DEPARTMENT OF THE NAVY
USNS HASSAYAMPA T-AO 145
FPO SAN FRANCISCO CA 96667

13 June 1985

Fm: Master, USNS HASSAYAMPA T-AO 145

To: P-24

Subj: P-24 memo of 24 May 1985

1. P- 24 memo rcvd 12 June. I will address each of the questions separately and provide a summary of the incident.

2. Correct time of the occurance is 2057 as per ship's log. The 2130 time is when the extent of injury became known.

3. Time of wave hitting was 2057 as noted above. Other times in the log are also correct; FALCON CHAMPION away at 2115 and maneuvering detail secured at 2117.

4. The ship was not making a turn at the time of the incident. The messenger line was still being recovered from the FALCON CHAMPION when the wave hit. Once the hoses were back aboard I altered course out from the CHAMPION to open the distance between ships; this was about two degrees to stbd of base course. When the wave hit it forced the ship back to port seven degrees and caused rapid closing of the ships. While I was getting the ship back in position the personnel on deck gave first aid to the injured, took them to the sick bay, and held muster to find if there was anyone overboard. Once all personnel were accounted for, a few men went back out to recover the messenger. When it was recovered I opened the distance between ships still more and waited until word was received from deck that all gear was secured prior to making a turn at 2135. That may have been the turn in question, but the ship would not have been making a turn with a line still over to the other ship.

5. With regard to taking 33 hours to get the injured personnel to the USS CARL VINSON: at the time of the incident the VINSON was nowhere in the vicinity. The nearest medical facilities were aboard the cruiser USS STERETT and were consulted by radio and sound powered phone at the earliest opportunity. The MEDEVAC to the VINSON on the 30th was made at extreme helo range and was also at the first opportunity.
Mr LAND is correct in thinking that UNREPing continued after the injuries occured. We don't arbitrarily withdraw from a major fleet exercise because of casualties; if there are questions concerning responsibility in a case like this they can be answered by any of the senior naval officers in MSCPAC.
With regard to the horse collar transfer; the initial MEDEVAC plan was to make two trips with the VINSON H-3 helo. While the helo was overhead word was received from the VINSON that there would be only one trip and to have all three casualties and the medical officer put aboard the helo. There were only two stretchers with floatation gear attached and the two worst cases were in them. The remaining alternative was the horse collar for Mr LAND. It should be noted that Mr LAND was ambulatory and the fractures were only a possibility; it should also be noted that even once he was on the VINSON with their sophisticated equipment, there was no fracture detected and it required further testing ashore to find it. If it had been available, a stretcher would have been used to transfer Mr LAND, but it wasn't and he received the next best choice.

6. The following is a summary of the incident: