AUTHORITY TO DISCLOSE

RECORD OF PROCEEDINGS OF COURT OF INQUIRY INTO

Death of Lt T. A. O'Donnell, DSD, RNZIR, and the Wounding of LCpl M. J. Ball, RNZSigs, Pte A. D. Baker, RNZIR and A. Ahmad in Bamyan Province, Afghanistan, 3 Aug 10

Pursuant to Section 200T of the Armed Forces Discipline Act 1971 (AFDA), as a superior commander of the Service concerned, I authorise the disclosure to:

the family the deceased,
the personnel who were wounded, and
representatives of the news media,

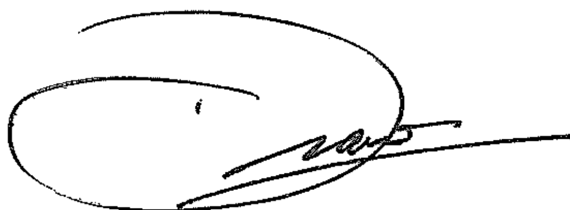
of:

A copy of the Record of Proceedings of the subject Court of Inquiry with the following excised in terms of the definition of official information in and pursuant to the provisions of Section 9 of the Official Information Act 1982:–

a. The List of Witnesses,
b. The names and identifying details of those to whom rights under AFDA Section 200N were accorded by the Court;
c. The names of Service personnel except the deceased and the personnel of the Court;
d. Information disclosure of which is likely to prejudice the security or defence of New Zealand or the international relations of New Zealand;
e. Information disclosure of which is necessary to protect the privacy of natural persons;
f. References to the evidence on which findings are based;
g. All evidence received by the Court; and
h. All submissions made to the Court,

as appears in the version of the Record of Proceedings which has been declassified and perused by me.

DATED at Trentham this 20th day of July 2011.



A. D. GAWN, MBE
Major General
Commander Joint Forces New Zealand

Summary of Court of Inquiry into the death of Lieutenant T. A. O'Donnell, DSD, RNZIR and the wounding of three other persons in Bamyan Province, Afghanistan, 3 August 2010

Background

The Court of Inquiry was assembled by Commander Joint Forces New Zealand on 10 August 2010, and completed on 18 July 2011. Evidence was taken from 59 witnesses and 129 exhibits were received. The incident itself occurred at approximately 1630 hours on 3 August 2010, and involved a patrol of the New Zealand Provincial Reconstruction Team (PRT) serving in Bamyan Province, Afghanistan. Lieutenant O'Donnell, the patrol commander, was killed, and three other personnel of the patrol were wounded, when the patrol was the subject of a deliberate attack combining a command wire improvised explosive device (CWIED) with rocket propelled grenades (RPG) and small arms fire.

The incident

On the day of the incident the patrol had been engaged in delivering various supplies to villages in the isolated and mountainous Kahmard District in the east of Bamyan Province. To effect this task the patrol was operating a mix of military and civilian vehicles, some of which were towing trailers. The few roads in the area are narrow, winding, dirt roads which are subject to frequent washouts.

The patrol had carried out deliveries of supplies and various meetings with local people, including members of the Afghan National Police serving in the District, before the incident. As the patrol was returning to its forward base area, along a route it had frequently used previously, it had to make a detour where the road had been washed out, across a roughly formed ford through the dry streambed. That detour involved a hairpin bend and a descent into the streambed, and necessitated that the patrol vehicles slow down.

As the leading patrol vehicle, which Lieutenant O'Donnell was commanding, entered the detour at approximately 1630 hours there was no indication of anything out of the ordinary. The other vehicles in the patrol were on the road, spaced out behind the lead vehicle. As the lead vehicle turned into the detour the CWIED was initiated, immediately immobilising that vehicle, injuring all those in it, and causing it to catch fire.

On the crews of the other vehicles observing the detonation of the IED they reacted, while both their vehicles and the immobilised lead vehicle came under sustained RPG and small arms fire from firing positions on high ground. That fire repeatedly struck all the vehicles. An immediate contact report was sent to the New Zealand PRT command post. The other personnel and vehicles of the patrol took up positions, from which they returned fire.

