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AIR RESCUE SERVICE HISTORICAL STUDY

HISTORY OF THE AIR RESCUE SERVICE (HATS)

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FOREWORD

This issue of the ARS History continues the historical approach utilized in the previous semiannual studies. No effort has been made to present a detailed report on the activities of each office and directorate making up this command, for much of this activity was routine and of little historical importance. This is especially true of offices whose primary numbered Air Force duties are standardized and whose functions are basically similar throughout the entire Air Force. This report concentrates on specific topics of importance which have begun, continued, or terminated during the historical period under consideration. Supplemental information, a roster of key personnel—including ARS Headquarters staff and subordinate unit commanders—the location of groups and squadrons, personnel statistics, and additional statistical information may be found in the ARS Statistical Summary in Appendix 1. Appendix 2 contains reproductions of news stories concerning ARS which have appeared during the historical period.

This history was prepared under the direction of Captain Ralph E. Dove, Chief, Office of Information Services; by Dr. Charles E. Hildreth, Historian, Office of Information Services, assisted by Grace A. Sneed, Secretary, Office of Information Services.

Like other Air Rescue Service historical studies, this history is subject to revision. Additional information or suggested corrections will be welcome.

MISSION OF AIR RESCUE SERVICE

Provide world-wide Air Rescue Service* for all Air Force and other U. S. military activities requesting such service.

Maintain assigned Air Rescue Service* facilities in operational readiness to permit rapid deployment in support of combat operations in any area.

Provide Air Rescue Service* for air crews or other personnel from enemy territory in support of combat operations.

Render Air Rescue Service* upon request to civilian aviation of the U. S. and to civil and military aviation of other countries in accordance with International Civil Aviation Organization (ICAO) procedures and policies of the Department of Defense.

Perform such other missions as are directed by the Chief of Staff, United States Air Force.

*NOTE: Air Rescue Service is aerial and ground search, dropping of survival equipment and medical personnel, and rescue of survivors.

CODE OF AN AIR RESCUE MAN

It is MY duty as a member of the Air Rescue Service to save life and to aid the injured.

I will be prepared at all times to perform my assigned duties quickly and efficiently, placing these duties before personal desires and comfort.

These things I do THAT OTHERS MAY LIVE.

POLICY OF AIR RESCUE SERVICE

Air Rescue Service exists as an integral part of the military air power of the United States; our primary mission is the support of the 137 Wing Air Force in being upon implementation of the EAP. The thoughts and efforts of every man in Air Rescue Service must be directed toward creating an organization better equipped and trained to carry out the recovery of irreplaceable airmen in the least possible time under combat conditions.

~~SECRET~~The ARS Today~~SECRET~~

Today, ARS has a three-fold mission. The day-to-day peacetime job remains, as it has from the inception of the command, an Area/Line of Communication mission. Rescue units provide protection along all the major air routes utilized by U. S. planes in their flights throughout the world, and stand ready to assist distressed persons of all color, creed, and nationality from the Iron to the bamboo curtain. Humanitarian in effect, this mission--aiding civilians as well as military personnel--has provided training for Rescue crews which will prove invaluable should war occur and the air lanes again be filled with combat planes moving to and from the battle front. The second mission reflects a wartime obligation and a peacetime training requirement--tactical recovery. This task calls for the utilization of Air Rescue Service capability within a theater of operations during a period of hostilities. It is not a new concept but was the stimulus for the first "air rescue" type operations during World War II, and the wartime combat job of the 3rd Air Rescue Group during the Korean conflict. The third mission is long range (or strategic) aircrew recovery. Responsibility for this operation was first vested in Air Rescue Service in 1954 when the 8th and 14th Groups were earmarked for support of the Strategic Air Command, and since that time have devoted their training to the support of the long range recovery program. ~~SECRET~~

Maintaining a high degree of proficiency in the face of these varied tasks has necessitated a concept of flexibility in all phases

