

## APPENDIX G

**COMBAT TRAINING CENTERS LESSONS LEARNED****G-1. Planning for Deployment to Combat Training Centers**

Planning for deployment to Combat Training Centers (CTCs) must begin months in advance of the actual departure date. Plans must include the following at a minimum:

- Arrange for PROFIS physician to accompany medical platoon to CTC. Coordinate through division surgeon at least 120 days prior to rotation.
- Determine transportation requirements: such as how many and what type railcars will be required for movement by rail (flat or box)? To determine the number of cars required, the weight and cube of all components (to include personal gear, CTA items, and leased items) must be established. Begin making transportation arrangements at least 6 months in advance of departure date; also coordinated the arrangements with your S4. The exclusion of any TOE items due to transportation constraints must be carefully evaluated for the impact on the mission.
- Arrange for the lease of essential equipment not provided for in the TOE. EXAMPLE: cardiac defibrillator/monitor, for use in real world medical treatment of patients. Arrange for the lease at least 6 months before the departure date to ensure that the item is on hand.
- Ensure that all medical equipment sets are complete. Request medical items (controlled/accountable drugs) at least 2 months before rotation.
- Ensure that all TOE equipment is on hand and in working order. Verify the status and availability of all equipment at least 2 months before rotation. Have all equipment serviced/ repaired as needed to be 100 percent operational.
- Arrange for POL support.
- Establish resupply support (including Class VIII) for items needed during the training period. Prepare signature cards for request and receipt of supplies. Arrange for support from HSS elements/hospital for patients requiring care beyond your unit capabilities.

- Prepare for prevention of heat injury casualties. EXAMPLE: Ensure water consumption policies are established and monitored. Personnel must drink water frequently.

- Establish food service support if not provided for in deployment instruction.

- Ensure sundry supplies are available for personnel.

- Prepare overlays showing BAS, AXP, PCP, and split treatment team locations, if maps of the operational area are available.

- Prepare OPORD, SOP, and HSSPLAN for medical platoon. Prepare input for inclusion in higher command and support elements' OPORD, SOP, and HSSPLAN.

- Prepare unit for mission through unit training at home station; begin training METL upon notification of rotation if not already in force.

**G-2. Medical Lessons Learned**

Lessons learned from medical units during CTC rotations are as follows:

- Medical platoon leadership not preparing/reviewing and forwarding feeder reports in a timely manner.

- Exclusion of physicians from CTC rotation is hindering the medical platoon in conducting realistic training.

- The crew on the M113 is inadequate to provide en route patient care. Two medics authorized (driver and treater); three required (driver, track commander, treater). Armor requires a track commander.

- Combat medic with radio required to man the AXP.

- Field artillery medical section does not have radios.

- BAS authorized systemic, pulmonary, and anaphylaxis resuscitative kit (SPARK), but no cardiac defibrillator/monitor.

- Work/rest not practiced by line units. Personnel working 30 plus hours without rest periods. Performance degraded after this length of time.
- Use of lensatic compass requires dismounting tracked vehicles. For accurate readings, the TC must be several meters from the vehicle.
- Early request for nonmedical vehicle Support in movement of mass casualties was not supported on a timely basis.
- Communications was hindered by radios being borrowed from medical units and not available for the BAS to contact the medical company.
- BAS M577s being used as alternate combat trains CPs. This violates the Geneva Conventions, jeopardizing the patients and medical units protection.
- BAS not employing the M51 shelter system during training. This prevented their training in the employment of the system.
- Resupply system for medical supplies inadequately planned for and ineffective.
- Cooled storage for IV solution not provided at the BAS. These solutions require protection from excessive heat such as desert/hot climate conditions (NTC environment).
- Medical platoon deploying without night vision devices although authorized by MTOE.
- Mass casualty plans need to be well developed, coordinated with supporting units/sections, documented in an SOP, and rehearsed during training.
- The medical platoon leader is a member of the staff and should be accepted as such. He should attend mission briefings and have the responsibility for medical planning and, in turn, brief the medical support plan. When the medical platoon leader is not included in the planning, this can result in missed coordination when the taskings are finally passed to the medical platoon.
- During the planning phase, the battalion needs to—
  - Develop a plan to access, handle, evacuate, and treat NBC casualties.
  - Look at methods for performing MEDEVAC missions.
  - Ensure the assets required for mission accomplishment are included.
  - Provide a plan for including the medics on the mission.
- The support for medical evacuation requires an analysis by the medical support element. They must determine the best methods to support the tactical operations based on the platoon's status and capabilities.
- Companies submitted an abbreviated MEDEVAC request which severely degraded casualty evacuation. Lines often omitted included site frequency, call sign, and security. This resulted in patients not being located and evacuation vehicles being destroyed. Units must become familiar with the MEDEVAC request format. It must be used during all field training exercises.
- An effective SOP for casualty evacuation; soldiers understanding of first aid procedures; and leaders awareness of the combat and field trains locations are instrumental in preventing soldiers dying of wounds.
- Coordination of medical evacuation operations must be emphasized within the battalion. The battalion needs to standardize procedures for designating patient collecting points and the hand over of patients to the medical company.
- Units need to triage/prioritize casualties for treatment and evacuation. When this is not done, soldiers with superficial wounds are treated before those with life-threatening wounds. A unit SOP for casualty evacuation can consolidate or coordinate the effort. The absence of sufficient medics and trained combat lifesavers can intensify the problem.

- When casualties were taken on the battlefield, self-aid or buddy aid was rarely administered. When aid and litter teams were identified, soldiers were uncertain of their duties/responsibilities as aid/litter team members. There was no plan or system in place to ensure casualties were treated and evacuated to the patient collecting points. Once at the patient collecting point, there was no triage during evacuation. If the company had two patient collecting points, casualties were evacuated to the other collecting point without regard to the type and extent of injury. On several occasions, the unit did not know that their casualties were never evacuated from the company patient collecting point. This resulted in soldiers dying of wounds.

- The medics in the line companies did not establish and maintain platoon and company patient collecting points effectively. The medics did not consistently organize collecting points to facilitate rapid evacuation of patients. Sites for LZ/PZs for MEDEVAC operations were not selected consistently or effectively. The lack of triage and treatment of patients resulted in several patients being designated as died of wounds. Though the technical proficiency was present, the ability to apply those skills to a tactical environment was not always evident.

- The battalion S1 and the medical platoon leader must develop a medical evacuation plan based on METT-T. The medical platoon leader supervises the execution of his portion of the plan in the forward area.

- The need to brief CSS personnel and rehearse their functions is just as critical as the rehearsals conducted by maneuver units. Route and convoy briefings, patient evacuation practice, and security reaction plans must all be briefed and practiced. Ensure rehearsals are conducted to the lowest possible level and for all probable contingencies in preparation for all operations.

- Classes (OPD/NCOPD) need to be caught which explain in detail the HSS system of a light infantry division. The battalion PA or personnel from the medical battalion should be considered as instructors. All FTXs need to incorporate HSS play in the scenarios, from squad through brigade level.

- The medical platoon leader needs to receive training from the medical battalion to include participation in their FTXs/CPXs. The battalion should give him time to learn his job and not overwhelm him with additional duties.

- The battalion medical platoon, in conjunction with the medical company, should war-game medical evacuation procedures to clearly define responsibilities and refine support requirements. This war-gaming can be conducted using the LOGMOD/ADMIN GTAs, various terrain models, and various missions which the battalion can receive.

- Practice preparation of formalized staff estimates and the service support paragraph or annex of orders. The formats and procedures must be practiced to ensure complete written or verbal orders are prepared for actual field operations. The most important requirement is to understand the format; to prevent the omission of critical information when orders are prepared in the stressful environment of a field operation.

- Practice using air ambulances to include support planning, LZ site selection and preparation, defense, and communications.

- War-game the coordination procedures used by the regiment to execute the HSS missions at all levels. These war games (executed using the MED SIM GTA and the LOGMOD GTA) are available from all local TASCs. They will assist in refining procedure and in structuring the HSS system at all levels.

- There needs to be cross-training to cover those MOSs that are one deep in the unit. Reassignments or injuries may keep these personnel from deploying. They may become incapacitated while in the field. Their absence will cause a decline in the quality of care being provided.

- Medical evacuation should have a dedicated radio frequency; it should be monitored by the medical company. If the SOI does not list a frequency, then employ a spare.

- The battalion aid station must establish and maintain communication with the supporting medical company at all times. When contact is

broken, the platoon leader must hastily rectify the situation. Presently, calls go through the field trains, brigade tactical operations center, and FASCO before being received by the supporting medical company. This caused a waste of time, delay in response, and ties up communication nets.

- Combat lifesavers are an integral facet of the HSS doctrine. They place life-sustaining skills

within each crew/team/section. With a minimal number of medical personnel assigned in the line units, the combat lifesavers and their equipment, add the required dimension of care that can decrease the number of died of wounds. In the mass casualty situations that occurred during this rotation, their valued training was not present.