Despite the RPG and small arms fire which struck the immobilised lead vehicle and the ground around it, the injured personnel from that vehicle evacuated the burning vehicle, and attempted to extract Lieutenant O'Donnell. He was unresponsive, and trapped by the damage caused to the vehicle by the initial IED blast. Their repeated efforts to get him out of the vehicle had to be abandoned to avoid their receiving further injuries from the fire they were under. They took cover in the dry stream bed, with one of them making his way, affected by eye injuries, to where the remainder of the patrol was located. The hostile

RPG fire was concentrated on the immobilised lead vehicle, which was struck between five and seven times.

The patrol was returning fire, and attempting to transmit details of the situation to the NZ PRT command post. The PRT commanding officer tasked another PRT patrol to proceed to assist the patrol, and the Afghan National Police also responded by agreeing to deploy Police to the area when requested by the PRT commanding officer. United States attack aircraft were also despatched to assist the patrol.

The members of the patrol heard an explosion from the burning lead vehicle. Another vehicle of the patrol had also been disabled, but personnel of the patrol moved forward to retrieve the personnel from the lead vehicle, using one of the remaining functional vehicles to provide protection. The two remaining wounded were evacuated and given first aid by a trained combat lifesaver. The patrol reported its casualty state to the PRT command post, and was advised that both Afghan National Police and PRT assistance was on its way. Helicopter evacuation of the casualties had been requested, but was hampered and ultimately precluded by deteriorating weather, so a military ambulance with an escort was despatched from the PRT base.

Once the Afghan National Police reached the patrol's location they cleared the area of the contact. The Afghan Police arrived well before the first PRT patrol, which on its arrival assisted in securing the area. The immobilised vehicles were destroyed. The combined PRT patrols, with the casualties and Lieutenant O'Donnell's recovered body, then moved back to the Afghan National Police station at the village of Do Abe. There they met the military ambulance and its escort, to which the casualties and Lieutenant O'Donnell's body were transferred. The ambulance and escort then commenced the return journey to the PRT base. The combined patrols secured themselves at the police station for the remainder of the night. The next day the site of the incident was examined. Subsequently, the destroyed vehicles were removed back to the PRT base.

The ambulance and escort reached the PRT base just after 0300 hours the next morning. The casualties were further treated and stabilised and aeromedical evacuation requested. A combination of weather and mechanical problems with aircraft meant that the evacuation flight, with the casualties and Lieutenant O'Donnell's body, was unable to depart for Bagram until approximately 1900 hours on 4 August 2010.

The casualties were fully assessed at a coalition hospital after they arrived at Bagram. The casualty with eye injuries was held in hospital for three days before he was able to return to Bamian. The other two casualties were assessed for aerial evacuation to New Zealand and cleared for air travel. They flew out of Bagram accompanied by a nursing officer, on the same aircraft as was transporting Lieutenant O'Donnell's casket. At all times Lieutenant O'Donnell was accorded full honours.

Subsequently, they were transferred to a Royal New Zealand Air Force Boeing 757 which had embarked an Aeromedical Evacuation Team, but having been diverted from another task was not configured to carry stretchers or equipped with medical equipment. That team provided medical support to the casualties on the flight through Perth, W.A. to Whenuapai, Auckland. The casualties' transfer to North Shore Hospital was supervised by military medical personnel. Both were subsequently released from hospital and returned to duty with their parent units in New Zealand.

Following arrival in New Zealand, Lieutenant O'Donnell's body came under coronial jurisdiction. When those processes had been completed, he was flown to Ohakea by

RNZAF C130, where his family met him. He was accorded full honours, and a military service for him was held at Linton Camp on 10 August 2010 before his funeral in Feilding on 11 August 2010.

Death of Lieutenant O'Donnell

The Court concluded that it was highly likely that Lieutenant O'Donnell was killed by the injuries from the detonation of the IED. The subsequent pathologist's report was of the view that he died instantaneously.

Court's assessment of incident

The Court considered that the attack on Lieutenant O'Donnell's patrol was likely to have been an opportunity attack, which would have occurred in any event. The patrol training and orders for reacting to an ambush were appropriate and enabled the patrol to extricate itself from the ambush area. The members of the patrol were considered to have displayed commendable professionalism which was also a reflection of the professionalism of and the training conducted by the late Lieutenant O'Donnell.

