

SSgt LaPointe/752-4888

22 November 76

ARRS Mission #246

CC / OPS OFFICER

1. On Friday 19 November 76, I was scrambled on a night rescue/support mission. As the alert team leader that evening I was not sure then and I am not sure now if adequate consideration was given to the possibility/necessity for a para-rescue deployment.
2. My primary concern is that if the RCC made a determination that the medical situation was such that it required a flight surgeon, than the situation was serious enough to conduct a mission jump for the purpose of giving prompt and initial treatment until the flight surgeon arrived.
3. The mission as reported to me that evening was that an individual (adult male) was stabbed in the leg with a hunting knife and was bleeding seriously (possibly arterial). I then requested from my aircraft commander if a PJ deployment was being planned. He told me that we were going out to flare and not drop PJ's. I then asked if the 130 arrived on scene 30-60min. prior to the H-3 if we could jump. I was then told that it was planned that we would not arrive on scene until the H-3 was to arrive (or just prior to the H-3).
4. Winds on scene were well within the limits of a training land jump and visibility was excellent. So weather was not a factor. A reception committee of local persons was available to be on the DZ to pick us up if we jumped. The DZ was a frozen river, which was strong enough to allow the H-3 to land on it. A recovery vehicle (the H-3) was planned to arrive on scene to med-e-vac the patient to a hospital. In my view of the situation that there was no reason not to deploy on this mission.
5. Medical decisions on patients CANNOT be made long distances away. In particular I mean that a correct determination on the patients condition cannot be made by the RCC or a flight surgeon on the basis of information given by non-medically trained individuals who are on scene. Repeatedly we are finding that incorrect diagnoses are being made by the RCC or Flight Surgeon on the basis of information received. It is a know fact that the

6. In view of the above, I have the following recommendations:

a. Pararescue team leaders input to mission prosecution, while the mission is in progress should be seriously considered by the RCC and aircraft commander. This after the fact discussion is not conducive to the complete utilization of pararescue capabilities.

b. Aircraft commanders should be briefed on utilizing their pararescue resources. They should also be briefed to actively solicit input on the mission from the PJ's while in flight.

c. It has been my experience here that Pararescuemen are expected to sit quietly in the rear of the aircraft or the section and if we are needed to go on any type mission, someone else will decide for us if we should go. I cannot recall a single instance in which the RCC has called us and asked us what we could do for them. It is my belief that both the RCC and the majority of my aircraft commanders do not in fact have an up-to-date knowledge of pararescue capabilities and when we should be utilized.

d. Utilization of pararescue forces should be considered in all cases where it cannot be conclusively determined that assistance is not required. Assistance could be in the form of rendering medical aid or just providing for the survival of the crashed/stranded person(s). At this time I do not believe that a single aircraft commander would deploy us on a mission where there are no injuries to assist in providing for survival. It is the obvious attitude that they (the survivors) will have to take care of themselves until the chopper arrives to pick them up.

e. Pararescue team members should be given more information on the SAR mission prior to launch. At this time we are called by one of the other crewmembers who passes the information to us. I recommend that the RCC when alerting the crew to scramble call the team leader so as to afford the team leader to opportunity to question the RCC on pertinent facts.

7. Your time spent on considering this matter is appreciated.

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