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|  |  | **Tactical Combat Casualty Care for Medical Personnel 03 June 2015**  **Care Under Fire** | The first phase of TCCC is Care Under Fire. |
|  |  | **Objectives**  •**DESCRIBE** the role of firepower supremacy in the prevention of combat trauma.  •**DEMONSTRATE** techniques that can be used to quickly move casualties to cover while the unit is engaged in a firefight.  •**EXPLAIN** the rationale for early use of a tourniquet to control life-threatening extremity bleeding during Care Under Fire. | Read text |
|  |  | **Objectives**  •**DEMONSTRATE** the appropriate application of the C-A-T to the arm and leg.  •**EXPLAIN** why immobilization of the cervical spine is not a critical need in combat casualties with penetrating trauma to the neck. | Read text  Note that “C-A-T” refers to a Combat Application Tourniquet |
|  |  | **Care Under Fire Guidelines**  1. Return fire and take cover.  2. Direct or expect casualty to remain engaged as a combatant if appropriate.  3. Direct casualty to move to cover and apply self-aid if able.  4. Try to keep the casualty from sustaining additional wounds. | Read the CUF guidelines. |
|  |  | **Care Under Fire Guidelines**  5. Casualties should be extricated from burning vehicles or buildings and moved to relative safety. Do what is necessary to stop the burning process.  6. Airway management is generally best deferred until the Tactical Field Care phase. | Read the CUF Guidelines |
|  |  | **Care Under Fire Guidelines**  7. Stop life-threatening external hemorrhage if tactically feasible:  - Direct casualty to control hemorrhage by self-aid if able.  - Use a CoTCCC-recommended limb tourniquet for hemorrhage that is anatomically amenable to tourniquet use.  - Apply the **limb** tourniquet over the uniform **clearly proximal to the bleeding site(s). If the site of the life-threatening bleeding is not readily apparent, place the tourniquet “high and tight” (as proximal as possible) on the injured limb** and move the casualty to cover. | Read CUF Guidelines |
|  |  | **Care Under Fire**  •Prosecuting the mission and caring for the casualties may be in direct conflict.  •What’s best for the casualty may NOT be what’s best for the mission.  •When there is conflict, which takes precedence?  •Scenario dependent  •Consider the following example: | In the hospital, the casualty **IS** the mission.  In TCCC, you have the casualty **AND** the mission. |
|  |  | SPEC OPS  Case Studies in Special Operations Warfare Theory and Practice | Let’s examine a scenario from this book by ADM McRaven. The scenarios in this book are all Special Ops, but the PRINCIPLES discussed apply to all combat units. |
|  |  | **Raid on Entebbe *by ADM Bill McRaven***   * 27 June 1976 * Air France Flight 139 hijacked * Flown to Entebbe (Uganda) * 106 hostages held in Old Terminal at   airport * 7 terrorists guarding hostages * 100 Ugandan troops perimeter security * Israeli commando rescue planned | This is one of the most famous hostage situations in history.[[1]](#endnote-1) |
|  |  | **Raid on Entebbe**   * Rescue 4 July 1976 * Exit from C-130 in a Mercedes and 2 Land  Rovers to mimic mode of travel of Idi Amin – the Ugandan dictator at the time * Israeli commandos dressed as Ugandan soldiers * Drove up to the terminal - shot the Ugandan sentry * Assaulted the terminal through 3 doors | The tactics used were ingenious:  DECEPTION, SURPRISE, and VIOLENCE |
|  |  |  | Here’s what the layout looked like.  Black arrows show the entry paths of the Israeli commandos. |
|  |  | **Raid on Entebbe**   * LTC Netanyahu – the ground commander – shot in chest at the beginning of the assault * What should the corpsman or medic do?     –Disengage from the assault?    –Start an IV?    –Immediate needle decompression of chest? | Imagine YOU are the combat medic on this operation.  What would you do now?  (Ask several people in the audience what THEY would do.)  Note that LTC Netanyahu was the brother of the future Prime Minister of Israel. |
|  |  | **Raid on Entebbe**  *“As previously ordered, the three assault elements disregarded Netanyahu and stormed the building.”*  *“At this point in the operation, there wasn’t time to attend to the wounded.*” | NO medical care at the moment.  Have to establish control of the tactical situation first. |
|  |  | Do seconds really matter in combat? | LTC Netanyahu died from his wounds.  The assault phase of the operation took 90 seconds.  Did the 90-second treatment delay affect his chances of survival? Probably not.  Would a 90-second delay in continuing the assault phase of the operation have made a difference? Absolutely. |
|  |  | **Ma’a lot Rescue Attempt *by ADM Bill McRaven***   * 15 May 1974 * 3 PLO terrorists take 105 hostages * Schoolchildren and teachers * When assault commenced, terrorists began killing hostages * 22 children killed, 56 wounded * The difference between a dramatic success and a disaster may be measured in seconds. | Look what even a momentary delay can mean to a hostage rescue operation OR OTHER TACTICAL ENGAGEMENTS.[[2]](#endnote-2) |
|  |  | **Care Under Fire**   * If the firefight is ongoing - don’t try to treat your casualty in the Kill Zone! * Suppression of enemy fire and moving casualties to cover are the major concerns. | Not every casualty scenario is a hostage rescue, but these basic principles apply.  Imperative to get your casualty “Off the X” and behind cover if you can. |
|  |  | **Care Under Fire**   * Suppression of hostile fire will minimize the risk of both new casualties and additional injuries to the existing casualties. * The firepower contributed by medical personnel and the casualties themselves may be essential to tactical fire superiority. * **The best medicine on the battlefield is Fire Superiority.** | Sustaining a minor wound in a firefight does not mean that you should disengage from the fight. |
|  |  | **Moving Casualties in CUF**   * If a casualty is able to move to cover, he should do so to avoid exposing others to enemy fire. * If casualty is unable to move and unresponsive, the casualty is likely beyond help and moving him while under fire may not be worth the risk. * If a casualty is responsive but can’t move, a rescue plan should be devised if tactically feasible. * Next sequence of slides shows the hazards of moving casualties before hostile fire is suppressed. | Unit members should be TRAINED to move themselves to point of first cover if able.  Don’t put two people at risk if it can be avoided. |
|  |  | 1) While under fire and without a weapon, Gunnery Sgt. Ryan P. Shane runs to Sgt. Lonnie Wells, to pull him to safety during USMC combat operations in Fallujah. | Here is a dramatic example of casualty movement during Care Under Fire. SGT Wells had sustained a fatal gunshot through his leg, which severed his femoral artery. From the moment he was hit, he was unable to conduct self-aid and did not respond to calls from his fellow Marines. |
|  |  | 2) Gunnery Sgt Shane attempts to pull a fatally wounded Sgt Wells to cover. | Read text |
|  |  | 3) Another Marine comes to help. | The third man on the left is Hospital Corpsman Joel Lambott, the platoon’s Corpsman. |
|  |  | 4) Gunnery Sgt. Shane (left) is hit by enemy fire. | Read text |
|  |  | 5) Gunnery Sgt Shane, on ground at left, was hit by insurgent sniper fire. | HM Lambott was struck in the heel just after GySgt Shane was injured. He provided life-saving care to GySgt Shane, directed his evacuation, and dressed his own injury. He stayed with the platoon and continued his duties during the operation. In this rescue attempt, the fate of the first casualty was unchanged and two additional casualties were sustained because effective enemy fire was not suppressed. |
|  |  | **Casualty Movement Rescue Plan**  If you must move a casualty under fire, consider the following:   –Location of nearest cover   –How best to move him to the cover   –The risk to the rescuers   –Weight of casualty and rescuer   –Distance to be covered   –Use suppression fire and smoke to best advantage!   –Recover casualty’s weapons if possible | **DON’T FORGET COVERING FIRE!**  If possible, let the casualty know what you plan.  Consider directing available vehicles to move into a position to provide cover. |
|  |  | **Types of Carries for Care Under Fire**   * One-person drag with/without line * Two-person drag with/without line * SEAL Team Three Carry * Hawes Carry | Read text |
|  |  | **One-Person Drag** | Advantages: No equipment required  Only one rescuer exposed to fire  Disadvantages: Relatively slow  Not optimal body position for dragging  the casualty  (Have other Instructors or students demonstrate) |
|  |  | **Two-Person Drag** | Advantage : Gets casualty to cover faster than with one-person drag  Disadvantage: Exposes two rescuers to hostile fire instead of one  (Have other Instructors or students demonstrate) |
|  |  | **Video: Two-Person Drag** | Click on video to play.  (Link to video file 0202V02 Two-Person Drag 140602) |
|  |  | **Two-Person Drag Using Lines** | Advantages: Can shoot while dragging Faster than dragging without lines Faster movement of the casualty to cover  Disadvantage: Exposes two rescuers to hostile fire instead of one |
|  |  | **SEAL Team Three Carry (1)**  Also called the Shoulder-Belt carry. | Advantages: May be useful in situations where drags do not work well  Less painful for casualty than dragging  Disadvantages: Exposes two rescuers to hostile fire.  May be slower than dragging  May be difficult in kit and with unconscious casualty |
|  |  | **SEAL Team Three Carry (2)**  Also called the Shoulder-Belt carry. | Casualty’s arms around shoulders of both rescuers.  Casualty uses arms to hold onto rescuers if able.  Rescuers hold casualty’s arms around necks if casualty not able to.  Both rescuers grab casualty’s web belt  Lift and go |
|  |  | **Hawes Carry**  Also called the Modified Firemen’s carry  or Pack Strap Carry. | Technique: Rescuer squats; casualty’s arms around rescuer’s neck; rescuer lifts with legs  Advantages: One rescuer  May be useful in situations where a drag is not a good option  Works much better than outdated fireman’s carry  Disadvantages: Hard to accomplish with rescuer and/or casualty’s kit in place  Difficult when rescuer is small and casualty is large  Often slower than dragging  High profile for both rescuer and casualty |
|  |  | **Carries Practical**  How NOT to Do It. | This is a good example of how NOT to carry your casualty.  For practical exercise:  Break up into groups of 6 or less students per instructor.  Use skill sheets in the TCCC curriculum that apply to each practical exercise.  Practice all of the carries covered. |
|  |  | **Burn Prevention in CUF**   * Remove casualty from burning vehicles or structures ASAP and move to cover. * Stop burning with any non-flammable fluids readily accessible, by smothering, or by rolling on the ground. | If flammable liquids like petroleum products cause a fire on the casualty’s clothing that you can’t put out, then you’ll have to cut the burning garments off. |
|  |  | **Burn Prevention in CUF**  Wear fire-retardant Nomex gloves and uniform! | Flame-resistant clothing can protect you from burn injuries.  Your unit needs these clothing items if you don’t have them already. |
|  |  | **The Number One Medical Priority in CUF**  **Early control of severe hemorrhage is critical.**  **–**Prior to TCCC and effective battlefield tourniquets, extremity hemorrhage was the most frequent cause of *preventable* battlefield deaths.    –Over 2500 deaths occurred in Vietnam secondary to hemorrhage from extremity wounds.    –Injury to a major vessel can quickly lead to shock and death.    –***Only life-threatening bleeding warrants intervention during Care Under Fire.*** | If you can only do ONE thing for the casualty – stop him from bleeding to death.  Do not treat minor bleeding during Care Under Fire. |
|  |  | **When is bleeding life-threatening?**   * There is pulsatile or steady bleeding from the wound. * Blood is pooling on the ground. * The overlying clothes are soaked with blood. * Bandages or makeshift bandages used to cover the wound are ineffective and steadily becoming soaked with blood. * There is a traumatic amputation of the arm or leg. * There was prior bleeding, and the patient is now in shock (unconscious, confused, pale). | These are indications that bleeding is or soon will be an imminent threat to the life of the casualty. |
|  |  | **Question**   * How long does it take to bleed to death   from a complete femoral artery and vein disruption? * Answer:     – Casualties with such an injury can bleed to death in ***as little as 3 minutes*** | 10% of animals in lab studies died within 3 minutes without hemorrhage control measures. |
|  |  | **Femoral Artery Bleeding** | Click on video to play.  This is FEMORAL ARTERTY bleeding in a pig.  It does not take long to die from this. |
|  |  | **Care Under Fire**  The need for immediate access to a tourniquet in such situations makes it clear that all personnel on combat missions should have a CoTCCC-recommended tourniquet readily available at a standard location on their battle gear and be trained in its use.  - Casualties should be able to easily and quickly reach their *own* tourniquet. | DO NOT bury your tourniquet at the bottom of your pack. |
