CASEVAC. These vehicles can be used from company CCPs to the BAS or



from the BAS to the ambulance exchange point. This will lessen the load on tracked ambulances, leaving them available for missions farther forward, where an armored vehicle has more survivability.

The medical platoon leader has a big part to play in the success or failure of the task force. He must be the staff expert on medical operations, developing and executing quality medical plans. Meanwhile, he must also be the platoon leader, ensuring that the platoon is trained and prepared to execute its wartime mission. He has the responsibility to make himself proficient and will develop his skills further by becoming intimately familiar with the tactical operations of the task force and the medical doctrine that supports it. If he reads no other doctrinal publication, he cannot be caught without a copy of *FM 4-02.4, Medical Platoon Leader's Handbook, Tactics, Techniques, and Procedures*. This publication offers a lot of very useful information and will provide the basic fundamentals of supporting different tactical operations.

*"The key to understanding the medical platoon CHS [combat health support] mission, as part of the battalion team, lies in two elements of the plan — the commander's intent and the purpose he envisions for the battalion and each company. The medical platoon leader's knowledge of the intent and purpose allows him to use his initiative*

*and to be proactive and exploit battlefield opportunities to accomplish the CHS mission."*

*FM 4-02.4, Medical Platoon Leader's Handbook*

Ensure a medical plan is published with the task force OP-ORD. An execution matrix and a sketch works very effectively. With these two documents, everybody in the task force will know all medical assets on the battlefield. The documents will place all assets sequentially, through the use of the matrix, and spatially, through the use of a sketch. The platoon leader needs to ensure the sketch includes all critical information, including grid coordinates, frequencies and call signs, and the assets available at different medical nodes. It should also include both adjacent and supporting medical nodes. If the fight goes to pot, somebody may need to contact and coordinate movement directly to them.

The platoon leader is responsible for ensuring that his medics are trained to perform their mission, and that they have a sense of pride that deservingly goes with their mission. In my mind, they have the second-most critical mission on any battlefield, the first being the tactical mission. Typically, medics are proficient in their medical-specific skills, but lack adequate common soldier's skills. Land navigation, day and night, is critical to performing their mission. It is important for them to understand tactical graphics to avoid battlefield dangers, like minefields. They must perform adequate maintenance on their assigned vehicles. They must ensure route recons are conducted from as far forward as the tactical situation permits, both during daylight and hours of limited visibility, back to the ambulance exchange point. Do not limit this reconnaissance to proposed main supporting routes; also include any other potential avenues they may need to use.

The platoon leader must plan, prepare, and train for chemical casualty decontamination. This is more than the medical platoon can do alone; we owe it to the soldiers we support to propose this training need with our chain of command. The medical platoon cannot accomplish patient decontamination with-

out assistance from other members of the task force.

The platoon leader must maintain a good working relationship with the supporting forward support medical company and not be afraid to ask the commander for help; most of them have been in the same position. Their job is to support you, but often, if unaware of your situation, they will be late providing help, if at all. The medical platoon leader must keep them current with his platoon's situation and the task force situation. If we approach it with the attitude of "those rear echelon folks can't do anything for me," that is exactly what you are likely to receive from them. The medical evacuation system relies on very good communications and the ability to work toward a common goal. Without this, we are destined for failure.

## Conclusion

While the concepts proposed in no way guarantee success, they will lead to a more successful execution of CASEVAC. At the CTCs, we all know that PFC Jones is going to be all right; after all, he is only a MILES casualty. He will probably be back for the next mission, so we do not focus efforts on CASEVAC until long after the battle is complete. In real life, PFC Jones may have died while we were celebrating a marvelous victory on the objective.

We may choose, or be forced by circumstances, to forgo CASEVAC training at home station, but then our level of effort will be directly proportional to our success at a CTC. I can only guarantee that, whether or not we choose to train at home station, we will execute CASEVAC during our two-week war at the CTCs just as we will in the real battle.

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