The protected mobility of the patrol's vehicles saved other patrol members from the small arms and RPG fire directed at them.

The Court noted that all personnel were trained to the required standard, identifying that the theatre indoctrination training on capabilities available only in Afghanistan had been constrained by time and was not in sufficient depth or breadth. Deficiencies as to training on specific items of equipment were noted and were the subject of recommendations. The performance of specific items of equipment was also reviewed.

Other matters

The Court also reported on the processes by which casualties are reported on through the NZDF, and by which the personal effects of casualties are handled.

The Court noted that the fact that the RNZAF Boeing 757 was not configured or equipped for casualty transport compromised the care that could have been given to the casualties.

The Court highlighted the determined and capable performance of the members of Kiwi Team 2 during the incident, the commendable conduct of the whole PRT after the incident, the forthrightness of the witnesses, and the assistance with the repatriation of the casualties and Lieutenant O'Donnell provided by other Coalition armed forces.

REGRADED BY COMMANDER JOINT FORCES NEW ZEALAND
MAJOR GENERAL A.D. GAWN DATED 20/7/11

20 JULY 2011
ECOR4: 6401

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COURT OF INQUIRY

assembled by

S85668 AIR VICE MARSHAL P.J. STOCKWELL, AFC

COMMANDER JOINT FORCES NEW ZEALAND

into

The death of X1016029 Lieutenant T.A. O'Donnell, DSD, RNZIR and the wounding of RNZ Sigs, RNZIR and , all of TG CRIB 16, Kahmard District, Bamyan Province, at 031633L August 2010.

FILE: 05202/1/KTZ CONTACT 03 AUG 10 AFGHANISTAN V1
FOLIO: 13
-7 MAR 2011
MD 392 No.: ECOR4
MD 392 FOLIO No.: 6011

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B NZPRT Strategic Plan 2010/2011 dated 17 Jun 2010
C CO Effects Guidance – July 2010
D Effects Card for DO ABE area
E Action Points from the NZPRT Effects Conference Held on 08 July 2010 (Copy)
F NZPRT SOP 302 – Movement and Patrolling
G NZPRT 305 – Immediate Actions Drills
H CD-R – Command Post Of the Future Electronic reporting records, NZPRT, KT2 Contact 03 Aug 10
I AAR – KT2 TIC 03 Aug 10 dated 09 Aug 10
J TU CRIB Four-week report dated Apr 2010
K S2 Weekly Summary and Assessment – 30 July 2010
L BAMYAN AO/AI SITEMP as at 021000 Aug 2010
M NZPRT BAMYAN Daily Intsum 214/10 dated 02 Aug 10
N BAMYAN Weather forecast – 2-10 Aug 2010
O KT2 TIC 03 Aug 10 – S2 Update (PPT) dated 04 Aug 10
P Breakdown of events leading up to and including contact dated 07 Aug 10 (PPT)
Q NZPRT SUPINTREP 004/10 KT 2 Contact 3 Aug 10 dated 11 Aug 2010
R Email Crib 16 S2/ HQ JFNZ J2 dated 29 Jul 2010
S S2 PPT Presentation to CDF – 03 May 2010
T PPT Presentation to Minister of Foreign Affairs – 18 Jul 2010
U PPT Presentation to COMJFNZ – 19 Jul 2010
V Email CRIB 16 S2 to Staff dated 261254 Jul 10
W NZPRT Meeting Record – OCCP Meeting – 03 Aug 10
X NZPRT Daily Intsums 03 - 18 Aug 2010 (Intsums 215 – 230 inclusive)
Y CD-R : E-copy + Hard Copy of KT2 Daily SITREP 02 Aug 10
Z CD-R: E-copy TIC sequence of events dated 04 Aug 10
AA TU CRIB16 Command Notebook – X1017058 Lt T.A. O'Donnell
AB CD-R: E-copy TG CRIB 16 CP SOPs
AC AAR – KT2 TIC 09 Apr 10 dated 18 Apr 2010
AD TU CRIB 16 – CP Ops Log dated 02-03 Aug 10 (+e-copy)
AE TU CRIB 16 OPORD 05/10: Op URCELA (Enduring) dated 15 Jun 10

AF	TG CRIB – SOP 105: Threat States and Force Protection Requirements (NZPRT S:NZPRT/1181./CRIB SOPS/ WORKING FOLDER)
AG	Incident report – Homicide/ IED incident opened 03 Aug 10
AH	KT 2 Medic – MIST notes, KT2 TIC 03 Aug 10
AI	Summary of Events for 3 Aug TIC in NE Bamyan (Kiwi 2) compiled by SNR JTAC –
AJ	Task Report – IED KARIMAK dated 11 Aug 10
AK	MD 907
AL	NZ Police 265A dated 04 Aug 10, Deceased Person Identification.
AM	NZ PRT SOP 700 - Medical
AN	HQ JFNZ SOP 190 – Medical Repatriation from Overseas Activities
AO	Notes taken by CRIB 16 S2 Cell during post incident interviews dated 04 Aug 10.
AP	A/S2 Reports Log – KT2 TIC 03 Aug 10
AQ	Op CRIB 5090 - Critical Incident Report of 032052ZAug10
AR	Op CRIB Incident Report (medical-in-confidence) dated 040343ZAug10
AS	Op CRIB 5090 NOTICAS – O'DONNELL dated 040332ZAug10
AT	Op CRIB 5090 NOTICAS – dated 040316ZAug10
AU	Op CRIB 5090 NOTICAS – dated 040317ZAug10
AV	Op CRIB 5090 NOTICAS – FOLLOW UP – dated 041532ZAug10
AW	Op CRIB 5090 NOTICAS – FOLLOW UP – dated 041531ZAug10
AX	Coronial Brief – not complete
AY	Media Release – CRIB S1 to HQ JFNZ PRO dated 04 Aug 10
AZ	NZ PRT CP COMMS SOP dated 22 Feb 10
BA	Revised NZ PRT Ptl Sigs Aide Memoir dated 17 Aug 10
BB	Op CRIB Loss of Stores signal dated 190329ZAug10
BC	EXCEL Spread sheet – AFNZ 164 Action. AFNZ 164 Certificate of condemnation of stores - TGC16/030, 031, 033, 034, 036, 038- 041, 043 - 048, 050- 052. NZ PRT TG 16 Loss and Damage Reports x 2.
BD	E-mail NZ PRT S4/ OC NSE dated 06 Aug 10
BE	MD311 Application to write off accountable stores – O'Donnell,
BF	E-mail NZ PRT S4/ dated 20 Aug 10
BG	NZ PRT TG CRIB Loss and Damage Report – HMMWV A-Frame
BH	HQ JFNZ SOP433 Deceased personnel – repatriation of remains to NZ.
BI	TG CRIB PRT SOP 415 – Death of a Serviceperson
BJ	Inventory of personal effects – X1017058 Lt T. A. O'Donnell as at 07 Aug 10.
BK	Inventory of personal effects – as at 07 Aug 10.
BL	Inventory of personal effects – as at 07 Aug 10.
BM	Statement –,
BN	Initial Report for Coroner
BO	Report of Weapon Inspection on Mk19 AGL NZA676, date of inspection 31st August 2010
BP	ROE Card – NZFOR ISAF (Afghanistan) dated 12 Oct 2006
BQ	NZPRT Road Threat State: Correct as at 111830 Apr 10
BR	Copy – CO NZPRT Notebook Extract – Force Protection comments – 25 Apr 2010
BS	Initial Analysis – Contact 03 Aug 10 – PPT Presentation
BT	Minute – TG CRIB Future Capabilities dated 24 Aug 2010
BU	Sign Over Sheet – Package 7058

BV ARIKI NSE AAR – NZPRT Incident of 03 Aug 10
BW Email - CRIB.NSE – OC to JFNZ J3 – SITREP fm BAF as at 042330 Aug 10
BX Discharge Summary for as at 06 Aug 10
BY Discharge Summary for as at 06 Aug 10
BZ NZ Police Form 265 – Certificate as to Extinction of Life
CA Transportation Control and Movement Document
Requisition and Invoice/ Shipping Document
Signature and Tally Record
Special Handling Data/ Certification
Military operations Record of Personal Effects of Deceased Personnel
CB OP TROY NZDSU QUCKREP dated 061329 Z Aug 10
CC OP NZ DSU Comment as at 17 Aug 10
CD Extract from HQ JFNZ J1 Br SOM Plot as at 15 Jul 10
CE Defence KEA Portal posting print outs – and

