Naval Historical Center
Oral Interview Summary Form

Interviewers:
CAPT (S) Mike McDaniel
CDR Karen Loftus

Interviewer's Organization:
Navy Combat Documentation Det 206
Navy Combat Documentation Det 206

Interviewee:
CDR Ronald D. Luka

Current Address:
Navy Annex, Arlington VA

Date of Interview:
6 Nov 2001

Place of Interview:
Navy Annex

Number of Cassettes:
One

Security Classification:
Unclassified

Name of Project: Pentagon Terrorist Attack Incident

Subject Terms/Key Words: Pentagon; Terrorist Attack; 11 September 2001; triage; evacuation; lessons learned; Defense Protective Service; FBI; carnage; Navy Command Center; renovation

Abstract of Interview:

1. Born in [redacted] IL. Father in Army in WWII. Moved to California at age 4 in the Los Angeles area. Went to high school and Glendale Junior College; then California State at Los Angeles. Fairly low draft number during Vietnam. Enlisted in Navy in 1970. Went to Hospital Corpsman school. Accepted at the Submarine Medical Technician's School and became an independent duty corpsmen on submarines. On Polaris missile boats and made 8 deterrent patrols. In early 80's finished bachelors degree through Southern Illinois University and was commissioned into the Medical Service Corps. Spent two years at Duke University and got a Masters Degree in Health Administration. Now serves as the Navy's Specialty Leader for Patient Administration and the head of the Beneficiaries Support Branch at BUMED. Total service over 31 years.
2. Biggest challenge is to make TRICARE successful and accessible. Retiree population is expanding and they are not necessarily co-located with military medical facilities.
3. Prospect of future of Navy medicine depends on funding from Congress such as TRICARE for Life, expanded medical benefits for reservists.
4. He is at BUMED, approximately two miles from the Pentagon. Can see the Pentagon clearly. 11 September was a beautiful, clear day; sky a deep blue. Heard of World Trade Center attacks via telephone from front office. Gathered around TVs. Ran up to 3rd floor; saw the smoke coming from the Pentagon. Surgeon General determined that 15-20 of the staff would remain and the rest went home.
5. On the 12th he and his boss, CAPT Miller, were ordered to go to the Pentagon and help in the identification of remains. Both have specialized in patient administration which involves liaison with a funeral home to do an inspection of the remains. Ensures body is embalmed properly and uniform is perfect.
6. At the Pentagon they were assigned to the temporary morgue area that the FBI was in charge of. It was somewhat of a morgue and more of an evidence recovery area. Joined

up with an Army chaplain to work with the FBI to see if there was any type of identification that could be put on the remains, either confirmed or not. They did not touch or handle the remains. FBI in control. Remains came in later in the day. Team of active duty soldiers would drive up and place the bags of remains in the morgue, really a temporary loading dock. Bags were opened; knew immediately that this would be difficult. Bags not full; remains were charred beyond recognition.

7. Most gratifying part of day was that 2 of the 30 remains could be identified. Those 2 must have died of smoke inhalation and were not burned. One individual still had his DoD badge and another had his name tag on. Positive ID's were made by the Dover mortuary using DNA identification. They left there about 2300. The following day the Army took over this function.
8. Talked to the SPRINT team later and that helped. Nothing could have prepared him for what he saw. Training may have helped deal with the experience.
9. Lessons learned: Communication problems between CACO and Dover led to misinformation being passed to families (a problem during the COLE incident.). Pers 06 involvement early on is essential. Plan is to transfer mortuary affairs to the Casualty Branch.
10. Some active duty issues he is still dealing with – the limited duty personnel; how to shorten the board processes and open up billets. Screen for overseas duty prior to cutting orders.
11. Others to interview: the Surgeon General His EA: Lt Michele Kane, 762-3702.

