



INQUIRY OFFICER'S REPORT INTO THE DEATHS OF PRIVATE T.J. APLIN, PRIVATE B.A. CHUCK AND PRIVATE S.T. PALMER IN AFGHANISTAN ON 21 JUNE 2010

References:

- A. CDF Instrument of Appointment and Terms of Reference dated 25 June 2010
- B. QA into SOTG Mass Casualty Event during Operations IVO SHAH WALI KOT, Northern KANDAHAR – 21 June 2010 dated 21 June 2010
- C. TF66 CONOPS OP [REDACTED] Network Disruption and Population Security [REDACTED] 20 to 21 June [REDACTED]
- D. DI(G) ADMIN 45-2 – *Administrative Reporting and Investigation of Alleged Offences within the Australian Defence Organisation* dated [REDACTED]
- E. DI(G) PERS 20-6 – *Death of Australian Defence Force Personnel* dated [REDACTED]
- F. DI(G) PERS 11-2 – *Notification of Australian Defence force and non-Australian Defence Force Casualties* dated [REDACTED]
- G. HQ JTF 633 SI(PERS) 04-06 – *MEAO Mortuary Affairs Management* dated 29 Apr 10
- H. CDF Directive 7/2007
- I. ADFP 06.I.4 – *Administrative Inquiries Manual*

Appointment and Terms of Reference

1. I, [REDACTED] Colonel (COL) [REDACTED] Cox, CSC, having been duly appointed by Air Chief Marshal (ACM) Allan Grant Houston, AC, AFC, Chief of the Defence Force (CDF), to inquire into the deaths of [REDACTED] Private (PTE) Timothy James Aplin, [REDACTED] PTE Benjamin Adam Chuck and [REDACTED] PTE Scott Travis Palmer in accordance with the Terms of Reference attached to the Instrument of Appointment (see Annex A), herein submit my Report.

Inquiry Officer Team

2. The Inquiry Officer (IO) Team consisted of me, as the IO, and the following Inquiry Assistants (IA):

- a. [REDACTED] Lieutenant Colonel (LTCOL) [REDACTED]
- b. [REDACTED] Major (MAJ) [REDACTED], and
- c. [REDACTED] Corporal [REDACTED]



Methodology

3. The IO Team moved from Australia on [redacted] July 2010, arriving in the United Arab Emirates (UAE) on [redacted] July 2010. Following reception training, the IO Team moved forward to Multi-National Base – Tarin Kowt (MNB-TK), TARIN KOWT, AFGHANISTAN (AFG) on [redacted] July 2010.

4. Upon arrival, after attending reception briefings, the IO Team immediately commenced interviewing some key witnesses prior to them returning to Australia (RTA). During these initial interviews, it quickly became apparent that apart from the wounded, a number of potential witnesses (including the other [redacted] members) had already RTA. These witnesses were interviewed on the IO Teams RTA.

5. I consulted the QA (Annex B) conducted by the Special Operations Task Group (SOTG)/Task Force 66 (TF66) Legal Officer, [redacted] dated 21 June 2010.

6. The IO Team was unable to visit the site of the incident due to the security situation, but this is not considered to be an impediment to the conduct of the Inquiry. A satisfactory appraisal of the incident site was able to be conducted through the examination of maps, imagery provided by [redacted] and through viewing [redacted] provided by TF66.

[redacted] A copy of this US Investigation Report was provided to the IO Team and is attached at [redacted]

Acknowledgement

8. The IO would like to personally thank and acknowledge the generous assistance provided by [redacted] for his cooperation in facilitating the release of the [redacted] US Investigation Report into the US UH60 crash.

Introduction

9. During the conduct of Operation (OP) [redacted] on the morning of 21 June 2010 at approximately 0339 hours (h) local (L) AFG time, one of the [redacted]

[redacted]

[REDACTED]

US Utility Helicopter 60 (UH60) – Call Sign [REDACTED] carrying an element of the Australian (AS) SOTG/TF66 – consisting of personnel from [REDACTED] PI and [REDACTED] led by [REDACTED] – whilst inserting into Tactical Area of Interest [REDACTED] crashed.

Background

10. The current main effort for COMD Regional Command (South) (RC(S)) is [REDACTED] a series of operations designed to create an effect that will neutralize the Insurgents (INS) ability to influence the population of [REDACTED] and create space for the Government of the Islamic Republic of Afghanistan (GIROA) to establish itself as a credible and effective alternative to the Taliban.

11. As part of [REDACTED] the International Security Assistance Force (ISAF) Special Operations Forces (SOF) was tasked to disrupt INS safe-havens and deny them freedom of movement [REDACTED]

12. OP [REDACTED] was a TF66 operation to disrupt INS [REDACTED] [REDACTED] Over the period 20 to 21 June 2010, [REDACTED] was conducting operations in accordance with (IAW) the approved concept of operations (CONOPS) as attached at Annex D. OP [REDACTED]

13. The TF66- [REDACTED] Scheme of Manoeuvre (SOM) involved a rotary wing (RW) insertion [REDACTED] The aim of these clearances was to [REDACTED]

Date, Time and Place of the Incident

14. The incident took place on 21 June 2010, at approximately 0339h L (0909h AEDT) in the vicinity of [REDACTED] SHAH WALI KOT, KANDAHAR Province, AFG.

[REDACTED]

Forces Involved

15. **Australian.** The AS Forces involved in the incident were:

a. 10 personnel (in the crashed US UH60) from [REDACTED] and [REDACTED] consisting of:

- (1) [REDACTED]
- (2) [REDACTED]
- (3) [REDACTED]
- (4) [REDACTED] PTE T.J. Aplin - [REDACTED]
- (5) [REDACTED] PTE B.A. Chuck - [REDACTED]
- (6) [REDACTED]
- (7) [REDACTED] PTE S.T. Palmer - [REDACTED]
- (8) [REDACTED]
- (9) [REDACTED]
- (10) [REDACTED]

b. Other ADF personnel in the participating US UH60 from [REDACTED] FE-[REDACTED], are listed at Annex F.²

16. **Afghan.** [REDACTED]

17. **Coalition.** The Coalition Forces involved in the incident were:

a. The [REDACTED] crew of the US UH60 from the US TF [REDACTED] Each of the [REDACTED] US UH60 had aircrew consisting of:

- (1) Two US Pilots; and
- (2) Two US Loadmasters.³

b. [REDACTED]

c. [REDACTED]

[REDACTED]

[REDACTED]

- [REDACTED]
- d. [REDACTED]
 - e. The crew of the US Blackhawk Aero-Medical Evacuation (AME) Helicopter;
 - f. Personnel at the [REDACTED] Role 2 Medical Facility at MNB-TK;
 - g. Personnel at the Coalition Role 3 Medical Facility at KANDAHAR Air Field (KAF); and
 - h. Personnel at the Theatre Mortuary Affairs Evacuation Point for mortuary support in [REDACTED]

18. **Civilian.** [REDACTED] TF66 contracted interpreter from [REDACTED] [REDACTED] were involved in the incident. One, [REDACTED] was in the crashed US UH60 and was Wounded-in-Action (WIA).

Synopsis of the Incident

19. On 21 June 2010, the second day of [REDACTED] at approximately 0339h L elements of TF66 [REDACTED] in [REDACTED] US UH60 were inserting into [REDACTED] SHAH WALI KOT, when one US UH60, carrying 15 personnel (10 AS, [REDACTED] [REDACTED] crashed in the vicinity of [REDACTED]. The resulting casualties were: two AS Killed in Action (KIA), eight AS WIA, one US KIA, four US WIA (one US civilian WIA was the contracted TF66 civilian interpreter). 11 WIA were evacuated by TF [REDACTED] and one WIA was evacuated by a US Blackhawk AME Helicopter to the Coalition Role 3 Medical Facility in KAF. Time from crash to wheels down at KAF was approximately 45 minutes. Shortly after his arrival, one AS WIA died-of-wounds (DOW) at the KAF Role 3 Medical Facility. The two AS KIA and one US KIA were evacuated by TF [REDACTED] to the [REDACTED] Role 2 Medical Facility at MNB-TK. The human remains (HR) of the third AS casualty, located at KAF, were transported to the [REDACTED] Role 2 Medical Facility at MNB-TK later that day.

20. An additional FE [REDACTED] with a [REDACTED] Headquarters [REDACTED] Group deployed to the incident by TF [REDACTED] Helicopters to coordinate the recovery and security operations. Once recovery was complete the Group were withdrawn back to TK. Following a request from TF [REDACTED] [REDACTED] returned to the crash site to conduct a final search and clearance of the wreckage and collect parts for future examination by crash investigators.

[REDACTED]

[REDACTED]

Witnesses

21. Statements and/or interviews were obtained from/conducted with the following members involved with the incident in AFG (see Annex G):⁴

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]
- e. [REDACTED]
- f. [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. [REDACTED]
- j. [REDACTED]
- k. [REDACTED]
- l. [REDACTED]
- m. [REDACTED]
- n. [REDACTED]
- o. [REDACTED]
- p. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

q. [REDACTED]
[REDACTED]

r. [REDACTED]
[REDACTED]

22. Interviews were conducted with the following members involved with the incident in Al Minhad Airbase (AMAB):

a. [REDACTED]
[REDACTED]

b. [REDACTED]
[REDACTED]

c. [REDACTED]

d. [REDACTED]
[REDACTED]

e. [REDACTED]
[REDACTED]

f. [REDACTED]
[REDACTED]