|  |  | **Care Under Fire**  Where a tourniquet can be applied, it is the ***first*** choice for control of life-threatening hemorrhage in Care Under Fire. | Forget about direct pressure, pressure dressings, and anything else if you have severe extremity bleeding in the Care Under Fire phase.  Go directly to a tourniquet. |
|  |  | **A Preventable Death**  Did not have an effective tourniquet applied - bled to death from a leg wound | The medic in this Army unit was killed in the battle in which this soldier was wounded.  Others in the unit attempted to control the bleeding from this soldier’s wound just below his left knee.  These improvised tourniquets were ineffective, and the soldier bled to death.  DON”T LET THIS HAPPEN TO YOUR BUDDIES! |
|  |  | **Tourniquet Application**   * Apply without delay if indicated. * Both the casualty and the medic are in grave danger while a tourniquet is being applied in this phase – don’t use tourniquets for wounds with only minor bleeding. * The decision regarding the relative risk of further injury versus that of bleeding to death must be made by the person rendering care. | Read text |
|  |  | **Tourniquet Application**   * Non-life-threatening bleeding should be **ignored** until the Tactical Field Care phase. * Apply the tourniquet without removing the uniform – make sure it is clearly proximal to the bleeding site. * **If you are uncertain about exactly where the major bleeding site is on the extremity (night operations, multiple wounds), apply the tourniquet “high and tight” (as proximal as possible) on the arm or leg.** | Read text. |
|  |  | **Tourniquet Application**   * Tighten the tourniquet until bleeding is controlled. * If the first tourniquet fails to control the bleeding, apply a second tourniquet just above (proximal to) the first. * Don’t put a tourniquet directly over the knee or elbow. * Don’t put a tourniquet directly over a holster or a cargo pocket that contains bulky items. | Read text. |
|  |  | **CAT-Logo_2015.jpg**  **Instructions for One-Handed Application** |  |
|  |  | **Step 1**  Insert the injured limb through the loop in the band and position tourniquet 2-3" above the bleeding site. If the most proximal bleeding site is not readily identifiable, place the tourniquet as high as possible on the limb. | Read text. |
|  |  | **Step 2**  Pull band **TIGHTLY** and fasten it back on itself all the way around the limb, but not over the rod clips. Band should be tight enough that tips of three (3) fingers cannot be slid between the band and the limb. If the tips of three (3) fingers slide under band, retighten and re-secure. | Read text. |
|  |  | **Step 3**  Twist the rod until bleeding has stopped. | Read text. |
|  |  | **Step 4**  Snap the rod inside a clip to lock it in place. **Check for bleeding and distal pulse.** If bleeding is not controlled, or distal pulse is present, consider more tightening or applying a second tourniquet above and side-by-side to the first. Reassess. | Read text. |
|  |  | **Step 5**  Route the band over the rod and between the clips. Secure with the grey securing strap. Record time of application. | Read text. |
|  |  | **Video: C-A-T One-Handed Application to an Arm** | Click on video to play. |
|  |  | **CAT-Logo_2015.jpg**  **Instructions for Two-Handed Application** |  |
|  |  | **Step 1**  Route the band around the limb, pass the red tip through the slit of the buckle, and position tourniquet 2-3" above the bleeding site. If the most proximal bleeding site is not readily identifiable, place the tourniquet as high as possible on the limb. | Read text. |
|  |  | **Step 2**  Pull band **TIGHTLY** and fasten it back on itself all the way around the limb, but not over the rod clips. Band should be tight enough that tips of three (3) fingers cannot be slid between the band and the limb. If the tips of three (3) fingers slide under band, retighten and re-secure. | Read text. |
|  |  | **Step 3**  Twist the rod until bleeding has stopped. | Read text. |
|  |  | **Step 4**  Snap the rod inside a clip to lock it in place. **Check for bleeding and distal pulse.** If bleeding is not controlled, or distal pulse is present, consider more tightening or applying a second tourniquet above and side-by-side to the first. Reassess. | Read text. |
|  |  | **Step 5**  Route the band over the rod and between the clips. Secure with the grey securing strap. Record time of application. | Read text. |
|  |  | **Video: C-A-T Two-Handed**  **Application to a Leg** | Click to start video. |
