

# Seven Years Later: The Questions the Navy Still Won't Answer About HSC-28

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*The death of AE3 Brandon Caserta and a pattern that still demands accountability*

## Opening

Eight years ago, AE3 Brandon Caserta died while serving in the United States Navy. What happened on June 25, 2018, did not occur in isolation. It happened inside Helicopter Sea Combat Squadron 28, known as HSC-28, within a command climate that had already been raising serious concerns.

Brandon walked onto his command's flight line and jumped into the spinning tail rotor of an MH-60S helicopter, in full view of those around him, including members of the very command responsible for his leadership, welfare, and safety.

That is not something that can be explained away. It is not something that can be minimized. And it is not something that happens without cause.

*What was happening inside that command that led a sailor to believe this was his only way out?*

Eight years later, that question still has not been answered. Instead, what has emerged is a pattern of warnings ignored, leadership failures left uncorrected, evidence that does not align with official findings, and a system that has yet to fully account for what happened.

What follows is not speculation. It is the record as the Caserta family understands it, based on documents, witness accounts, official reports, phone records, complaints to oversight agencies, and years of unanswered questions. It is a record of contradictions, missed accountability, and a command climate that still demands scrutiny.

## A Pattern Inside HSC-28

The death of AE3 Brandon Caserta was not a single failure. It was the result of a pattern. It was a pattern of ignored warnings, toxic leadership left unchecked, corrective actions ordered but not enforced, official reports contradicted by evidence, and witnesses who were silenced through threats, fear, and intimidation.

For the Caserta family, the central question has never changed: why were so many warning signs ignored, and why did accountability never follow?

HSC-28 was not simply a command with personality conflicts or difficult leaders. According to numerous accounts provided to the family, it was a hostile and abusive environment where sailors feared retaliation, leadership concerns were ignored, and those in power appeared to protect themselves and each other. When a command reaches that point, the problem is no longer isolated misconduct. It becomes a failure of command responsibility.

## AE1 Jared Brose: Ordered Action, No Enforcement, False Record

According to records obtained after Brandon's death, AE1 Jared Brose was removed from deployment and ordered to attend anger management due to concerns involving toxic leadership, abusive conduct, and misuse of authority while deployed. Commands do not take that step lightly. The order itself was an acknowledgment that intervention was necessary.

That intervention never occurred.

Despite the seriousness of the conduct that resulted in his removal from deployment, AE1 Jared Brose was returned to duty at HSC-28 under what was characterized as a “second chance.” According to the Caserta family, that decision was made by his immediate leadership, Chief Sheila Hennard and Master Chief Pete Larette, and was supported by the command leadership, Commander Whitmer, Executive Officer Trevor Prouty, and Command Master Chief David Tokarski. This was a command-level decision made with awareness of prior conduct.

This was not an isolated personnel action. It was a command decision made by leaders who had direct knowledge of Brose’s prior conduct and the concerns surrounding his leadership. A decision that ultimately led to Brandon’s death.

The record, as presented by the Caserta family, reflects the following:

- Brose was removed from deployment due to substantiated concerns involving toxic and abusive behavior
- Chief Hennard and Master Chief Larette had supervisory authority and awareness of those concerns
- Despite that knowledge, they authorized his return to the command environment without verified corrective action

That decision is central.

It did not mitigate risk—it reintroduced it.

It did not enforce accountability—it deferred it.

And it did so within the same chain of command that had already failed to correct the underlying issues. This places responsibility not solely on the conduct of one individual, but on the leadership decisions that allowed that conduct to persist.

When a known risk is identified, and those with authority choose to retain and reintegrate that risk without effective intervention, the consequences are not unforeseen; they are predictable.

The Caserta family asserts that the decision by Chief Hennard and Master Chief Larette to return Brose to duty was not a corrective measure; it was a failure to act on known information.

That failure did not exist in isolation. It is consistent with a broader pattern of leadership decisions within HSC-28 in which known issues were acknowledged, but not resolved.

The United States Navy Inspector General later confirmed that Brose did not attend the mandated training. Despite that, both the NCIS report and the command's internal investigation recorded that he had completed it, and that same assertion was communicated to the media.

This is a material contradiction. It is not a clerical error. It is a discrepancy between verified fact and official finding.

Additional witness accounts provided to the Caserta family further elevate the seriousness of the underlying conduct. Brose was involved in taking bets with other sailors on when another sailor might take his own life. That behavior is not merely unprofessional. It is incompatible with any standard of leadership, directly relevant to command climate, and a profound breach of basic human decency.

The sequence is clear: corrective action was ordered, compliance did not occur, and official reports stated that it did. That sequence raises two unavoidable questions: who verified completion, and on what evidence? And who allowed an inaccurate statement to stand as fact in an official investigation?

When ordered corrective measures are not enforced and are then documented as completed, the failure is not limited to one individual. It extends to the integrity of the command and the reliability of the investigative process itself. The result is a record that does not match reality. When the record cannot be trusted, accountability cannot be achieved.

## **Chief Sheila Hennard: Supervisory Authority, Knowledge, and Affirmative Failure to Act**

Chief Sheila Hennard, as the immediate supervisor within the chain of command, exercised direct authority over AE1 Jared Brose and bore responsibility for enforcing standards of conduct and ensuring the safety and well-being of sailors under her charge. The record, as presented by the Caserta family, establishes that Hennard had direct knowledge of Brose's conduct before his deployment and conduct that led to Brose's removal from deployment, including substantiated concerns regarding toxic leadership and abusive behavior.

Despite that knowledge, Hennard participated in the decision to return Brose to duty under the characterization of a "second chance." This was not an administrative oversight or passive omission—it was an affirmative exercise of command authority.

That decision carries consequences.

It reflects a determination to retain a known risk within the command environment without verified corrective action, without documented remediation, and without safeguards to prevent recurrence. In doing so, Hennard did not mitigate the identified risk—she authorized its continuation.

Under principles of supervisory responsibility, knowledge of misconduct combined with authority to act creates an obligation—not a discretion—to intervene effectively. Failure to do so is not neutral. It is consequential.

The sequence is clear:

- **Documented misconduct**
- **Established supervisory authority**
- **Affirmative decision to retain and reintegrate**
- **No verified corrective action**

From an accountability standpoint, responsibility does not rest solely with the individual who engaged in the misconduct—it extends to the supervisor who, with full knowledge, permitted that misconduct to remain within the command.

The Caserta family asserts that this decision was not merely a lapse in judgment, but a failure to exercise the duty required of her position—one that contributed to the continuation of a known harmful environment within HSC-28.

## **NC1 Remmy Spence: Control Over Brandon's Future**

NC1 Remmy Spence served as the command career counselor and, by his own account, presented himself as a mentor to Brandon. In that role, he was not merely processing paperwork; he was also responsible for managing the team. He was responsible for helping guide a sailor's career and ensuring accurate information was provided about orders and opportunities.

According to the Caserta family, Spence had direct knowledge of what Brandon was enduring and failed to act. As a Navy Counselor, Spence knew all about the leadership problems within HSC-28 and later provided incomplete or misleading information to investigators.

The family also raises serious concerns about Brandon's career orders. Brandon had been selected for Naval Aircrewman Operator, one of the most demanding aircrew jobs in the Navy. Patrick Caserta says Spence called him after Brandon received his orders and said, "See, I told you I would take care of your son." Patrick reports that call is preserved in his phone records. Brandon was supposed to leave HSC-28 in March, but Brandon broke his collarbone. Spence ended up cancelling the orders. According to the family, Spence told Brandon and Patrick that the delays were caused by the Detailer when the family was told by the detailer that Spence himself was responsible for canceling and delaying the orders. The detailer told Patrick that he needed Brandon and would have given Brandon orders immediately.

The family also reports that Spence required Brandon to redo his Aircrewman package multiple times, delaying his transfer and keeping him inside HSC-28 longer than he should have been. Brandon transferred to Aviation Electrician school with a broken leg after leaving the SEAL program and could have transferred to Aircrew school with a broken collarbone

For the Caserta family, this was not an administrative oversight—it was a consequential failure. They assert that Spence's actions, and his failure to act, kept Brandon in a toxic command environment he was fully aware of, long after Brandon should have transferred. Brandon was a high-performing sailor with orders to leave. If command convenience was allowed to override his safety and the broader needs of the Navy, that is not negligence—it is a failure of duty.