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Transcript of Interview:

Interviewee Information:

Born in [redacted] IL. Father was in the Army in WWII. Moved to California at age 4 in the Los Angeles area. Went to high school and Glendale Junior College; then California State University at Los Angeles. Fairly low draft number during Vietnam. Enlisted in the Navy in 1970. Went to Hospital Corpsman school. Accepted at the Submarine Medical Technician's School and became an independent duty corpsmen on submarines. Assigned to Polaris missile boats and made eight deterrent patrols. In early 1980's finished bachelors degree through Southern Illinois University and was commissioned into the Medical Service Corps. Spent two years at Duke University and got a Masters Degree in Health Administration. Now serves as the Navy's Specialty Leader for Patient Administration and the head of the Beneficiaries Support Branch at BUMED. Total service over 31 years.

Topics Discussed:

TRACK ONE

Q. (5:41) Give us a brief synopsis of the training and education initiative and broadly what are some of the specific issues you are dealing with at a BUMED during this time in history.

A. The biggest challenges, and not just for myself, but Navy medicine in general is making TRICARE operation – making it really work. Trying to make sure that healthcare for all our beneficiaries is accessible. One of the issues that seems to come up over and over, as the Navy has gotten smaller, we've gradually closed hospitals and shut down a lot of the direct care infrastructure, and yet our retiring population keeps expanding and they're not limited to where we happen to have military facilities. The whole issues about providing care for the retirees and their families is very important to us and keeping our promise that we made to them trying to provide that benefit wherever they live. It certainly is a challenge every day. I deal with a lot of active duty issues. Again, as the Navy has gotten smaller we are looking closely at the population on limited duty or the ones that are going through medical boards and trying to do what we can to expedite this process to keep our Sailors productive and keep them fully deployable.

Q. (7:29) With all your years of experience, do you see a bright prospect of the future of navy medicine or is it a long road ahead?

A. It's an interesting question. The answer really is that it sort of depends on which way congress wants us to go. We certainly see a bright future for it, but it is dependent on the resources we are given. Right now things are looking pretty good. Congress has really enacted a lot of new programs – come up with a TRICARE for life program—you may have heard about it; expanded pharmacy benefits and added benefits for reservists. Things are looking good.

Q. (8:20) I'm jumping ahead a little bit, but do you see the 11 September incident and the events that followed that do you see that as having an effect on congress' attitude, or is it too early to tell?

A. I think it is a little early to tell. If anything, the events of the 11th of September have sort of refocused us on what really is our primary mission -- the military readiness and support of our active duty forces. It's sort of a dichotomy. Sometimes when we have this medical infrastructure, but our active duty population is relatively healthy and with some exceptions generally doesn't generally require a lot of resources to provide services we need for our active duty. Most of it goes to the family members, retirees and their family members. But, then an incident like this focuses on – makes us realize that our prime mission is to make sure that those ships and Sailors and Marines are ready to go when the time comes.

Q. (9:37) Tell us about the events leading up to and the day of 11 September. Just walk us through your day, that day.

A. Our day at BUMED – we're on the other side of the Potomac River about two miles from the Pentagon –right across the street from the State department and the natural topography there is that we can see the Pentagon quite clearly although it is about two miles away. The thing that is remarkable about the 11th of September is that it was such a beautiful day and there was not a cloud in the sky. It was one of those rare days when the sky just has the deep blue color like everything is perfect and it could not have been a nicer day. We started hearing reports of the initial attack on the World Trade Center

Q. (10:37) Do you remember how you heard that initially?

A. We had received a call from our front office saying that there was an issue going on and everybody gathered around the TVs that were available and we were listening to the CNN reports about the World Trade Center. And then it seems to me that we heard right about the time that the second plane hit shortly after the Pentagon had been hit also. I ran up to the third floor in our building which had a clear view and we could see this enormous column of smoke coming from the Pentagon. I called to some people around me and we all gathered around the window, looking at this horrible sight and then throughout the day of the 11th – well, initially the Surgeon General made some quick assessments of the situation. Not knowing what to expect, we sent most of our staff home early in the day and had only kept fifteen or twenty people in our compound.

Q. (12:12) Who would the Surgeon General talk to at the Pentagon, and did he do that that day?

A. That was out of my direct -- I don't know the exact communications, but apparently someone had called him from the Pentagon fairly early on and advised him what was going on.