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it is almost--if not absolutely--certain that our nation will be subject to aerial attack. It is of great concern to this command that upon completion of the projected reorganization we will have been "wring out" to the point of ineffectiveness in the 21.²² ~~SECRET~~

The primary basis for the new USAF concept of rescue was the study declaring that 70 percent of all air crashes occurred in the proximity of air bases. The influence of this 70 percent accident factor was so far-reaching on the operations of the Air Rescue Service, this headquarters was prompted to investigate and analyze the conclusion. Ignoring the fact that these are peacetime figures, the percentage figure itself is worthy of examination. It was discovered that 49 percent of all accidents occurred during the landing phase; 15 percent occurred during the takeoff phase; 5 percent occurred during the go-around phase; 2 percent occurred during the taxi phase; 2 percent were undetermined; and 27 percent occurred in flight (away from base). Examining these statistics it was evident that 51 percent of the accidents (49 percent landing and 2 percent taxiing) were not the type for which Air Rescue aircraft were required. They were incidents best handled by land vehicles--crash trucks, ambulances, etc.--which were available and better suited to provide immediate assistance. This reduced the 70 percent factor used as a basis for the local base rescue concept to 19 percent. Of this 19 percent (takeoff and go-around phases) only an unknown portion occurred beyond the accessibility of base crash facilities--partially justifying base helicopter

facilities. It is readily observed that the major portion of this 70 percent accident factor is in favor of crash truck activities.²³

Twenty-seven percent of the accidents occurred in flight and had no air base crash facilities immediately available to offer assistance. Totaling 464 major accidents, they were of the type that relied entirely upon ARS area coverage. It follows therefore that Air Rescue Service facilities are actually being withdrawn from an area of vital necessity and being established in areas of lesser need.²⁴

Rephrasing of ARS Policy

Responsibility for this reduction may rest partially on this command "because of our constant promotion of the humanitarian aspect of our mission."²⁵

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In the past, Air Rescue Service has been discussed and considered by higher and lateral agencies as a service with a peacetime and humanitarian mission. In fact, when peacetime missions, assistance in flood disaster areas, and innumerable individual incidents were discussed, these actions began to appear as the primary mission in our own minds. This was a fallacy but it may have been a decisive factor in the decision to curtail ARS. It may be noted that the 8th Air Rescue Group, which is 100 percent EMP and 0 percent peacetime missions, was not affected. In light of this, the fact that the work performed by Air Rescue during periods of peace was in actuality training for combat conditions

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Maritime Region--The Coast Guard has been designated as the Maritime Region Coordinator. This region includes all territorial waters and the open sea, as defined in the National SAR Plan. Those Air Rescue groups and squadrons whose missions cross the boundary from the ZI into the Maritime Regions will be approached by the Coast Guard seeking agreements on the use of ARS search and rescue facilities. The position of this command in regard to those agreements is that in all search and rescue incidents concerning distressed or lost U. S. Air Force aircraft, equipment, or people, Air Rescue Service will be designated as the controlling agency at any time we so request. As Regional Coordinator of the Inland area, we will reciprocate in this respect with other services. By so doing, ARS will maintain its position as the primary air rescue agency for the Air Force. In all other incidents controlled by the Coast Guard this command will assist to the best of its capabilities.⁵²

LONG RANGE AND TACTICAL THEATER RECOVERY

Although Wring Out has created the greatest stir, a basic reorganization occurred within Air Rescue Service during this historical period which was more constructive in that it has strengthened the organization's position for combat operations.⁵³