## **Master Chief Pete Larette: Knowledge, Authority, and Failure to Intervene**

Master Chief Pete Larette, serving as Maintenance Master Chief at HSC-28, exercised direct supervisory authority over AE1 Jared Brose and held responsibility for the environment in which Brandon Caserta worked.

The record, as described by the Caserta family, establishes that Larette had both knowledge of ongoing misconduct and the authority to act.

In a phone call to Patrick Caserta—witnessed by Teri Caserta and preserved by the family—Larette reportedly stated, "Brandon is useless to me because I can't deploy him," followed by, "I've got your back, brother." These statements are not incidental. They reflect a command perspective in which a sailor's value was reduced to immediate deployability, rather than duty of care or long-term service.

More critically, Larette acknowledged in both Inspector General and NCIS reporting that he was aware of abusive conduct by Brose and that he elevated those concerns to Executive Officer Trevor Prouty more than a week before Brandon's death.

That establishes the following:

- **Knowledge** of ongoing abusive conduct within the chain of command
- **Authority** to intervene, escalate, or ensure corrective action
- **Notice** provided to senior leadership prior to a fatal outcome

The question is not whether Larette knew.

**The question is what he did with that knowledge.**

There is no indication that effective corrective action was taken. There is no evidence that the known risk was mitigated. There is no record that the environment was changed.

A sailor remained in a documented toxic command climate.  
Known issues persisted.  
No effective intervention occurred.

Under principles of command responsibility, reporting misconduct does not end the obligation. It initiates it. When a senior enlisted leader has knowledge of harm and the authority to act, failure to ensure that action is taken is itself consequential.

The Caserta family asserts that decisions made within this leadership structure—including the handling of Brandon's transfer and the lack of intervention regarding Brose—had the foreseeable effect of keeping Brandon in a known harmful, toxic and abusive environment.

Despite these facts being presented to both the Naval Criminal Investigative Service and the United States Navy Inspector General, the family states that no meaningful accountability followed. Larette was allowed to retire with full benefits

This presents a fundamental issue:

- **Known misconduct**
- **Established authority**
- **No effective action**
- **No accountability**

That sequence is not an oversight. **It is a failure of duty.**

Despite the established knowledge, authority, and failure to act, Larette was permitted to retire from the Navy with full benefits. No disciplinary action appears to have impacted his career or retirement. The absence of consequence is not incidental—it is instructive. It signals that even where duty is not fulfilled, accountability may not follow. From an accountability standpoint, this outcome raises a critical question: **what consequence exists for a failure of duty when the result is the loss of a service member's life?**

## **Chief Doug Delassandro: Missing Property and No Meaningful Investigation**

The Caserta family has raised serious allegations involving Chief Doug Delassandro, including the taking and withholding of Brandon's personal property and mail after his death. According to the family, Brandon's driver's license, wallet, credit cards, and mail were not returned. The day after Brandon died, the family went to the post office to change his address from both the command and barracks in an effort to preserve and receive mail they believed could contain relevant information.

To this day, the family reports receiving none of Brandon's mail, not packages they had sent him, not letters from family or friends, and not other correspondence. The unauthorized taking or withholding of personal property, financial items, and mail raises serious legal concerns under both military and civilian law. It also raises concerns about possible interference with evidence.

The family also reports that numerous items were missing from Brandon's barracks room, including clothing, uniforms, electronics, a custom handmade pen, and cash. They state that money originally in Brandon's wallet was removed and replaced with what was non-genuine currency or fake bills. After they reported these concerns to NCIS and provided photographs and serial numbers, several items, including the custom pen and electronics, were returned. Other items, including cash, uniforms, and additional personal effects, were never recovered.

The sequence raises fundamental questions: who maintained custody of Brandon's belongings, why were items missing, why were some returned only after independent identification by the family, and why were others never accounted for?

After being boxed, Brandon's belongings remained in the custody of HSC-28. When the family received them, they were in poor condition and bore clear evidence of repeated access—multiple layers and types of packaging tape indicating the boxes had been opened and resealed numerous times. This was not consistent with standard handling and raises further concerns about how, and by whom, those belongings were accessed prior to their return.