|  |  | **After a Tourniquet has been Applied**   * After ANY tourniquet application, monitor the casualty closely to ensure that the tourniquet remains tight and that bleeding remains controlled. * Reassess – reassess- reassess! | Read text. |
|  |  | **Other Tourniquets**   * **The SOF Tactical Tourniquet (SOFTT) by Tactical Medical Solutions, Inc.** * **Equally recommended along with the C.A.T. by the CoTCCC for carriage by Combat Medics on the battlefield.** | The SOFTT is also recommended by ISR and the CoTCCC. It was found to be 100% effective in stopping arterial flow in arms and legs in laboratory testing. Anecdotal reports say the SOFTT may be more effective than the C-A-T in individuals with large legs. It is not fielded as widely as the C-A-T at present, but feedback from medics regarding its use has been good.  (NOTE: Instructional slides for the SOFTT may be found in the Supplementary Modules folder.) |
|  |  | **Other Tourniquets**   * Emergency and Military Tourniquet (EMT) by Delfi Medical Innovations, Inc. * The EMT is and excellent tourniquet and is recommended by the CoTCCC for use in evacuation platforms and medical treatment facilities, but not for carriage by medics on the battlefield at this point. | The EMT from Delfi was found to be as effective as the C-A-T in testing at the ISR. It was found to be better than the C-A-T in reports from Military Treatment Facilities in theater. The EMT is significantly more expensive. |
|  |  | **Impact of Tourniquet Use Kragh - Annals of Surgery 2009**  • Ibn Sina Hospital, Baghdad, 2006  • Tourniquets are saving lives on the battlefield  • Better survival when tourniquets were applied BEFORE casualties went into shock  •31 lives saved in this study by applying tourniquets prehospital rather than in the ED  • **Estimated 1000-2000 lives saved as of 2008 by**  **tourniquets (data provided to Army Surgeon General via an internal communication)** | Most importantly – apply tourniquets **ASAP** when they are needed.  Survival is improved if shock is ***prevented.*** |
|  |  | **Safety of Tourniquet Use Kragh - Journal of Trauma 2008**  • Combat Support Hospital in Baghdad  • 232 patients with tourniquets on 309 limbs  • CAT was best field tourniquet  • No amputations caused by tourniquet use  • Approximately 3% transient nerve palsies | Remember at the start of the GWOT, we were still losing casualties to extremity hemorrhage.  We’re doing much better now.  This study documented 232 LIVES SAVED in this ONE hospital in a ONE-YEAR period.  MINIMAL complications from tourniquet use. |
|  |  | **Examples of Extremity Wounds That Do NOT Need a Tourniquet**  Use a tourniquet ONLY for severe bleeding! | Neither wound is life threatening - bleeding is minimal.  A tourniquet should not be used on these two wounds or other wounds like them where the bleeding is not severe. |
|  |  | **Tourniquet Mistakes to Avoid!**  • Not using one when you should  • Using a tourniquet for minimal bleeding  • Putting it on too proximally if the bleeding site is clearly visible  • Not taking it off when indicated during TFC  • Taking it off when the casualty is in shock or has only a short transport time to the hospital  • Not making it tight enough – the tourniquet should both stop the bleeding AND eliminate the distal pulse  • Not using a second tourniquet if needed  • Waiting too long to put the tourniquet on  • Periodically loosening the tourniquet to allow blood flow to the injured extremity  *\* These lessons learned have been written in blood. \** | These are common mistakes made by first responders applying tourniquets. |
|  |  | **Tourniquet Pain**  • Tourniquets HURT when applied effectively  • Does not necessarily indicate a mistake in application  • Does not mean you should take it off!  • Manage pain per TCCC Guidelines | It is expected that tourniquet application will cause some pain, but it will also save your casualty’s life. |
|  |  | **Questions?** |  |
|  |  | **Tourniquet Practical** | For practicals:  Break up into small groups  About 6 or 7 students per instructor  Use skill sheets in the TCCC curriculum that go with each practical |
|  |  | **Hemorrhage Control**   * Some wounds are located in places where a tourniquet cannot be applied, such as:     – Neck    – Axilla (armpit)    – Groin   * **T**he use of a hemostatic agent (e.g., Combat Gauze) is generally not tactically feasible in CUF because of the requirement to hold direct pressure for 3 minutes. | BUT the casualty may get to cover and hold direct pressure over his own wounds as part of self-aid. |
|  |  | **Airway – Will Cover in TFC**  No immediate management of the airway is anticipated while in the Care Under Fire phase.  – Don’t take time to establish an airway while under fire.  – Defer airway management until you have moved casualty to cover.  – Combat deaths from compromised airways are relatively infrequent.  – If casualty has no airway in the Care Under Fire phase, chances for survival are minimal. | We will address airway in the Tactical Field Care phase. |
|  |  | **C-Spine Stabilization**  Penetrating head and neck injuries do not require C-spine stabilization  – Gunshot wounds (GSW), shrapnel  – In penetrating trauma, the spinal cord is either already compromised or is in relatively less danger than would be the case with blunt trauma. | In studies from the Vietnam conflict, of those casualties with penetrating neck trauma, only 1.4% would have benefited from C-spine stabilization.  C-spine stabilization takes 5-6 minutes even for experienced medical providers.  This is too much time to spend in the Care Under Fire phase on an intervention that is not proven to be necessary |
|  |  | **C-Spine Stabilization**  Blunt trauma is different!  – Neck or spine injuries due to falls, fast-roping injuries, or motor vehicle accidents may require C-spine stabilization.  – Apply only if the danger of hostile fire does not constitute a greater threat. | Do not provide C-spine stabilization if the danger of hostile fire constitutes a greater threat in the judgment of the medic. |
|  |  | **Summary of Key Points**   * Return fire and take cover! * Direct or expect casualty to remain engaged as a combatant if appropriate. * Direct casualty to move to cover if able. * Try to keep the casualty from sustaining additional wounds. * Get casualties out of burning vehicles or buildings. | Ask questions to cover key points. |
|  |  | **Summary of Key Points**   * Airway management is generally best deferred until the Tactical Field Care phase. * Stop life-threatening external hemorrhage if tactically feasible.   – Use a tourniquet for hemorrhage that is anatomically amenable to tourniquet application.  – Direct casualty to control hemorrhage by self-aid if able. | Ask questions to cover key points. |
|  |  | Questions? |  |
|  |  | **Scenario Based Planning**   * If the basic TCCC combat trauma management plan for Care Under Fire doesn’t work for your specific tactical situation – ***then it doesn’t work***. * Scenario-based planning is critical for success. * Incorporate likely casualty scenarios into unit mission planning! * The following is one example. | The TCCC guidelines are not a rigid protocol.  **Nothing in combat is.**  Think on your feet! |
|  |  | **Convoy IED Scenario** | Let’s consider a scenario commonly encountered in Iraq and Afghanistan.  Improvised Explosive Devices (IEDs) are a very common cause of injury in these two theaters. |
|  |  | **Convoy IED Scenario**   * Your element is in a five-vehicle convoy moving through a small Iraqi village. * Command-detonated IED explodes under second vehicle. * Moderate sniper fire. * Rest of the convoy is suppressing sniper fire. | Read text in action sequence |
|  |  | **Convoy IED Scenario**   * You are a medic in the disabled vehicle. * Person next to you has bilateral mid-thigh amputations. * Heavy arterial bleeding from the left stump. * Right stump has only mild oozing of blood. | Read text in action sequence |
|  |  | **Convoy IED Scenario**   * Casualty is conscious and in moderate pain. * Vehicle is not on fire and is right side up. * You are uninjured and able to assist. | Read text in action sequence |
|  |  | **Convoy IED Scenario**  **First decision**:  •Return fire or treat casualty?    –Treat immediate threat to life    –Why?       •Rest of convoy providing suppressive fire       •Treatment is effective and QUICK  •First action?    –Tourniquet on stump with arterial bleed | Read text in action sequence  Ask individuals in audience to answer questions |
|  |  | **Convoy IED Scenario**  **Next action?**  •Tourniquet on second stump?    –Not until Tactical Field Care Phase    –Not bleeding right now  **Next actions?**    •Drag casualty out of vehicle and move to best cover    •Return fire if needed    •Communicate info to team leader | Read text in action sequence  Ask individuals in audience to answer questions |
|  |  | **Questions?** | This is the end of Care Under Fire. The scenario will be continued in Tactical Field Care. |

1. **Raid on Entebbe**

   This is one of the most famous hostage situations in history.