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A major problem faced by this headquarters has been to provide the overseas theater commanders with long range rescue coverage for their operations and at the same time provide a

thoroughly efficient tactical rescue force. The problem has been further complicated by the necessity of supplying the Strategic Air Command adequate support for its long range mission. The 8th Air Rescue Group has been assigned the task of SAC coverage as its primary mission but in time of war this group has as its secondary mission the support of operations in the theaters of war. Where the priority for the first mission ended and the second began was uncertain and has caused concern in both SAC and ARS Headquarters.⁵⁴ To resolve this problem and insure the availability of the 8th Air Rescue Group for SAC operations-- while at the same time maintaining ARS capability for Area/Line of Communications, tactical recovery, and long range recovery within the theaters--Headquarters USAF formulated an over-all reorganization proposal which won the approval of ARS, SAC, USAFE, and FEAF late in 1955.⁵⁵ ~~SECRET~~

The basic provisions of this reorganization incorporated the following changes: (1) The energies of the 8th Air Rescue Group were devoted exclusively to SAC support; (2) In both USAFE and FEAF the ARS forces were reorganized so as to provide one unit in each theater which would, in time of need, devote itself exclusively to the long range recovery operation within the theater; (3) The operational control of these squadrons was placed under the theater commander and the specific recovery concept (communication, authentication, intelligence, etc.) to be used was made the prerogative and responsibility of the theater commander concerned; (4) Because of the limited forces available,

overland travel. In these same helicopters, Rescue became the first service to give blood plasma transfusions to wounded men while airborne on their way to the rear.

Rescue came out of the Korean War the most highly decorated unit in Korea. More than that, the concepts that had been worked out in peacetime had been proven valid, and the lessons learned will be of future value should the organization be called on again under similar circumstances.

Pararescue

No account of Rescue work would be complete without mention of the Pararescue teams. Pararescuemen are among the best trained men in the Armed Forces today. Precision parachutists, highly trained medics, experts on survival, these men will jump under almost any conditions if the possibility exists that there is a life to be saved. Heroism is their stock in trade.

On April 16, 1954, two of these men, T/Sgt Elliott Holder and S/Sgt Robert Christiansen, jumped to the crash site of a Navy patrol bomber high on the Greenland polar ice cap, far above the Arctic Circle. They jumped in the faint hope that someone might have survived the crash. High winds nearly dragged Holder to his death over a 1,900 foot precipice. Landing about one and a half miles from the crash site, tremendous effort was required to reach the crash site. At one point the two men spent three hours traveling a quarter of a mile on the steep, icy slopes.

Upon reaching the wreckage the remains of nine crewmembers were discovered. A howling Arctic storm with winds over 100 miles an hour pinned the Pararescuemen down for 11 days. On the 12th day, when the winds subsided, they were picked up by helicopter and returned to their base.

A more successful mission occurred on the 13th of February 1953. Shortly after midnight, T/Sgt Charles Abbott and S/Sgt John Bowers jumped over the flaming crash of a B-36 near Goose Air Base. It was 20 below zero when they stepped out of their SC-47. After landing, it took them four hours to crawl a mere 300 yards through the deep drifted snow before they finally reached the survivors. Despite the hard going, they were able to treat the injured and at dawn 14 survivors and the Pararescuemen were taken by helicopter back to Goose Air Base.

These are but two of the many jumps made by these ARS Pararescuemen. In Rescue work minutes lost in reaching survivors can be the difference between life and death. By jumping, Pararescuemen can sometimes cut hours off the time that would be lost while ground parties made their way to the scene of a disaster.

THE LAST SIX MONTHS

Statistical Summary

Rescue activity for the past six months carried on the traditions of the ten year period. The pace for the current historical period shows a slight increase over the same period