Despite multiple complaints submitted to the United States Navy Inspector General and detailed information provided directly to Naval Criminal Investigative Service, the Caserta family states that Chief Doug Delassandro was never formally interviewed or subjected to a comprehensive investigation. According to the family, he was effectively shielded from meaningful scrutiny and subsequently allowed to continue his career, ultimately receiving a commission as an officer. This sequence is not procedural—it is consequential.

When credible allegations involve potential theft, interference with mail, or possible obstruction of evidence, the obligation is not discretionary; it is mandatory. Failure to initiate or complete a thorough investigation under such circumstances raises serious concerns regarding the enforcement of standards, the integrity of the investigative process, and whether accountability was actively avoided. The issue is not whether allegations were made. The issue is what was done in response to them. According to the Caserta family, the answer is: nothing.

## **Command Master Chief Tokarski: Evidence Versus Statement**

The Caserta family also raises serious concerns about statements made by Command Master Chief David Tokarski to investigators. Tokarski reportedly told NCIS that his communication with Brandon's father, Patrick Caserta, occurred after Brandon's death. Patrick's phone records show a different timeline.

According to the family, the first call between Patrick and Tokarski occurred while Brandon was still alive. The second call also began while Brandon was alive, with Brandon's death occurring approximately three-quarters of the way through that conversation. The documented time of death, combined with timestamped phone records, directly contradicts Tokarski's reported account.

Between those two calls, Tokarski confronted Brandon in a manner described as yelling and threatening, rather than securing immediate assistance for him. He then reportedly returned to his office and called Patrick again. This scene occurred in the Geedunk where Brandon was working in front of other sailors.

These facts raise significant questions about whether material information was misrepresented to investigators. Providing false official statements in an investigative context is a serious matter under military law. The family says NCIS had access to Patrick's phone records and screenshots. The Navy Inspector General was also provided this information. Yet, according to the family, no corrective or disciplinary action followed.

Tokarski was later forced to retire a year later when articles came out about Brandon's death. He subsequently obtained a civilian position at Naval Air Station Norfolk involving oversight of Limited Duty service members. For the Caserta family, the question remains direct: when documentary evidence contradicts statements made to investigators, why was nothing done? And, knowing Tokarski was involved in Brandon's murder, why was he hired to oversee a vulnerable group of sailors?

## Executive Officer Trevor Prouty: Knowledge Without Action

As Executive Officer, Trevor Prouty had direct responsibility for command climate and oversight of senior enlisted leadership. According to accounts provided to the Caserta family, Prouty was routinely informed about issues involving Brandon and the toxic environment within HSC-28.

Senior enlisted leaders, including NC1 Remmy Spence, Master Chief Pete Larette, Command Master Chief Tokarski, and Chief Shelia Hennard, reportedly had visibility into what Brandon was experiencing. This placed Prouty in a position where he definitely knew about the conditions affecting Brandon and the torture Brose was doing to him.

It's clear that Prouty minimized or denied his awareness during official investigations. There are also serious concerns surrounding Command Climate Surveys. The family reports that they repeatedly attempted to obtain those surveys but were blocked. This matters because multiple sailors told the family they specifically named Brose and other toxic leaders in survey comments, describing his anger, abusive leadership, hostile behavior, and toxic treatment of subordinates who hoped Brose would be disciplined. Brose was never held accountable for his actions or for driving Brandon to suicide. The Casertas call this murder by suicide.

One sailor told the Casertas that at least thirteen sailors brought him their written comments to review for grammar and clarity before submission. According to that sailor, the comments consistently described serious concerns about Brose and the command climate. If those surveys contained direct evidence of toxicity and were ignored, withheld, or never meaningfully addressed, then the Navy failed to act on one of its own internal warning systems.

Prouty was later promoted to Captain and assigned to command at sea as the Executive Officer of USS John E. Kennedy (CVN79). For the Caserta family, that promotion raises a disturbing question: how does a system reward leaders when serious concerns about their prior command climate remain unresolved?