   Background information for Instructors (excerpt from Wikipedia article “Operation Thunderbolt”): **Operation Thunderbolt** was a counter-terrorist hostage-rescue mission carried out by the Special Forces of the Israel Defense Forces (IDF) at Entebbe Airport in Uganda on 4 July 1976. A week earlier, on 27 June, an Air France plane with 248 passengers was hijacked by Palestinian and German terrorists and flown to Entebbe, near Kampala, the capital of Uganda. Shortly after landing, all non-Israeli passengers, except one French citizen, were released.The IDF acted on intelligence provided by the Israeli intelligence agency Mossad. In the wake of the hijacking by members of the militant organizations Revolutionary Cells and the Popular Front for the Liberation of Palestine, along with the hijackers' threats to kill the hostages if their prisoner release demands were not met, the rescue operation was planned. These plans included preparation for armed resistance from Ugandan military troops.The operation took place at night, as Israeli transport planes carried 100 commandos over 2,500 miles (4,000 km) to Uganda for the rescue operation. The operation, which took a week of planning, lasted 90 minutes and 102 hostages were rescued. Five Israeli commandos were wounded and one, the commander, Lt. Col. Yonatan Netanyahu, was killed. All the hijackers, three hostages and 45 Ugandan soldiers were killed, and thirty Soviet-built MiG-17s and MiG-21s of Uganda's air force were destroyed. Ugandan army officers at a nearby hospital killed a fourth hostage.The rescue, named **Operation Thunderbolt**, is sometimes referred to retroactively as **Operation Jonathan** in memory of the unit's leader, Yonatan Netanyahu. He was the older brother of Benjamin Netanyahu, who served as the two-time Prime Minister of Israel from 1996 to 1999 and from 2009- the present.The operation is widely considered one of the greatest and daring Special Forces operations in history considering the high-risk nature of the commando raid, distance from home territory, and casualty and hostage rescue ratio. [↑](#endnote-ref-1)
2. **Ma’a lot Rescue Attempt**

   Background information for Instructors (Excerpt from Wikipedia article “Ma’a lot Massacre”): The Ma'a lot massacre was a terrorist attack, which included a two-day hostage taking of 115 people, which ended in the deaths of over 25 hostages. It began when three armed Palestinian terrorists of the Democratic Front for the Liberation of Palestine entered Israel from Lebanon. Soon afterwards they attacked a van, killing two Israeli Arab women and entered an apartment building in the town of Ma'alot, where they killed a couple and their four-year-old son. From there, they headed for the Netiv Meir elementary school, where they took more than 115 people (including 105 children) hostage on 15 May 1974, in Ma'alot. The hostage-takers soon issued demands for the release of 23 Palestinian militants from Israeli prisons, or else they would kill the students. On the second day of the standoff, a unit of the Golani Brigade stormed the building. During the takeover, the hostage-takers killed the children with grenades and automatic weapons. Ultimately, 25 hostages, including 22 children, were killed, and 68 more were injured. [↑](#endnote-ref-2)