Another area in which cooperation with the Base Medical Facility is important is in planning the activities of the group surgeon. We have always felt that there is ample work in the Rescue group to keep a group surgeon busy. However, in view of the desire of some group surgeons to maintain their proficiency in specialties other than aviation medicine, we have always said that the group surgeon should be permitted to engage in such hospital activities as he wishes to, as long as they do not interfere with his Rescue duties. We know that he cannot adhere to a regular schedule of hospital activities because of his flying responsibilities and the requirement that he make frequent staff visits to the squadrons of his group. In at least three of the groups presently possessing surgeons we have recently had misunderstandings with the local hospital commanders. These commanders, being used to having control over all surgeons on the base, have attempted to increase the amount of work the Rescue surgeon does in the base facility. In addition they have indicated a desire to have him accept a regularly scheduled responsibility, usually for holding sick call. Our attitude has been to support the group to the hilt in preventing compromise of the effectiveness of the surgeon to the group. However, this attitude is not shared by other major commands, and they are supported to some extent by the Surgeon General. Basically it boils down to this. If more hospital commanders indicate dissatisfaction with the amount of work they obtain from our group surgeons, and if this dissatisfaction is conveyed through major commanders to the Surgeon General, it is likely that Rescue will lose all its surgeons. They will be reassigned to the base and the base will be given the responsibility of providing aeromedical assistance to Rescue. It goes without saying that Rescue would suffer if we had to obtain such assistance from Flight Surgeons who lacked familiarity and interest in Rescue, and who were able to devote only a fraction of their time to us. Therefore, I see no alternative but to request that you try to come to a complete understanding with the hospital commander on the base where your group headquarters is located. Try to help the hospital commander understand the scope of the aeromedical job in Rescue. Inform him of the frequency of staff visits required of your surgeon. Let him see that your surgeon has a full time job. But in addition, to clinch the cooperation, let your surgeon assist in the sick call duties, particularly for Rescue personnel and their dependents. If it is necessary to have your surgeon participate in the general sick call and pull Medical Officer of the Day occasionally, then it looks as if we will have to let him do that. However, be most careful that the hospital commander realizes that Rescue duties do come first, that those duties arise at unpredictable times, and that although he retains the responsibility for what our surgeon does in his hospital, we must retain the responsibility for when he does it. The group surgeon himself is probably the best person to discuss this with and to determine if any more concessions need be made in the interests of good will. However, these concessions will probably benefit the Air Force as a whole, and should help cement good relations with the base if they are made sincerely and generously.

- c. Maintain a suspense file (preferably in the operations section as they have the prime interest) on all groundings and try to have paperwork accomplished in time to reach the action headquarters prior to ninety days after the suspension was imposed. If the deadline is approaching, use air-mail and request Aeronautical Orders number, paragraph, and date, by TWX, although this is normally done by ARS Headquarters. An "Expedite" slip attached to the correspondence will catch the eye of the Adjutant at any echelon and will often reduce administrative delay.
- d. Use ARSR 160-1 and MR 36-1 as guides to the composition of requests for removal of suspensions. This should reduce the number of times correspondence has to be returned for corrections and additions.
- e. Be certain that suspensions of ARS personnel are not confirmed by other commands. When this happens a delay is caused because only USAF or the other command can remove that suspension. This is particularly important when ARS personnel are grounded while on TDY, at schools, on extended operations or projects, or at RON points.

There are two additional steps that we have planned to assist in the prompt removal of suspensions. The first is to compile a pamphlet for the individual flyer to assist him in monitoring his suspensions. It will contain much of the information discussed above and will list all pertinent regulations, manuals, and policies. The second thing we wish to do is to obtain permission from MATS to have certain remote groups and squadrons come under the operational control commander as far as returns to flying are concerned. This will limit mail lag and will insure uniformity of review in that theater by a headquarters more familiar with the operational characteristics and the mission load of the squadrons.

Coordination With Base Medical Facilities

It is not too generally known that the Base Flight Surgeon has the prime responsibility for the vigorous prosecution of the Aircrew Effectiveness Program for all flying units on his base including active participation in the medical training of Air Rescue crews and teams. In units where there is not an active or otherwise satisfactory medical training program for the crews and rescue teams, it will often help if the Base Flight Surgeon is consulted. In discussing the problem the fact that AFR 160-69, Aircrew Effectiveness Program, lists these responsibilities can be brought out. At the same time an effective, practical medical training program can be discussed. The use of base and civilian hospital facilities for the practical training of Pararescue personnel is discussed in the new ARSM 50-1.

PARARESCUEPhysical Qualifications for Parachute Status

Most of our Pararescue teams are located at non-MATS bases where the base medical facility has no way of being familiar with MR 160-3, Physical Qualifications for Parachute Duty. It often happens that when an airman presents himself for physical examination prior to requesting parachute status, the Base Flight Surgeon proceeds to give him a Flying Class III examination. He does not realize that paragraph 135 of AFM 160-1 lists a specific physical examination for parachute duty. He does not realize that MR 160-3 directs that waiver authority for parachutists assigned to Rescue units be retained at Hq ARS. Because of this, and since the local flight surgeon is the waiver authority for airmen taking the Flying Class III examination, some of our jumpers have been qualified as physically fit for parachute duty and in some instances have been given waivers in violation of the above cited directives. It is most important that we check all physical examinations for parachute duty to see that they are conducted in accordance with the proper paragraph of AFM 160-1. Further, we must check all waivers for jumpers to insure that they are granted by Hq ARS.

New V-Slot Parachute

The latest word is that the new parachute should reach the using end of the supply pipeline by the first of the year. At that time we will attempt to convert completely to the new parachute. Since packing and using precautions are quite critical with this parachute, it is most important that they not be jumped until the jumpers are completely checked out. Since each of the ZI squadrons has received five of the handmade versions of this parachute, we have numerous jumpers in the ZI checked out already. We will assign official out-checkers to squadrons as they start to get the new parachute. We want to use instructors who have received their own instruction directly from this headquarters or from WADC, and we request that you not assign this instruction duty to a Pararescue man just because he has recently shipped in from the ZI and has had some jumps on the new parachute. We do know where the suitable instructors are, and will see that you get the services of someone who will insure safe and effective use and packing of this new parachute.

The new parachute definitely is safer to use by virtue of its decreased opening shock, its slower rate of descent, and its much slower rate of oscillation. Therefore from the jump safety point of view, it is desirable to use the new parachute exclusively as soon as enough are on hand. Two recent accidents would probably never have happened if the

new parachute had been used instead of the old E-1, and yet in both organizations in which these accidents occurred, the new parachute was available but the E-1 was being used. This was due to the natural reluctance of the parachutist to convert to the unfamiliar item after learning to depend on the other to save his life. We must combat this tendency and restrict the use of the old E-1 parachute to those instances where the new parachute is not available. In this way we can anticipate a reduced accident rate and an increased Pararescue potential.

Deletion of Aeromedics

I would like to direct your attention to the new ARSM 50-1 with respect to use of Pararescue personnel as crewmembers. Specifically this relates to participation in normal aircrew training. The new Training Manual lists the training requirements necessary to insure proficiency in performing aircrew member duties. It will be necessary for the Pararescue man to participate in aircrew training to an extent that insures proficiency in hoist operation, delivery of MA-1 Sea Rescue Kits, and the other prescribed duties. However, since he has a heavy alert schedule and extensive quarterly training requirements for ground training, Pararescue training, and field training, it will be manifestly impossible for him to participate in all aircrew training. He should participate to the extent necessary to demonstrate proficiency in his aircrew duties, but should not be required to shoot twenty successive water landings or to fly extended night navigation check rides.

Basically there will be little or no change in his job. He has always been available and frequently used for all sorts of missions in any type of aircraft. This continues except that now he is the only one available and he will get paid for it. On every rescue effort it will be necessary to depend on him to establish that final link to the survivors, whether it be by hoist, landing, raft, overland, or by parachute. His training must be so controlled that it encompasses all these varied activities, and it must not concentrate on one aspect at the neglect of another. In short, the mission can be summarized as searching for the survivors, delivering the Pararescue man to them by the most expeditious means, and then supporting and assisting him in their care and recovery.