## Silencing Through Fear: Commander Duane Whitmer

On the day Brandon died, Commander Whitmer reportedly gathered sailors under his command and delivered a message no service member should ever hear. Instead of compassion, transparency, or a commitment to truth, he warned and threatened his sailors that speaking to the Caserta family or to the media would result in mutiny charges and confinement at Leavenworth Prison.

Under the Uniform Code of Military Justice (UCM), mutiny is one of the most serious offenses a service member can face. It is intended for conduct that threatens command authority and military order. Invoking such a charge in response to communication with a grieving family or the press raises serious legal and ethical concerns.

According to accounts provided to the Caserta family, this was not a one-time statement made in the emotion of the moment. The same threat was repeated after the first article about Brandon's death was published, again after additional reporting, and again when a reward was offered for information that could help the family uncover the truth.

*The message was clear: speak out, and your career - and your freedom - would be taken.*

That is not leadership. It is coercion. When sailors are threatened into silence, truth is not protected. It is buried. Fear of reprisal creates a chilling effect that discourages witnesses from coming forward and compromises the integrity of any investigation before it begins.

The Caserta family also questioned HSC-28 Commanding Officer Duane Whitmer why he did not personally notify them of their son's death. According to the family, Whitmer stated he was "following protocol" and that casualty officers were responsible for making that notification.

For the family, that explanation raises a broader and deeper question. In a command where serious concerns had already been raised, protocol was strictly followed in notifying the family, yet, according to their account, those same standards were not consistently applied to issues involving leadership conduct, safety, or accountability.

**When protocol is invoked in one instance but not enforced in others, it is not simply procedure; it reflects judgment.**

Whitmer was later forced to transfer to Maryland, where he served as a flight instructor. While personnel transfers can occur for many reasons, the timing, following mounting public scrutiny, raises a critical question: was this accountability, or avoidance?

The alleged conduct warranted far more than reassignment. The first threat invoking mutiny should have triggered immediate removal from command and formal review. Instead, no such accountability is evident. Rather than being relieved and investigated, Whitmer was allowed to continue his career in a new assignment. That was not corrective action. It was displacement.

When a commanding officer uses the threat of extreme punishment to silence communication, and the response is transfer rather than discipline, the failure is not only within one command. It is within the system responsible for enforcing standards.

## **Captain Allen Worthy: Oversight Without Intervention**

Captain Allen Worthy held a command-level position overseeing multiple helicopter squadrons (13) at Naval Air Station Norfolk, including HSC-28. He was above Whitmer in the chain of command and had responsibility for readiness, safety, and command climate across subordinate units.

According to information compiled by the Caserta family, multiple suicides occurred within the broader command structure during June 2018, including several in the weeks and days leading up to Brandon's death. When multiple service members die by suicide in a compressed timeframe, that should trigger urgent command action. Safety standdowns exist for this reason. They allow leadership to pause operations, address risk, communicate resources, and confront dangerous patterns before more lives are lost.

The Caserta family asserts that no command-wide safety standdown occurred in response to these deaths, and says several sailors corroborated that point. The issue is not whether one safety standdown can guarantee a life will be saved. The issue is whether reasonable, available steps were taken when warning signs were impossible to ignore.

Following public reporting about Brandon's death, Worthy was forced to retire from active duty. According to the family, repeated attempts to contact him went unanswered. He later accepted a civilian safety-related position with the Navy in San Diego, CA. For the Caserta family, this raises a painful question: how can a senior leader preside over repeated loss of life and then move into a safety role without public accountability?

## **Witness Statements and Material Inconsistencies**

The Caserta family has also identified significant inconsistencies in statements provided by three female sailors, Katrina Carden, Kristen Cummings, and Mileika Miki, who were in regular and ongoing communication with Brandon before his death. According to the family, these individuals were not casual acquaintances. Brandon communicated with them frequently through daily text messages, personal conversations, and ongoing support, including while deployed. The family possesses extensive text message records documenting the nature, frequency, and depth of those relationships.

Yet in statements provided to NCIS and the Navy Inspector General, these individuals reportedly minimized those relationships, stating they did not know him well. The family believes that assertion is directly at odds with the documented record.