CF Observations – Repatriation of remains to NZ by J133
CG J133 Actions Completed Record
CH Email J18 Pers Welfare to J133 – Wash-up of Casualty Welfare Support
CI Email J133 to J1 Psych – Repatriation Wash-up – Psych points
CJ Email J43-2/ Crib S4 of 130137 Aug 10 – Return of Pers Kit
CK Email J45/ J43-2 of 101001 Sep 10 – Write-off action
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CM Email J43-2 of 150831 Sep 10 – Equipment Damaged/ Destroyed
CN Email Crib S4/ J43-2 of 172222 Sep 10 - Update
CO Excel Spreadsheet – Equipment involved in 03 Aug Contact
CP HQ JFNZ SOP 10-52 – Medical Assistance or Repatriation dated 24 Aug 10
CQ Annex A to HQ JFNZ OP SOP 10-52 – HQJFNZ Medical Repatriation Procedures dated 31 Mar 09
CR HQ JFNZ 4500/1/24 – Review of HQ JFNZ PDT Cell dated Aug 10
CS NZCTC 3450/5/1 – TG CRIB 16 OLOC Achievement dated 26 Mar 10
CT NZCTC 3450/2/22 – Joining Instruction: TG CRIB 16 PDT 15 Feb-19 Mar 10 dated Dec 09
CU HQ NZCTC 3450/5/1 – WNG O 14/09: TG CRIB 16 DLOC, Spec Trg and PDT dated Nov 09
CV HQ 3LFG 3450/2/22 – OPORD 17/09: TG CRIB 16 DLOC, Spec trg and PDT dated Dec 09
CW TG CRIB 16 PDT Training Programme as at 18 Feb 10
CX 2 Sigs Sqn 4500/1 – OPORD 34/09 – TG CRIB 16 Comms Spec Trg dated 11 Dec 09
CY NZCTC- Light Skin Counter Vehicle Ambush Drills PPT presentation as given on TG Crib 16 PDT
CZ C-IED PPT presentation as given on TG Crib 16 PDT
DA MD462 – NZDF Consignment Note – Pers Effects
O'Donnell dated 15 Sep 10
dated 15 Sep 10
dated 23 Sep 10
DB Consignment Note9579695613 dated 19 Aug 10
DC Email of 14 Sep 10
DD PPT Presentation – Defence Inquests Unit (UK)

DE Extract – Presentation by

DF Extract –Death Investigation and the Coroner's Inquest (AS) – International Disaster Management and Mass Fatalities pp 260-261

DG MD460 – Body of Deceased and Casket Air Waybill dated 7 Aug 10

DH MD460 – Requisition for Movement – Personal Effects (O'Donnell) and Unaccompanied Personal Effects dated 18 Aug 10

DI Email JMCO Mov Op/ re: Lt O'Donnell Personal Effects from theatre

DJ 2/1st Battalion 5091/1 – AAR for Funeral of Lt T.A. O'Donnell, DSD, RNZIR dated Aug 10

DK MD430A – Inventory of Personal Effects – X1017058 Lt T.A. O'Donnell

DL MD430A – Inventory of Personal Effects (Items RTNZ from TG Crib 16) – X1017058 Lt T.A. O'Donnell

DM NZCTC 4500/1/24 - OP ARIKI Operational Preparedness Review Report dated 18 Jun 10

DN Dental Identification of Human Remains – Labplus, Auckland City Hospital dated 08 Aug 10

DO Op J1 Hlth Debrief Notes as at 04 Oct 10

DP Crib 13 Training Notes dated Nov 2008

DQ Email J833-2/ of 12-13 Jan 10

DR Email J833-2/ from 18 Jul – 16 Sep 2008

DS NZDF 03130/ISP/EF – NZDF Rules Of Engagement for OP ENDURING FREEDOM – AFGHANISTAN (less) dated 10 Sep 02

DT NZDF 03130/DSC/EF – Amendment to NZDF Rules of Engagement for OP ENDURING FREEDOM – AFGHANISTAN (less) dated 10 Mar 06

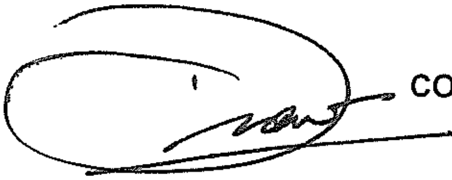
DU Email of 061056 Aug 10

DV Email 2/1st Battalion/ Adjt 1 NZ Sigs Regt of 101622 Aug 10

DW Email 2 Sig Sqn of 110816 Aug 10

DX Email of 131440 Oct 10

DY Coronial Autopsy Report – Timothy O'Donnell – dated 29 Oct 10



COMMENTS BY ASSEMBLING AUTHORITY

1. I have carefully considered the report of the Court of Inquiry into the circumstances surrounding the 3 August 2010 insurgent attack against a NZDF patrol in Bamyan Province, Afghanistan. The proceedings of the Court of Inquiry were conducted over the period August to 22 October 2010 and involved hearing evidence from 59 witnesses. I consider that the members of the Court of Inquiry have thoroughly examined the incident and I accept their conclusions. They are to be commended for their diligence in carrying out the task.

2. I note in particular the Court's favourable comments concerning the actions of all KT2 patrol members in the immediate aftermath of the contact, and the observation that this is testament to the professionalism and commitment of Lieutenant O'Donnell in preparing his patrol for their tasks. The performances of are particularly noteworthy. I also note the Court's positive comments concerning the way in which all CRIB 16 personnel dealt with the aftermath of the incident and retained their operational focus.

3. The Court of Inquiry has made 69 recommendations as a result of their investigation. These, together with the actions taken so far to address them, are contained at Annex A to these Comments.

4. The Court commented on the approach to training and preparation of NZDF personnel for CRIB deployments, recommending that a review be conducted to ensure that training and preparation are based on current in-theatre equipment and TTPs. While this is accepted and these areas have been and will continue to be reviewed, it may not always be possible to provide access in NZ to the exact types of equipment that might be available to in-theatre units given that they are often sourced from coalition partners. The approach adopted currently is to provide a Theatre Indoctrination Course (TIC) for new rotations that will bring them up to OLOC on any equipment not available in NZ before commitment on operations. While not ideal, this recognises the difficulties in being able to acquire and support new capabilities in NZ when there can be considerable access, funding and logistic support issues in introducing such into the NZDF at short notice to meet an operational requirement. In the 3 August incident, it is important to remember that KT2 were more than four months into their deployment and therefore at a high level of operational capability with the issued equipment. I do accept, however, that there were deficiencies in the initial training on such systems as Blue Force Tracker and the MK 19 AGL.

5.

6.

7. The decision as to whether or not to conduct VP drills will always be up to the tactical commander based on the specific situation. In the type of environment and situation confronting KT2, the speed of advance would have been significantly compromised had VP drills been performed at all potential VPs. While VP drills performed at some points and at irregular intervals is valid for the type of situation in Bamyan, I do not believe that the failure to carry them out in this case was a factor in the outcome. If they had stopped to perform the drills, it is possible that they may have been at greater risk from the insurgent element positioned close to the ambush site.

8.

Nevertheless, these issues are worthy of discussion in tactical training situations to highlight the risks of certain actions.

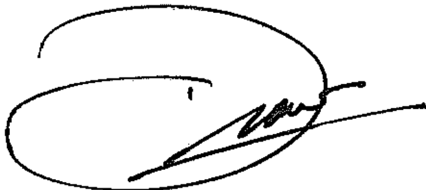
9. The report raises a number of issues concerning the health support provided to repatriate the two wounded servicemen. The decision to repatriate the two wounded personnel by RNZAF B757 receives some negative comment. I confirm that CDF and I were fully cognisant of the importance of the two soldiers being fit to travel on the B757 before we committed to that course of action. However, it appears that a misunderstanding between the US medical authorities at Bagram and the NZDF concerning the AME fit of the B757 led to the decision to recover them on the B757 without the desirable level of medical capability. While it will always be preferable to have an appropriate AME fit on the B757 when carrying wounded NZDF personnel, this may not always be possible. The decision to carry wounded or not will be a risk management one based on the nature of the injuries, the medical support available, and the aircraft configuration.