Q. (12:38) Would that have been the DeLorenzo Clinic?

A. No. The Surgeon General wears two hats. He's the Chief of the Bureau of Medicine Surgery, but under a certain general hat he's OP-093. He actually is on the CNO staff and he has a small staff at the Pentagon and those were probably the people that contacted him. We pretty much evacuated most of our military and civilian staff at that point and kept about fifteen to twenty mostly senior people back to just deal with whatever was going to come up throughout the rest of the day, not knowing where all this was going ,and whether there was going to be additional attacks. And then by five in the evening, it seemed pretty clear to the Surgeon

General that nothing more really had happened that day and released us to go home on the 11th, where we pretty much stayed by our TV's all night and were in a sort of heightened recall status. We had cell phones and were ready to be recalled if necessary at that point.

Q. (14:03) We've heard from other people and I believe the Air force and the Army mentioned doing this -- sent very junior people in to recover the remains and you just said that the decision was made that fifteen to twenty of you who are senior were left behind. Is that a decision you made consciously not to let the junior personnel be involved?

A. No. Actually we are a headquarters command. We have very few junior people. Most of the people there are senior officers and we don't provide any medical care or anything like that.

Q. (14:39) So you didn't have any young corpsmen to worry about?

A. No. We don't provide care there. It's more like our corporate headquarters.

Q. (14:48) What is going through your mind on the evening of the 11th? You're sitting there watching television, you know you are getting ready to be involved. What kind of mental preparations are you doing?

A. Well, not just on my mind, but on most of my associates also was when is the next shoe going to drop? What else? Is this the end of the series of events, or is this the beginning of an all-out attack on the United States? The thing I remember most is the uncertainty of it all. What is going to happen? What are we going to do? What's going to happen to us? What will our response be?

Q (15:30) Are you picturing or have an understanding of what your role is going to be in the coming days?

A. In this little corporate group that we kept behind, those were certainly issues that we talked about. Mostly our concerns were the readiness of our hospitals, what's going to be asked of our medical folks throughout the world, what will be expected of them, what demands will be placed on them, will we be expected to deploy them? Those were sort of the discussions we had that day.

As an aside, one of the issues in the overall medical planning is that there are defined steps for when we go into a contingency status that there's medical people at our hospitals that have deployable platforms. Some go to hospital ships, some go to fleet hospitals, some go with the Marines and then we have reservists that dome in and back-fill where we had staff that we may have needed to send forward. So all these things were running through discussions. What's our next step going to be? Of course, any time you have discussions about going to war or going into combat, there's a lot of things that run through medical people's minds about, what about preventative medicine, does everyone have shots, this kind of discussion. If there are chem-bio attacks, does the staff know what they are supposed to do and what resources do they have? Those kinds of things.

Q. (17:31) What happened from there? That is the evening of the 11th.

A. Just to go back to one thing, to show some of the uncertainty that was going on during the 11th during the day, is that after the Pentagon was attacked – probably somewhat foolishly on our behalf—but we all wanted to go outside to see more clearly what was going on at the Pentagon. Since we sit on top of a hill anyway, we made ourselves nice targets if there had been any other

sort of follow-on attack. Just to illustrate some of the uncertainty was that and what we understand more in retrospect as we are all standing outside, we hear this tremendous boom and this was after the Pentagon had already been hit. So our immediate impression was that something else in the capital area had been hit – the Capitol building or the White House, or the State Department and we're just wondering, what else is going to happen now that there is another explosion. What it turned out to be was that the jets were being vectored in. It was a sonic boom, but if you are sitting on the ground and nobody is explaining that to you and it sounded like another explosion somewhere. So there is looking back on it now that the initial response was tremendous uncertainty and not really knowing what was happening.

There are all kinds of rumors being discussed, and all kinds of things that in retrospect turned out to be misinformation later on, but you don't know that at the time, so there is this feeling of uncertainty. We had no further recalls on the night of the 11th. I came in as normal on the 12th and we did have some uncertainty as to whether we were going to have everyone come in that day or whether is would be like a snow day. But OPM basically said that this is a work day for civil service and this was expected to be a regular work day for us, so we did have to call some of our staff and inform them that they were expected to come in on that day because some of them were not sure what exactly our expectations were. So anyway, by 10 o'clock on that day we had pretty much our normal staff at work and my boss, Captain Art Miller received a call from the Pentagon that he and I were ordered to go to the Pentagon and assist with identification and remains. The reason probably that the two of us who were singled out for this is that we both have – and I understand that you'll be talking to him a little bit later on –both of us have backgrounds in patient administration and part of an administration officer's training is in decedents affairs. One of their duties is when we have an active duty member die that we have

standing contracts with funeral homes in the area and remains are taken to a local federal home for preparation, but then it is the patient administration officer's responsibility to go to the funeral home before the active duty member's remains are dressed. We 're trained to do an inspection of the remains. There are things we look for in our training; make sure that the remains are properly embalmed and that they're not open areas that are leaking. Basically, our job is to make sure the remains are on the return to their families that they look good and are a credit to the Navy. So we inspect these remains before their uniforms are on and then we stand by the funeral home puts their uniforms on and we make sure the uniforms are absolutely perfect. If we have to get them a brand new uniform we will. We make sure their medals and ribbons are absolutely perfect and everything is just as it should be.

Q. (22:47) Is everybody that's in patient administration trained in that?

A. The officers are.

Q. (22:53) How are you trained in that?

A. There is a formal navy course at the Naval School Health Sciences here at the Bethesda compound and all the patient admin officers are trained on that particular thing. So I would assume the reason Captain Miller and I were called is because we have some training in this and some familiarity with these issues. And over the course of our experience we would have spent time in funeral homes and morgues, and have some experience in dealing with the dead and those issues. Both of us have done it enough that it's not going to disturb us particularly and that's part of the job and I've done it many times. I don't know how many times Captain Miller has but I'm sure he has done a fair amount.

Q. (23:51) How many times would you say you have done it?

A. Probably sixty or seventy times. A fair amount of experience in dealing with death and bodies and remains and cremains – issues that surround those. So we drove over to the Pentagon not knowing exactly how this was all going to work out; only that we had been asked to go over there and when we got there, we met with the officer that had been working with the Command Center and basically had requested this type of support. And we were assigned to go over to the temporary morgue area that the FBI was in charge of. It was sort of a morgue area, but it really was an evidence-recovery area. As you know, this was criminal investigation and the FBI had overall cognizance abut it. Myself and Captain Miller representing the Navy and there were two – two enlisted Air Force folks and an Army chaplain. All three of us were dispatched there by our parent services and our tasking really was that work with the FBI as the remains come to this area, see what you can find out. If there is any type of identification you can put on the remains either confirmed or not. It still would be useful information to our navy command post. Basically, that's what we were doing – any type of identification even however preliminary it might have been to report that.

Q. (25:57) And what tools did you have to identify the remains?

A. The way it was structured, this was very much an FBI operation, this was considered an evidence area, so we weren't actually touching and handling the remains. FBI basically said, you guys stand here, don't cross this line and we'll provide you with any type of information they could uncover. So most of my recollections for that day is most of the day was spent in waiting. Sort of in anticipation that something was coming but not knowing exactly what it was.

So later in the day they started bring the remains in. A truck would drive up, there would be a team of mostly active duty soldiers that would carry the body bags out of the truck and place them in this temporary morgue which basically was the loading dock. And then the FBI had a large contingent of evidence recovery – recovery people, photographers, weapons experts, anything they thought they needed that could help. And they would take one of their bags of remains over to a particular area, open the body bags and their not really moving the remains around a lot. These body bags pretty much unfold like a zippered bag that pretty much opened like a book so you don't have to move the remains. The two of us looked at each other and knew it would be difficult as soon as we saw them coming off the truck as all these body bags are of the same size, but some looked only half full and some only a quarter. We knew it would be pretty gory inside, but in all my experience with death and bodies, I was still unprepared for what I saw. These were for the most part, these remains were just charred beyond recognition. It was pretty horrible to look at. It was the kind of thing that actually may have had a greater emotional impact if they hadn't been so charred but they were so unrecognizable as humans. I felt bad. I felt like I should have more of an inpact – emotional impact than it did. It looked like a piece of firewood or something. Various stages not all of them were burned beyond recognition, but the majority of them I could not look at them and associate being a human, at that same time that far destroyed.

The most gratifying part of the day was the sum of thirty remains going by or through this process at the time we were involved. Two of them were what we thought that maybe they, rather than being right in the flames themselves, may have died of smoke inhalation or that a greater distance from the actual flames. It was quite gratifying that one individual still had his

DoD tag with his picture and another one had his name badge, so we were able to report to the Command Post preliminary identifications on two of the remains. As difficult as the day was, it was very gratifying that we were able to, for those two families in that case, to make a positive ID in report back as I am sure you are aware of them, the positive ID were made by the Dover Air Force Base mortuary later on and using DNA sampling techniques.

Q. (31:33) We're going up there next week.

A. It made it feel like the whole day was worth it. That we were able to give a report on at least two of the cases, that we were fairly comfortable with the identification as was the FBI.

Q. (31:57) You weren't able for any of the other ones?

A. No.

Q. (32:03) Now at this point you are dealing with the Navy, Army and civilians. You don't know what space or, everybody is brought to the same place, right?

A. Right. And you could not for most of the ones we saw, you couldn't even venture a guess whether they were active duty or civilian – everyone looks the same in death. It was sort of ironic that the two that were recognizable were both Navy petty officers.

CDR Loftus: (33:42) We know about them. We talked to their Division Officers and one of the petty officers in charge of the mortuary felt the same way as you did when he worked on them up there. He was very gratified that they were whole and intact and looked so well. And took pride in their uniform.

Q. (33:20) How long did that go on?

A. That went on throughout most of the day. We left about 2300 or so, because the FBI was shutting down for the evening and weren't trying to bring out any more remains. We went down the following day, PERS had found some other people for the following day so for myself and Captain Miller it was just most of the day throughout the 12th.

Q. (34:04) And all your years of experience, did you ever see anything close to this magnitude?

A. No.

Q. (32:12) How do you cope with that?

A. Well, the fact that I had dealt with human remains many times in the past I thought because of that experience that this would not have tremendous effect on me. I don't think it has had a monumental impact, I just assumed not seen what I had seen, but it did help that almost against my will that I was called over to talk to one of the SPRINT team folks. I'm glad that I did. It helped to hear the others that were involved in doing this same sort of thing, to hear their perceptions and found that my feelings and perceptions were not much different than theirs. To share a horrible experience somehow made me feel a little bit better to discuss it.

Q. (35:33) We found a lot were not aware of the SPRINT team or don't have an understanding of what they can do or feel, 'I don't need that'. It might show a sign of weakness to see one. When someone mandated that you would go, where do you think that know-how came from? Do you feel they had an understanding for how important that was?

A. Maybe I didn't appreciate it as much as I should have and in retrospect, I think it was a wise choice and I think it was useful.

Q. (36:09) When we spoke to the Cole Sailors (*USS Cole*), and the whole chain of command would ask the question, 'who were some of the heroes, who stood out'? The majority of answers came back, 'people on the SPRINT team' or, actually one individual that was there that helped to put it together. It was really interesting to see that perspective many months later because we were five months after the incident with how they looked back and saw how important that part was from an understanding and some of what they were feeling.

Again, I'm looking at all your years of experience and being around -- this is a two-fold question --is there any way to prepare people for this in your field of work, and/or is there a way of identifying people that could be placed in the bag.

Commander Loftus mentioned some of the other services it seemed like some really junior people in there that didn't have medical backgrounds and all were putting to and it was incredibly traumatic. In the Cole incident, there were some people that helped with the initial recovery that just happened to be identified because they had that makeup and EMT training. Obviously, you don't want someone to be exposed to this unless they have to be, but is there a way of – I'm looking at this from 'lessons learned' standpoint. Are there some things that you would put in place or recommend to put in place to help identify some of those? God forbid that this should happen again.

A. I have given it some thought. I think it is something to receive training and may help somewhat are people in the medical field perhaps can get more used to general bleeding and bodily fluids and things like that that would help someone to deal with it a little bit easier, but

realistically whether you are from a medical background or from an operational background, nothing could possibly adequately prepare somebody to deal with these types of issues. And it must have been very much the same thing during World War II or on the beaches or on the shipboard attacks that you kind of grit your teeth and do what you have to do. But there is nothing that can adequately prepare somebody for what they will see. Probably the people that would come closest to this are people that deal with air crashes. They handle it the best. I don't see how you can train everybody to be at ease in that situation.

Q. (39:36) Are there any lessons learned from this whole incident that you can think of?

A. Well, some of this is still evolving, but for us on the BUMED side, some of the lessons we learned were more from the Cole than from the Pentagon attack. What we found and this is really not public information, there were some communication problems in regards to the CACOs and the families on the return of the Cole remains to Dover. The information was not communicated well from Dover to the CACOs and as a result the CACOs got some misinformation and, of course, once you start passing misinformation to the families, then everybody is going to take a beating. It's not something we want to do. One of the reasons we think this happened is that there is an artificial distinction between BUMED and BUPERS on how these things are handled. BUPERS, PERS 06, thought that 066, the casualty branch, they manage the CACO program and communications with the family, and these people weren't really involved initially in the Cole disaster, so it was medical people passing information to the CACOs that weren't trained in what needed to be communicated and what needed to be verified before being passed. Things like that. So the lesson we learned is that we wanted PERS 06 more involved early on in these things. And for the Pentagon bombing when this happened we

immediately insisted that PERS 06 people be in Dover at the mortuary. And PERS in this case, sent a Captain from Naval District Washington (Editors Note: this was CAPT Steve O'Brien, USNR, also interviewed for this project) was also sent to Dover to be the senior person for communication and liaison. It worked tremendously much better than for the Cole thing so I guess the point I would make is that our lesson was with the Cole, not so much with this one. This went much smoother. What we are engaged presently is continuing evolution of this between the mortuary affairs program and the casualty branch. I've got a meeting scheduled at PERS in abut two weeks to discuss this further and what we would like to do is transfer mortuary affairs from medical side to the PERS side. That would make it more in alignment to how the other services do it. The mortuary affairs in the Army is handled by the Quartermaster Corps. The Air Force I believe it's similar to that or through their personnel side of it. Neither Army or Air Force medical side is involved in mortuary affairs. And I think that aligning mortuary affairs and the casualty branch closer together is going to make it run even smoother in the future if we ever have to do this again. That's kind of where we are headed.

Q. (44:00) How does that work in hospital? If you took it out of the medical center and put it over in casualty.

A. It works on two levels. There still has to be someone on the medical side at the hospital to take care of immediate action -- counsel the family, make arrangements for transfer of the remains, things like that. We're not talking about giving that part of it. Just who owns mortuary affairs as corporately. That's what we're talking about.

Q. (44:37) So you still have medical working for PERS 06?

A. Right. It would be medical people but they would be performing a PERS function.

Q. (44:48) I want to ask you about -- you mentioned what we were talking earlier about training and there wasn't anything that would prepare people for this. We have talked with some aviators who said that the aviation training may have helped some perform a little bit better because they are taught quickly to deal with something and then put it in the box and just keep on going. Is there something in your training that does that as well?

A. Nothing in my training, but that's how on a personal level I deal with it. You know, here's this and put it aside, here's the mission and just focus on that. I can understand why aviators would say that. Whether that can be effectively taught I'm not so sure.

Q. (45:45) That's the kind of question I was thinking personal as well. I saw an accident one time that I still see vivid memories of what I saw. How do you keep those scenes from reoccurring or do you?

A. I think that time is the only thing that can help that. I still see some images and I will probably never forget what I saw.

Q. (46:28) What would you say is the hardest thing that you had to deal with?

A. I guess the hardest thing to deal with was looking at those charred and just horribly disfigured remains and feeling bad more for their families and their loved ones that they will never see that member and wife. Just gone forever. This feeling of frustration and sadness for the families.

Q. (47:13) Is that a similar feeling that you've had all those other times the sixty or seventy times you've been around it?

A. More so for this. Most of the ones that I deal with routinely in my career they were not nearly so. These were people that died of cancer, cancer, maybe a car accident, and suicides. But never to this degree of disfigurement and being so unrecognizable.