The volume and content of the communications indicate that Brandon trusted these individuals and confided in them, including sharing concerns about his command environment and specific issues involving Brose and others. The family asserts that many of these messages, particularly those expressing distress, were ignored or not meaningfully addressed by these friends.

Brandon also left lengthy personal letters to these individuals, further evidence of the level of trust and connection he believed existed. Taken together, the evidence presents a contradiction between documented, consistent, personal communication and statements to investigators minimizing those relationships.

From an investigative standpoint, the issue is not friendship. The issue is whether individuals with direct knowledge of a service member's condition and concerns provided complete and accurate information to investigators. When the record does not reflect reality, accountability cannot follow.

## **Potential Violations: Obstruction and Integrity of Records**

Based on the inconsistencies identified by the Caserta family, including conflicting statements, missing or withheld information, and discrepancies between documented evidence and official reports, serious questions arise regarding the integrity of the investigative record.

Under the Uniform Code of Military Justice, actions such as obstruction of justice, falsifying official statements, or the destruction or alteration of official documents constitute significant offenses when they impede an investigation or misrepresent material facts.

The issues presented in this case, unreconciled contradictions, missing documentation, statements that conflict with verifiable evidence, and witnesses not interviewed, raise the question of whether the investigative process was fully preserved and whether all relevant information was accurately maintained and reported.

From an accountability standpoint, when evidence is contradicted, documentation is incomplete, and records do not align with verifiable facts, the issue is no longer limited to misconduct within a command, it extends to whether the process designed to uncover the truth was itself compromised.

**If the integrity of the record is in question, then the integrity of the findings must also be questioned.**

## **Fear of Retaliation: A Witness Afraid to Speak**

In 2019, the Caserta family was contacted by a sailor who had agreed to speak with a Military.com reporter regarding Brandon's death. Just days before the article was scheduled to be published, the sailor called the Casertas in distress. According to the family, she was crying and expressed fear that her name might appear in the article, even though her identity was not intended to be disclosed.

She told them she was pregnant and deeply concerned about losing her military benefits. More specifically, she feared that speaking with the media and communicating with the Caserta family could result in retaliation, including the possibility of being dishonorably discharged. The Casertas reassured her that her statement would remain anonymous.

The significance of that call is not speculative. A service member who was willing to speak became afraid that telling the truth could cost her career and livelihood. That fear did not arise in a vacuum. It reflected a command climate in which the perceived consequences of speaking outweighed the protections service members should have had.

The Caserta family later became aware, through publicly available social media information, of a personal connection between this sailor and NC1 Remmy Spence, who was identified as the godfather of her child. While

no conclusion is drawn from that relationship, it adds another layer of concern regarding potential influence, perceived pressure, or conflicts affecting willingness to speak openly.

When a witness is afraid to tell the truth, the system is not functioning as it should.

## **Command Climate: Experience, Pattern, and Accountability**

Patrick Caserta served 22 years in the United States Navy as both a fleet and recruiting counselor. Over that career, he saw a wide range of commands and leadership environments. By his account, nothing he experienced compares to what he later learned about HSC-28.

This is not simply opinion. It is context from a seasoned sailor who understood what right looked like.

According to information provided to the Caserta family, multiple serious incidents occurred within the command during the time Brandon was assigned there. One sailor told the family she experienced repeated sexual harassment and assault while at HSC-28. The family states that Whitmer did not meaningfully address the situation and that the sailor was placed in the same work area as her alleged abuser. The Casertas were told by this sailor that Brandon escorted her to her car at night because she did not feel safe.

That fact stands on its own. If a service member does not feel safe walking to her vehicle outside her own command, under a policy of zero tolerance, then the policy is not being enforced and the command is not under control.

That is not merely a policy failure. It is a leadership failure.

The pattern does not end there. According to the Caserta family, in the years following Brandon's death, no member of his command has taken visible responsibility. Instead, individuals continued to advance, retire, transfer, or transition into post-service roles without public accountability. From an accountability standpoint, that sequence matters: allegations of misconduct within the command, documented breakdowns in trust and safety, a death under those conditions, and no visible consequence for those in authority.

That is not resolution. It is avoidance.

## **Funeral Absence and Command Accountability**

In the days following Brandon Caserta's death, the absence of his command was as telling as any report or investigation. According to the Caserta family, not a single member of Helicopter Sea Combat Squadron 28 (HSC-28) attended his funeral. No flowers were sent. No condolences were offered. No acknowledgment came from those who had served alongside him or held responsibility for his leadership and well-being. In the military, where honor, unit cohesion, and respect for the fallen are deeply ingrained values, such silence raises a profound question: **what does it say about a command when it cannot—or will not—stand for one of its own in death?**

## **Training Failures and Command Responsibility**

Additional concerns raised by the Caserta family involve the training and qualification standards on the HSC-28 flight line. According to the family, required qualifications were not consistently enforced, and in some cases were signed off without the underlying work being properly completed—a practice commonly referred to as “gun-decking,” or the falsification of qualifications.

Such practices represent more than procedural shortcuts; they reflect a breakdown in standards that directly impact safety, readiness, and accountability.

From a command responsibility standpoint, the obligation to ensure proper training and qualification does not rest with individual sailors alone. It rests with leadership.

When qualifications are approved without verification, the responsibility extends up the chain of command.

The Caserta family asserts that, following Brandon's death, the command leadership—including Commander Whitmer and the broader chain of command—failed to conduct a full and transparent accounting of the circumstances, and did not meaningfully pursue the underlying causes.

Their concern is not limited to one failure, but to a pattern:

- Standards not enforced
- Oversight not exercised
- Accountability not pursued

In such an environment, the issue is no longer isolated misconduct—it becomes systemic failure.

For the Caserta family, the question is not simply what happened to Brandon, but whether the command structure responsible for his safety fulfilled its duty—and what accountability exists when it does not.

When standards are ignored and oversight fails, the consequences are not theoretical—they are real, and they are borne by the service members who rely on that system to protect them.

## **HSC-28: A Command Climate in Breakdown**

Taken together, the accounts surrounding HSC-28 present a deeply troubling picture. This was not simply a command with difficult personalities. It was, according to numerous accounts, a hostile and abusive environment where sailors feared retaliation, leadership concerns were ignored, and those in power protected themselves and each other.

The reported failures include known toxic leadership left uncorrected, sailors' complaints ignored or minimized, Command Climate Surveys withheld or obstructed, corrective actions ordered but not enforced, false or inaccurate information appearing in official reports, witnesses allegedly threatened into silence, investigative discrepancies left unresolved, and no meaningful accountability for senior leaders.

Command Climate Surveys are supposed to identify problems before they become tragedies. If those surveys contained warnings and those warnings were ignored, the system failed exactly where it was supposed to work.

The question is not whether warning signs existed. They did. The question is why proper questions were not asked, why evidence was not pursued, and why accountability did not follow.

## **The Broader Issue: Blame, Silence, and Systemic Failure**

The absence of accountability and the failure to be fully transparent and confront what happened, is not an isolated occurrence within the Armed Forces. It is part of a broader pattern.

Less than a week after Brandon's death, the NCIS liaison for the Caserta family told them that the sailors they contacted from Brandon's phone records were speaking with them "only because they felt sorry for them."

In that moment, the family's effort to find answers was dismissed and not treated as a legitimate search to uncover the truth, but reduced to pity. Instead of encouraging transparency or supporting a grieving family, the message was clear: their pursuit of answers was unwelcome.

This is part of the broader issue where voices are minimized, witnesses are discouraged, and families are left to fight for the truth on their own.

Across the country, countless military families are left seeking answers, accountability, and the truth after the loss of a loved one. In the civilian world, such failures trigger independent investigations and measurable consequences. Within the military, those same expectations are too often met with silence, internal control, and unresolved findings.

Too often in military suicide cases, the individual is blamed while the command environment is ignored. That framing allows institutions to reduce complex failures to personal struggle. It shifts attention away from toxic leadership, abuse of power, retaliation, career threats, and the failure to intervene.

Mental health matters. But it is not the entire picture. Command climate matters. Leadership conduct matters. Abuse of authority matters. Retaliation matters. Silence matters. When those factors are ignored, accountability disappears.