23. Statements and/or interviews were obtained from/conducted with the following witnesses or others involved with the incident in AS:

a. [REDACTED];

b. [REDACTED];

c. [REDACTED];

d. [REDACTED];

e. [REDACTED];

f. [REDACTED];

g. [REDACTED];

h. [REDACTED];

i. [REDACTED];

[REDACTED]

[REDACTED]

- j. [REDACTED]
- k. [REDACTED]
- l. [REDACTED]
- m. [REDACTED]

24. Statements were obtained from the following individuals in key organisations in ADF:

- a. [REDACTED]
- b. [REDACTED]

Authority to Conduct the Operation

25. The incident occurred during the conduct of normal framework operations. These activities were appropriately endorsed by COMD JTF 633, MAJGEN J. Cantwell, on 29 May 2010.⁵ The approval for [REDACTED] operations was approved IAW Australian National requirements [REDACTED] on 1 June 2010.⁶

26. The [REDACTED] approval came from [REDACTED]. All decision briefs and approvals are contained at Annex H.

27. **Finding** – The operation on 21 June 2010 was appropriately authorised.

Involvement by Civil and Service Authorities

28. The local ADFIS representative commenced the ADFIS Investigations into the deaths of PTE T. Aplin, PTE B. Chuck and PTE S. Palmer immediately.⁸ The HR of all three personnel were documented, fingerprinted and photographed by

[REDACTED]

[REDACTED]

[REDACTED]

ADFIS (all three ADFIS Reports are at Annex I).⁹ The HR of all three personnel was escorted to AS to ensure continuity of evidence IAW current procedures.¹⁰

29. Observations of the Coronial Post Mortems were obtained by the [REDACTED] MEDICAL OFFICER (MO) [REDACTED]

30. **Finding** – The observations of the [REDACTED] MO [REDACTED] present at the Coronial Post Mortems indicate that the injuries sustained by PTE T. Aplin, PTE B. Chuck and PTE S. Palmer were consistent with a helicopter crash. However, the formal Coroner's Reports are yet to be received.

Involvement by Local Civilians

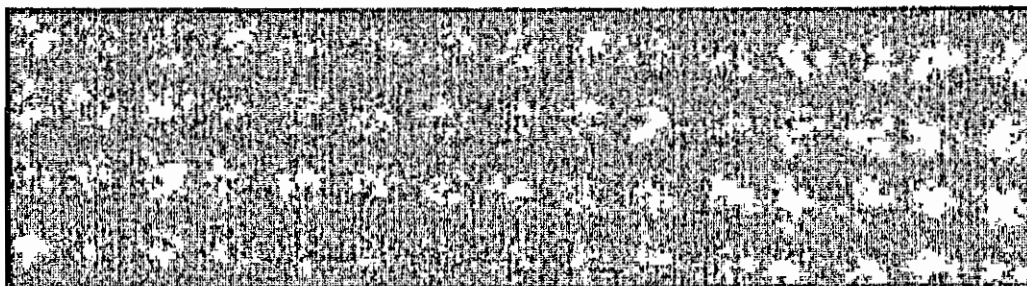
31. There is no evidence of involvement by local civilians in this incident.

Deaths and Injuries

32. **Deaths – Australian.** PTE T. Aplin and PTE S. Palmer were KIA as a result of their US UH60 crashing. PTE B. Chuck later died of wounds as a result of their US UH60 crashing and was pronounced life extinct shortly after his arrival at the KAF Role 3 Medical Facility. All three personnel were involved in a combat related activity at the time of their deaths or injuries. A summary of their respective cause of death is as follows:

- a. PTE T. Aplin died of multiple injuries as a result of a helicopter crash. His injuries not survivable and it is likely that he died instantly.
- b. PTE B. Chuck died of multiple wounds as a result of a helicopter crash. His injuries were not survivable.
- c. PTE S. Palmer died from catastrophic multiple injuries as a result of a helicopter crash. His injuries were not survivable and he died instantly.¹²

33. **Deaths – Coalition.** One US Servicemen, [REDACTED], was KIA during the US UH60 crash.¹³



[REDACTED]

34. **Injuries – Australian.** Seven FE- [REDACTED] personnel, from [REDACTED] were wound-in-action (WIA).

35. **Injuries – Coalition.** Three US Servicemen [REDACTED] were WIA.¹⁴

36. **Injuries – Military Contracted Civilian.** One [REDACTED] Interpreter, contracted to Australia through [REDACTED] was injured.

Loss and Damage of Service Property

37. The US UH60 crash site, following the extraction of the casualties, was physically searched four times.¹⁵ The four searches encompassed the crash site and the area immediately surrounding it. The first search was conducted by [REDACTED] PI, FE- [REDACTED] during the period immediately after the crash [REDACTED] during this search, most [REDACTED] items [REDACTED] were recovered. The second search, almost immediately following the first [REDACTED] was conducted by the [REDACTED] this search was primarily to recover [REDACTED] Concurrent to the second search, [REDACTED] PI, FE- [REDACTED], conducted the third search of the crash site and a sector search of the immediate surrounds [REDACTED]. A fourth search was conducted by [REDACTED] Force Element – [REDACTED] (FE- [REDACTED]) during the afternoon, prior to the destruction of the wreckage of the US UH60.¹⁶

[REDACTED]

a. **Phase One –** [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

b. **Phase Two –** [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

[REDACTED]

[REDACTED]

US Investigation Report Findings

39. The key findings of the [REDACTED] US Investigation Report, commissioned by [REDACTED] were:

- a. The mission on 21 June 2010 was planned and conducted within all US Directives and SOPs.²⁰
- b. All US flying crew had extensive flying experience flying with night vision goggles (NVG), as well as in a combat environment.
- c. The only significant change to the mission on 21 June 2010 was that the flight decided to adjust enroute altitude to [REDACTED] feet, from [REDACTED] feet, due to [REDACTED] and to help mitigate risk. All US crew members flew a similar mission the night prior and determined flying at [REDACTED] feet would reduce the workload demanded of the aircrew.²¹
- d. Everyone in the aircraft was wearing the required personal protective equipment.²²
- e. There were no mechanical, aircraft power or serviceability issues identified.²³
- f. After TF66 were picked up, the flight took off as briefed from MNB-TK at [REDACTED]. The flight proceeded at [REDACTED] to the start point and then [REDACTED] feet above ground level (AGL) during the enroute portion of the flight. At [REDACTED] the flight turned left [REDACTED] descended as briefed to an altitude [REDACTED] landing profile. At [REDACTED] made the '5 minute out' call from landing zone (LZ). The terrain thereafter levelled off into a flat open area with very low contrast to features on the ground.
- g. Audio transcripts show [REDACTED] (the US KIA) asking the pilot 'How low are you going down Sir?' [REDACTED] prior to impact. No enemy



fire or threat was observed, nor were any distress calls made prior to the crash.

- h. Technical data shows during the final [REDACTED] seconds of the flight a constant collective setting decrease from [REDACTED] with a corresponding torque (power) decrease from [REDACTED]. During this time, the altitude decreases from [REDACTED] to zero feet. [REDACTED]
- i. At [REDACTED] impacted the ground at [REDACTED] wherein there was no evasive movements or indications of mechanical failure, which is known in the aviation community as 'controlled flight into terrain' (CFIT). The location was near [REDACTED]. [REDACTED]
- j. The crash site was open desert terrain with a slight upslope at the point of impact. After [REDACTED] impacted, the helicopter rolled and the fuselage caught fire as it came to rest. The aircraft impacted at [REDACTED] rate of descent.²⁴

40. **Contributing Causes of UH-60 Crash.** The US Investigator points out that aircrew coordination within the flight contributed to the crash. They found that there were no internal calls from anyone in the flight indicating the change in altitude or intended actions. Though the flight turned and descended IAW the brief, heading and altitude change calls help with the crew situational awareness and alert every crew member in the flight to changes in flight profile. [REDACTED] only questions the pilot on the low altitude just [REDACTED] prior to impact. It is noted in the Report that crew members can often become focused on one task, but effective crew coordination may alert that crew member to redirect their attention to ensuring flight safety in a dynamic environment.

41. Although the US aircrew were appropriately qualified, the US Investigator points out that this does not mean they were immune to the limitations inherent to NVG. The low illumination, hazy visibility and low contrasting ground terrain made an instrument scan essential for the mission on 21 June 2010. Though pilots naturally rely on visual cues outside the aircraft, in such an environment not cross checking altitude and airspeed gauges can quickly result in an unrecoverable flight profile (Annex K).²⁵

42. **Finding** – The crash was caused by a lack of aircrew coordination during the approach to the designated LZ.



[REDACTED]

Environmental Conditions

43. **Terrain/Incident Site.** The terrain at the incident site was open dasht. A flat open area with very low contrast to features on the ground.

44. **Weather.** Windy conditions and a high temperature for that time of night (33 degrees) were reported and it was clear and dry.

45. **Visibility.** The briefed lunar illumination on the morning of 21 June 2010 was 76 percent. Though illumination was 76 percent, it was considered moderate risk illumination, the moon having set at 0046h L that morning. The moon angle was approximately 26 degrees below the horizon at the time of the crash. The visibility briefed on the 21 June 2010 was 9000 metres with dust and haze possible. The ceiling was briefed to be 'skies clear'. According to witnesses, visibility was decreased in the vicinity of the crash site due to haze.²⁶

46. **Contribution of Environmental Conditions to the Incident.** The environmental conditions did not directly contribute to the incident. However, the evidence provided in the US Investigation Report indicates that the low illumination, hazy visibility and low contrasting ground terrain contributed to difficulties in operating within the environment.²⁷

47. **Finding –** The environmental conditions did not directly contribute to the incident.

Operational Conditions and Factors

48. **Pre-Operational Intelligence.** [REDACTED]

[REDACTED] This [REDACTED] Group [REDACTED] had been active in coordinating a large amount of attacks on coalition forces over the past 18 months. This [REDACTED] Group was reported as responsible for multiple attacks on [REDACTED]

[REDACTED] There were multiple reports that INS were using the designated area to run Improvised Explosive Device (IED) training in addition to recouping for further attacks. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

49. The [REDACTED] was reported as a known INS high activity zone. [REDACTED]

[REDACTED]

50. **Previous Operational Activities.** There were a range of operations conducted by TF66 and TF [REDACTED] prior to the 21 June 2010. All missions had been conducted successfully and some had made significant achievements against INS elements.³⁰ Of particular note was a similar mission flown just 24 hours prior to the incident that contained a similar operational profile, flown by the same US aircrew (see Annex L).³¹ It is also noted that FE [REDACTED] members were both highly experienced and well trained in the conduct of such missions.³²

51. **Operational Planning - Mission.** [REDACTED]

[REDACTED]

52. **Orders.** TF66 Orders provide a comprehensive assessment of the target and tasks. The orders also included comprehensive AME instructions/orders (see Annex N).³⁴ The Air Mission Brief (AMB) was conducted on 20 June 2010 for operations to occur 20 to 21 June 2010. FE [REDACTED] and TF [REDACTED] members attended a 'go/no go' brief at 0100h L on 21 June 2010. This included US flight crew briefs.

53. **Command and Control.** A clear command and control (C2) structure was developed for FE [REDACTED] elements while on the ground.³⁵ Whilst airborne, C2 remained with the US aircrew.

54. **Finding** – There is no evidence to suggest that the operational conditions and factors contributed to the incident.

Training and Procedures

55. **Training - General.** All personnel within [REDACTED] were appropriately qualified in a range of special force courses and competencies. They also took part in a specific rotary wing (RW) training exercise [REDACTED]

[REDACTED]

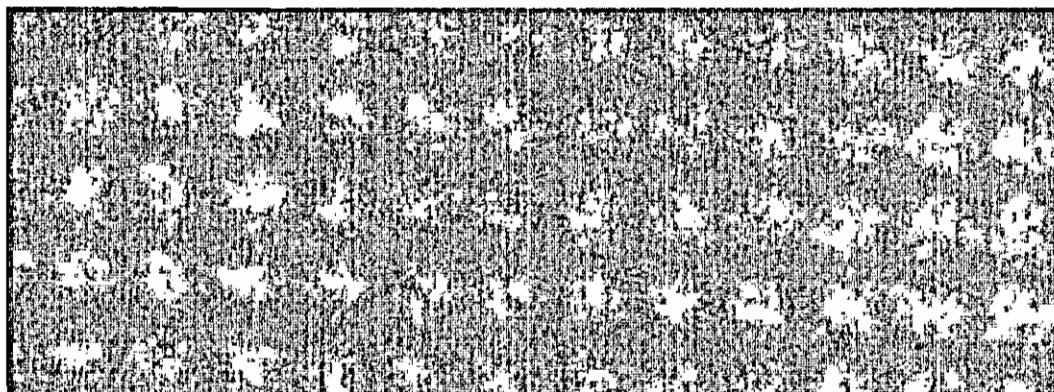
[REDACTED] in 2009) [REDACTED] involving inserting onto targets using helicopters. This additional training was then built upon during the Mission Rehearsal Exercise (MRE) and Mission Specific Training [REDACTED] prior to deployment to AFG.³⁶ This additional training consisted of all aspects of mission related operations, including full mission profiles, planning procedures and briefings.

56. **Mission Planning.** The mission planning is well established and detailed. The Mission Appreciation Process included a risk assessment which covers the threat to force risk and also threat to mission. From this process the CONOPS is developed and informs the need for [REDACTED] approval requirements or other [REDACTED] notifications. The process also includes a Rehearsal of Concept (ROC) drill which is run for all deliberate missions. During this phase TF [REDACTED] and TF66 members walk through every stage of the mission in detail.

57. **Safety.** The standard safety requirements were briefed and adhered to IAW with operational requirements. The brief included the requirements for seating and wearing of harnesses/seatbelts.³⁷

58. **ADFIS Training.** The ADFIS representative at MNB-TK, [REDACTED] performed exceptionally well despite not being fully qualified to carry out all his expected duties.³⁸ Fortunately, a detailed brief on the duties expected of him was delivered to him in country by [REDACTED] the OIC ADFIS who was an experienced Military Police officer, prior to the first incident. It is recommended that ADFIS review DVI training requirements to support Mortuary Affairs operations in MEAO.

59. **Mortuary Affairs Officers (MAO).** The MAO aspects were handled very well due to the professionalism and dedication of the members in AFG and AMAB. However, most MAO had little or no experience prior to entering the MEAO. There were several theoretical and administrative exercises conducted as part of the MRE prior to deployment, which enabled successful completion of the basic requirements.⁴⁰ It is considered that this training could be enhanced by a MAO course.⁴¹ It is understood that a two day MAO course has previously been



[REDACTED]

conducted by HQJOC. It is recommended that Mortuary Affairs (MA) training be reviewed to support designated MAO.⁴²

60. **Finding** – There were no training or procedural deficiencies or issues that contributed to this incident.

61. **Recommendations** – I recommend that:

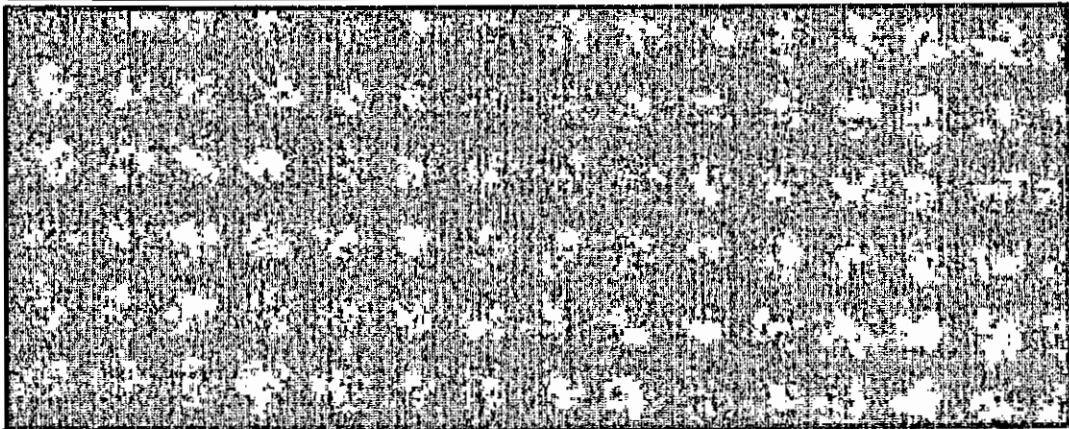
- a. ADFIS review DVI training and capability requirements to support Mortuary Affairs operations in MEAO, and
- b. Mortuary Affairs training be reviewed to support designated MAO.

Post Incident Events and Factors

62. **Timeline.** An event timeline based on electronic reporting and supported by witness statements is at Annex O.⁴³

63. **Medical Treatment.** Immediate medical treatment was administered by personnel from Call Signs [REDACTED], who landed IVO the crash. This treatment appears to have been primarily coordinated and administered by [REDACTED] PI [REDACTED] (Medic) [REDACTED]. The initial triage was conducted in chaotic conditions (see Annex P).⁴⁴ [REDACTED] conducted initial triage and also directed loading of the WIA post immediate first aid in a timely and efficient manner.⁴⁵

64. **Incident Site Coordination.** The crash site was controlled and coordinated by [REDACTED] for the majority of the time and during the critical period immediately following the crash.⁴⁶ He quickly organised support to [REDACTED] and established security whilst gaining a clear picture of the situation on the ground and providing essential information to both members on the ground, TF [REDACTED] aircrew and higher HQ.⁴⁷ His control and direction to all members enhanced



[REDACTED]

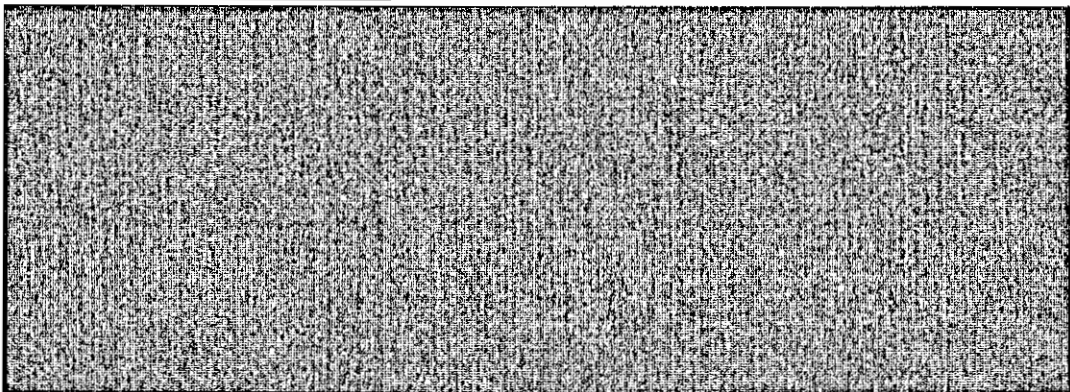
coordination and significantly contributed towards the timely response. There is also evidence of individuals performing noteworthy actions to save lives.⁴⁸

65. **CASEVAC.** The initial CASEVAC involved the use of all of the remaining US UH60 from TF [REDACTED] that were on site. Shortly after Call Sign [REDACTED] crashed, Call Signs [REDACTED] landed IVO the crash. Elements from [REDACTED] Call Signs provided immediate area security and initial medical treatment. The initial scene presented to the members was one of a helicopter on fire with men calling for help and also members still trapped in the downed aircraft. The prompt evacuation of the WIA was achieved through the removal of the seating from Call Signs [REDACTED], in order to facilitate the loading of the WIA by US and AS personnel.⁴⁹

66. The rapid response provided by the remainder of the US aircrew and AS personnel was crucial in saving the lives of a number of the WIA. The swift coordination, treatment and subsequent evacuation of the WIA resulted in a turn around time of 45 minutes from crash to arrival at the KAF Role 3 Medical Facility.

67. **KAF Medical Support/Response.** The treatment of the WIA at the KAF Role 3 Medical Facility was professional and meticulous. The prompt actions of both AS and US medical staff significantly contributed to the stabilisation, repatriation (via Germany), and subsequent recovery of the WIA.⁵⁰ A list of injuries sustained by the WIA is attached at Annex Q.⁵¹ In her post mortem observations, [REDACTED] notes the following in relation to the medical treatment provided to PTE B. Chuck: 'There was a heroic and genuine attempt at resuscitation due to the limited injuries evident externally, but his injuries were not survivable'.⁵²

68. **Casualty Notification.** The notification of casualties was conducted IAW established policies and procedures. It was noted that there is no differentiation in extant AS procedures for single incident reporting and multiple incident reporting. In a mass casualty event, such as this, having to adhere to single incident reporting procedures (including individual reporting timeframes) did impose additional workload on already busy HQ staff.⁵³



[REDACTED]

69. **Casualty Identification.** There initial casualty identification difficulties arising from the incident [REDACTED]

[REDACTED] The issue highlighted key procedural and capability deficiencies within extant AS Mass Casualty Disaster Victim Identification (DVI) procedures. A DVI capability is required when difficulties arise in identifying human remains. The DVI capability could include the ability to fingerprint, conduct DNA analysis, medical examination and dental examination. The current deficiencies in the MEAO are:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]
- d. [REDACTED]

70. There is currently no DVI capability to support MEAO. [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

71. [REDACTED]
[REDACTED]

- a. [REDACTED]

[REDACTED]

[REDACTED]

b.

[REDACTED]

c.

[REDACTED]

72. **Immediate Interim Report - DVI.** An immediate interim report was sent to CDF to highlight the gap in DVI capability within MEAO. HQ JOC is currently taking the lead to coordinate an interim solution.

73. **Repatriation.** There were no major issues with the repatriation of PTE T. Aplin, PTE B. Chuck and PTE S. Palmer. The various ramp ceremonies and their subsequent funerals occurred in an appropriate manner showing due respect for fallen soldiers.⁵⁶

74. **Psych Support.** All members involved in the incident were offered psych support.

75. **Findings – I find that:**

- a. AS and US members of TF66, TF [REDACTED] and at KAF Role 3 Medical Facility provided outstanding support and service, as part of a professional team, which directly contributed towards saving the lives of AS and US servicemen involved in the crash on 21 Jun 2010.
- b. All casualty reporting was in accordance with Defence policy and procedures.
- c. There is currently no MEAO DVI capability.
- d. There were no major issues with the repatriation of PTE T. Aplin, PTE B. Chuck and PTE S. Palmer.

76. **Recommendations – I recommend that:**

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- b. A DVI capability be explored to support HQ JTF 633 in the event of a mass casualty [REDACTED]
- c. A review of casualty reporting procedure is conducted to ascertain if there is scope for development of a multiple casualty reporting procedure in order to reduce time and administrative burden on staff.

Other Factors

77. **Equipment.** There is no evidence that equipment or equipment issues contributed to the deaths of PTE T. Aplin, PTE B. Chuck and PTE S. Palmer or the injuries sustained by the other [REDACTED] PI and [REDACTED] personnel travelling in the US UH60 that crashed.

78. **Drugs and Alcohol.** There is no evidence that drugs or alcohol were involved or contributed to the deaths of PTE T. Aplin, PTE B. Chuck and PTE S. Palmer or the injuries sustained by the other [REDACTED] PI and [REDACTED] personnel travelling in the US UH60 that crashed.

79. **Findings – I find that:**

- a. There is no evidence that equipment or equipment issues contributed to the incident.
- b. There is no evidence that drugs or alcohol were involved or contributed to the incident.

Performance of Duty

80. From a detailed assessment of the evidence gathered, there is no evidence of any AS personnel failing in the performance of their duties. On the contrary, there is evidence of noteworthy and courageous performances under very difficult circumstances by the following personnel:

a. [REDACTED]

b. [REDACTED]

[REDACTED]

[REDACTED]

c. [REDACTED]

81. **Finding** – There is no evidence of any AS personnel failing in the performance of their duties.

Conclusion

82. PTE T. Aplin and PTE S. Palmer were KIA as a result of their US UH60 crashing. Their injuries were fatal and no medical intervention would have saved their lives. PTE B. Chuck DOW and was pronounced life extinct shortly after his arrival at the KAF Role 3 Medical Facility, due to injuries he sustained from the US UH60 crash. All three personnel were involved in a combat related activity at the time of their deaths.

83. PTE T. Aplin, PTE B. Chuck and PTE S. Palmer were undertaking a duly authorised operation and were appropriately trained and had prior experience in similar missions.

84. The [REDACTED] US Investigation Report into the US UH60 crash highlights that it was the caused by a lack of aircrew coordination during the approach to the designated LZ, with key contributing factors being a combination of poor illumination and restricted NVG operating conditions.

85. The personnel of the patrol performed creditably in dangerous and chaotic circumstances. The ability of patrol members to administer life saving first aid, extract WIA in a timely and efficient manner whilst maintaining security and team cohesion is a testament to their training.

86. Training, intelligence, planning and orders were all IAW prescribed policies and procedures, with no shortfalls being identified.

87. A Commission of Inquiry is unlikely to discover any further relevant material, information or evidence in the context of this incident.

Findings

88. I find that:

- a. The operation on 21 June 2010 was appropriately authorised.

[REDACTED]

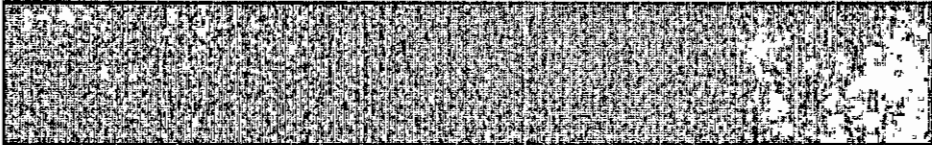

[REDACTED]

- [REDACTED]
- b. The observations of the [REDACTED] present at the Coronial Post Mortems indicate that the injuries sustained by PTE T. Aplin, PTE B. Chuck and PTE S. Palmer were consistent with a helicopter crash. However, the formal Coroner's Reports are yet to be received.
 - c. The crash was caused by a lack of aircrew coordination during the approach to the designated LZ.
 - d. The environmental conditions did not directly contribute to the incident.
 - e. There is no evidence to suggest that the operational conditions and factors contributed to the incident.
 - f. There were no training or procedural deficiencies or issues that contributed to this incident.
 - g. AS and US members of TF66, TF [REDACTED] and at KAF [REDACTED] Medical Facility provided outstanding support and service, as part of a professional team, which directly contributed towards saving the lives of AS and US servicemen involved in the crash on 21 Jun 2010.
 - h. All casualty reporting was in accordance with Defence policy and procedures.
 - i. There is currently no MEAO DVI capability.
 - j. There were no major issues with the repatriation of PTE T. Aplin, PTE B. Chuck and PTE S. Palmer.
 - k. There is no evidence that equipment or equipment issues contributed to the incident.
 - l. There is no evidence that drugs or alcohol were involved or contributed to the incident.
 - m. There is no evidence of any AS personnel failing in the performance of their duties.
 - n. I find that the circumstances surrounding the deaths of PTE T. Aplin, PTE B. Chuck and PTE S. Palmer do not warrant the appointment of a CDF COI.


Recommendations

89. I recommend that:
- [REDACTED]



- a. ADFIS review DVI training and capability requirements to support Mortuary Affairs operations in MEAO.
- b. Mortuary Affairs training be reviewed to support designated MAO.
- c. 
- d. A DVI capability be explored to support HQ JTF 633 in the event of a mass casualty 
- e. A review of casualty reporting procedure is conducted to ascertain if there is scope for development of a multiple casualty reporting procedure in order to reduce time and administrative burden on staff.
- f. The appointment of a CDF COI into this matter is not warranted.



 COX, CSC
Colonel
Inquiry Officer

28th October 2010

Annexes:

