

WHO ARE WE FAILING?

by Sean D. McKay

As tactics pertaining to terrorism response, active shooters and counter-narcotics operations continue to evolve, the techniques of “casualty extraction” remain somewhat nonproductive and stagnant. Many of our teams, if called upon to save one of our own, would probably utilize **traditional carries, tactics and movements** which are proving to be **ineffective and unrealistic, and may actually increase the risk of unnecessary operator injury and/or death.**

These “legacy” techniques taught nationwide such as the **Fireman’s Carry, Two Person Fore-and-Aft Carry, Rifle Carry, Poncho Carry, and One/Two Person Extremity Drag** are riddled with universal pitfalls. The following points are but a few of the problems associated with these conventional rescue techniques:

- **Traditional methods of dragging (vest straps and extremities) do not allow the rescuer leverage in movement (body mechanics) often exposing unprotected regions of the body**
- **Conventional techniques prove ineffective due to cover/concealment issues**
- **Traditional extraction techniques are manpower intensive and not practical**
- **Failed attempt slows tactical initiative on the target**
- **Excessive time in the target zone endangers personnel**

We can learn from firefighters nationwide who are continually developing new and innovative ways of saving other firefighters and themselves in a variety of dynamic and dangerous environments. The fire service utilizes a Rapid Intervention Team (RIT) concept when firefighters operate in an IDLH (Immediate Danger to Life and Health) environment. RIT is a preselected, highly trained element poised for immediate rescue with mission specific equipment and personnel. The sole purpose of the RIT is to rescue other firefighters when things go bad. RIT operations are outlined in the NFPA 1500 guidelines.

Personnel recovery operations in the tactical and fire environments have much in common. Rescue operations in both environments are typically accomplished by small, high-speed elements consisting of limited manpower and equipment operating in low visibility environments that require personnel to maintain a low profile. Both are often further complicated by significant time constraints coupled with the issues of incontinent victims due to personal protective equipment. A new paradigm of unconventional rescue techniques is required to address a newer and increasingly hostile and lethal tactical environment. These techniques must address specific

Dissecting the Requirement for High Threat Extraction

On December 7th, 1998, a multi-disciplinary panel consisting of physicians, physician assistants, and combat medics was convened at the Special Operations Medical Association Conference. At the direction of the U.S. Special Operations Command Medical Technology Development program, this panel of experienced tactical trauma providers analyzed nine tactical trauma management scenarios related to the Battle of the Black Sea (Somalia, 1993). This panel developed a consensus opinion on 58 key points for further research objectives, which was published under the title **“Tactical Management of Urban Warfare Casualties in Special Operations”** (Military Medicine, volume 165, supplement 1, 1999).

Many of these key points such as improved tourniquets, hypotensive resuscitation, effective hemostatic agents, pre-hospital antibiotics and the inclusion of colloid IV solutions, have all been integrated into Tactical Combat Casualty Care with quantified success throughout the Global War on Terror.

It is essential to note that standardized practical solutions to some of these critical deficiencies have yet to be implemented. North American Rescue has conducted an extensive two year examination to address Key Points number 41, 42, and 43 all pertaining to casualty movement under duress during tactical operations. These key points were extrapolated from Scenario 8, “Quick Reaction Force Casualty in an Exposed Location”, moderated by LTC Cliff Cloonan. During this scenario an enormous focus on creating a capability to move casualties more effectively in the high threat environment became apparent. A partial listing of these notable quotes includes the following:

“Urban warfare casualties should generally be moved to the best tactical location as quickly as possible before treatment for their injuries is undertaken.”

“Retrieval of casualties from open areas was often complicated by intense small arms fire in Mogadishu. Improved casualty retrieval and area denial methods to include smoke,



threat assessment, utilization of asymmetrical tactics, and utilization of unconventional medical philosophy. Unconventional warfare requires asymmetric rescue. This is accomplished through the implementation of innovative and revolutionary high threat immediate extraction tactics and techniques that will template a more rapid treatment of casualties. The applied science and study of extraction, focuses on empowering operators and medics to effectively perform immediate high threat extraction on injured team members and injured civilians. This facilitates early exposure to the tiered Tactical Combat Casualty Care (TCCC) guidelines. These guidelines implement treatment modalities addressing the three most preventable causes of death, and disability within the tactical operating environment.

TCCC addresses casualty movement during the Care Under Fire (CUF) phase. It is imperative that we appreciate the importance of extraction in the continuum of care from the point of wounding. Consider casualty movement as a unique medical procedure under certain conditions. Our training must reflect the same emphasis on extraction as all other medical procedures in the tactical environment. All too often extraction must occur from the location where the victim was hit and went down, without the casualty's ability to assist the movement. This exponentially increases the risk to the rescuers now forced to operate in a zeroed in location. When examining the top three preventable causes of death in the tactical environment (extremity hemorrhage, tension pneumothorax, and airway), we note that all are time critical. For example, a casualty can potentially bleed out from a complete femoral artery and vein disruption in two to four minutes. The clock begins the countdown from the time that the injury happens, not the implementation of the rescue. The U.S. military has realized enormous success in preventing combat death during tactical operations throughout the Global War on Terror by adapting and applying the TCCC guidelines. How many more lives (casualty and rescuer) will be saved with the implementation of safer, more effective, and immediate extraction techniques?

The latest evolution of North American Rescue is the Voodoo® High Threat Extraction line. This targeted approach will increase success of personnel recovery and survivability in the operational arena facilitating the transition from Care Under Fire to Tactical Field Care. By utilizing a scientific approach, the Voodoo® line focuses on empowering Operators and Medics to effectively perform immediate high threat extraction on injured team members. This capability in turn facilitates a more rapid intervention of tiered TCCC guidelines and treatment modalities that address the three most preventable causes of death associated with tactical operations.

Since there is no "silver bullet" for extraction nor any one technique that successfully encompasses all rescue scenarios, it is imperative that the operator have multiple options at his/her disposal. Our Voodoo® product line of extraction gear is expressly designed and constructed to meet the rigorous challenges and critical adaptabilities intrinsic to rescue in hostile conditions. Each item designed was built to allow the rescuer perform the following:

- **Maintain engagement with threat**
- **Utilize improved body mechanics (maintain an anatomically correct posture) to rapidly extract larger weight**
- **Maintain natural postures and positions that preclude shifting of personal protective equipment (PPE) that either obviates that equipment or exposes additional unprotected body regions**
- **Decrease manpower needs in zeroed in location**

diversions, custom-made or field-expedient casualty retrieval devices (such a length of line with a snap link), ...

"What is the best technique for moving the casualty to cover in this particular setting? What if the medic weighs 140 pounds and the casualty weighs 220 pounds? Again, this is very situation and environment-specific, but I do think that it is a perfect example of where realistic training is absolutely critical."



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