The Caserta family has heard from service members across the military who describe similar fears: fear of speaking up, fear of retaliation, fear that seeking help could damage their careers, and fear that leadership will protect itself first.

That is why The Brandon Act matters. The Brandon Act was created to give service members a confidential way to request a mental health evaluation outside their chain of command. It was born from the truth that sometimes the chain of command is part of the problem.

But laws alone are not enough. If leaders can threaten witnesses, ignore surveys, falsify records, delay transfers, protect abusers, and retire or be promoted without consequence, then reform is incomplete.

## **From Grief to Action: The Brandon Act**

After Brandon's death, Patrick and Teri Caserta took their fight to Congress. They were not lobbyists. They were parents carrying their son's story and asking lawmakers to understand why service members needed a confidential way to request mental health support without retaliation.

What began as a search for answers became a mission. In 2019, the Casertas walked the halls of Congress, meeting with offices and explaining why service members should not have to go through the very chain of command they may fear in order to ask for help. Their first trip gave them momentum when a member of Congress agreed to sponsor the bill in the House.

Over the next several years, Patrick and Teri returned to Washington again and again. They met with members of Congress, staff, military leaders, and organizations willing to stand with them. At the same time, service members and families began reaching out through The Brandon Act Facebook page and website, sharing stories that sounded painfully familiar: fear of speaking up, toxic command climates, and uncertainty about how to get help.

In 2021, after two years of advocacy, The Brandon Act was passed as part of the National Defense Authorization Act. The law created a pathway for service members to confidentially request a mental health evaluation without first going through their chain of command.

In 2023, The Brandon Act was implemented across the Department of Defense. But implementation is only the beginning. The Casertas continue hearing from service members and families who say they were never told about The Brandon Act, were unsure how to use it, or were discouraged from invoking it. A law can only save lives if service members know it exists and are supported when they use it.

Patrick and Teri continue working with members of Congress and military leaders to strengthen awareness and accountability. They continue advocating for signage, education, training, and outreach so every service member knows help is available.

The Brandon Act cannot bring Brandon back. But the Casertas believe it can help protect those serving today. Their mission remains simple: make sure Brandon's story leads to change, and make sure no other family has to experience this kind of loss.

## About The Brandon Caserta Foundation

The Brandon Caserta Foundation was created out of love, loss, and a promise. Its mission is to protect the lives of service members by improving access to mental health care, increasing awareness of toxic command environments, and advocating for accountability and systemic reform within the military.

Through education, outreach, and policy advocacy, including continued work around The Brandon Act, the foundation works to ensure service members know their rights, understand how to seek help, and do not have to face fear or retaliation alone.

Everything Patrick and Teri do is for Brandon and for the men and women who serve our country every day. They believe asking for help should **never** come with fear, leadership should protect and not harm, and every service member deserves to be seen, heard, and supported.

## Conclusion: The Cost of Silence

Seven years later, the questions remain. What happens when leadership fails, evidence contradicts official findings, and no one is held accountable?

In that kind of system, truth becomes negotiable. Silence becomes survival. Accountability becomes optional. And service members pay the price.

For the Caserta family, this is not about revenge. It is about truth. It is about accountability. It is about making sure no other family has to fight this hard just to have obvious questions asked.

HSC-28 was a command that failed Brandon. It showed what happens when toxic leadership is allowed to operate without transparency, oversight, or consequence.

**When responsibility is diffused across a chain of command, but no individual accountability is established, where does accountability ultimately reside?**

For the Caserta family, that question remains unanswered.

And until it is answered clearly, transparently, and with accountability, the broader concern remains: **that the conditions which contributed to this case may continue to exist elsewhere.**

And when that happens, the cost is not measured in reports, promotions, transfers, or retirements.

*It is measured in lives.*

For more information on The Brandon Act, please visit the website at [www.thebrandonact.org](http://www.thebrandonact.org)

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## **Editor Note**

This article reflects the accounts, documentation, and allegations provided by Patrick and Teri Caserta, parents of AE3 Brandon Caserta. Where allegations are described, they are presented as such. The core purpose of this article is to identify unanswered questions, documented contradictions, and unresolved accountability concerns surrounding HSC-28 and the death of AE3 Brandon Caserta.