Q. (47:55) Where do you see yourself going from here career-wise?

A. As I said, I'm pretty old. I've got about a year left. here– my tour at BUMED. And I own a home in the Memphis area. That's where I expect to retire to and what I'm trying to work on right now is BUPERS now on a lot of active duty issues and I think I still have some things to contribute and making things better for our Sailors. I have to be realistic. I'm coming up on 32 years and I can't stay around too much longer. I'm looking forward to retirement in the Memphis area eventually and getting into the civilian healthcare world.

Q. (49:15) What do you think you can still contribute to help make life better for the Sailors? Some of the issues you still have to offer.

A. A couple of issues I touched on are still trying to get resolved is the whole issue of limited duty process, what happens when a Sailor is on limited duty process, in a limited duty status. How can we get them fit and back to an operational status more quickly. How can we track them better and make sure we don't lose them to close cognizance so that they stay on limited duty longer than they need to. Right now we have about 1.5 percent of the active duty force on limited duty. If we could drop that even half a percent, we're talking about thousands of Sailors per year that are already on active duty that can be deployed on ships. As it is now, it isn't easy

to recruit these days. If we can make better use of what we already have, then we're far better off. There's savings to be made and efficiencies to be gained. Sailors didn't come in to hang around hospitals, they came to be in harm's way.

Q. (51:00) Any other issues you would like to see contribute to before you get out?

A. Because of the many years I have spent on ships and in an operational status, I just always have a warm spot in my heart for operational readiness. We have got several issues there that I would like to work on. One of the issues that we're starting right now is the issue of suitability screening where a Sailor gets orders to go to sea and then right before they transfer to go to sea, we say 'woops, you're unsuitable to be deployed.' Try to refine this system to be more pro-active than if there are Sailors with conditions that make them undeployable that we identify them earlier on and take care of them sooner so that when somebody does get orders to sea that the navy has a reasonable assurance that they're going to be fit and carry out their orders and not disrupt this whole pipeline and timing of reliefs and schools, and training, things like that.

Q. (52:30) Such as what? What kind of issues?

A. Just to elaborate on this issue. When there is a Sailor on sea that is up for orders to shore and may have additional schools planned, they may have a job on shore duty that requires them to be licensed at a certain time. And the Sailor that was due to come from shore duty to relieve them on the ship, then at the last minute, we make a determination that person is unsuitable to carry out their orders. Well, it just doesn't disrupt that person, it disrupts this whole pipeline of planned transfers and moves, and perhaps that ship would like to send that person off to carry out their orders to school, but they maybe the only one on that ship with that particular skill so that

entails them to stay aboard longer and it disrupts this whole pipeline. So that is one of the issues we're working on now to try to be more pro-active and do this screening farther out so the detailer has more assurance that when they do cut orders, the member will be able to carry out his orders. As it stands right now, the screening is triggered by the orders, not vice-versa.

Q. (54:03) Are there some issues that are more common than others as far as making someone undeployable?

A. Knee problems are probably the highest and biggest offender, back problems.

Q. (54:18) Seasickness, is that one?

A. No, never. If they get to that point, we already know if they are going to be seasick.

Q. (54:30) Can you think of some others we should talk with about this incident?

A. The only thing and I don't know if this is in your plans already, but you may want to think about having an interview with the Surgeon General and getting his perspective and what his concerns are. I'm sure he would be happy to talk to you.j

Q. (55:05) Who would be the best one to go through?

A. His aide.

Q. (55:09) Do you know his or her name?

A. Lieutenant Michele Kane and her number is [redacted]. I don't know what his schedule is, but I think he would have some interesting information.

Q. (55:38) Anybody else?

A. I think he would be the key.

Q. (55:45) Anything else you want to add for the historical record?

A. I think we've about covered it.

Q. (55:53) Commander Loftus, do you have any questions?

A. No, I can't think of any.

CAPT McDaniel: (56:00) Well I just want to, as a fellow naval officer, thank you for all that you have done in your thirty-plus years and your part in this incident as well. Someone has to do it, but just thank you so much for what you've done.

A. Thank you.

Transcribed by;
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