10. For CRIB 18, major changes to capability and weapon systems have been implemented, in part as a result of this Court of Inquiry. Deployment of NZLAV in particular is aimed at provided enhanced protected mobility, improved organic firepower, and integral night surveillance capability. Improvements to armour protection, crew and dismounts' seating, situational awareness systems, and casualty carrying modifications will all add significantly to the overall capability of patrols operating in the Bamyan AO, particularly in the north east. In addition, a range of new and upgraded weapon systems will further enhance patrols' ability to deal more effectively with enemy engagements. Coupled with improvements to Theatre Indoctrination Course training, I am confident that patrol teams are now even better equipped and prepared to deal with combat situations.

11. In summary, the enemy engagement on 3 August 2010 that resulted in the death of LT Tim O'Donnell and injuries to two other soldiers was the result of a well planned and executed ambush.

The insurgent group was determined and well positioned to undertake the complex engagement using IED and small arms/RPGs. The response by KT2 was conducted

professionally and with courage and commitment by the members of the patrol. I am confident that the lessons identified and recommendations made by the court have been appropriately reviewed and actions either initiated or completed as necessary.



A.D. GAWN
MAJGEN
COMJFNZ
18th July 2011

COMMENTS BY ASSEMBLING AUTHORITY

REF	RECOMMENDATION	ACTION	STATUS
	Health Service Support		
1.a (p.525)	HQ JFNZ standardise the use of Business Class travel arrangements for any future AME team deployed forward, to meet anticipated rest requirements.	Agreed in part. Adequate rest for the AME medical team is a principal planning consideration when making travel arrangements. In this situation the AME team deployed (as a 'pre-positioning' exercise) before the casualty repatriation details had been confirmed. These arrangements were made on the assumption there would be a time-delay (and by implication a rest period) prior to the casualties RTNZ. In future if there is doubt about rest-periods for the medical teams prior to RTNZ then Premium Economy or Business Class seating will be recommended.	**Actioned**
1.b. (p.525)	Best medical practice takes precedence.	Agreed. Decisions regarding the method and timing of medical repatriations are always made on the basis of medical need in an effort to ensure the best health outcomes for the casualty. Other factors (such as cost, convenience etc) are distant secondary considerations and largely influence decisions around the options available to meet the primary intent. This was the situation for this repatriation. In this situation there was 'higher-level' direction that if possible the deceased and the casualties should RTNZ on the same aircraft. Based on the medical information available at the time it appeared that this direction could be met without adversely affecting the comfort and health outcomes of the casualties. It only became apparent during the actual flight back to NZ that casualties' medical status was worse than reported by the in-theatre medical personnel. Whilst the long-term health outcomes for the casualties were not likely to have been adversely affected by these arrangements, the repatriation carried a degree of unknown risk which was undesirable. Changes to the HQ JFNZ SOPs regarding information sharing between HQ JFNZ and the medical elements in-theatre have been made to ensure better visibility of casualty medical status prior to the finalisation of repatriation plans.	**Actioned**
1.c. (p.525)	Dedicated use of RNZAF 757 for Strategic AME should have a mandatory air ambulance fit suitable for the carriage of stretcher-borne patients, with appropriate stocks of medical stores and	Agreed in part. AME 'pallets' for use on the RNZAF 757's have been developed as part of the RNZAF AME project. This equipment would have been used in this situation had the aircraft been deployed for the AME task from Whenuapai. Given the size, weight, and complexity of the medical equipment required to support an AME, it is impractical to have this equipment held as basic equipment onboard the 757's. The Pallet system is ready to fly and awaiting A/C Certification – full certification for the 757 and C-130 is	**Actioned**

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	equipment.	expected by the end of 2011. Until full certification has been received, the aircraft are able to operate with the AME pallet system under concession of ACC. Additional training by selected personnel has been undertaken allowing for up to Medium Dependency Transfers without the need for additional support from civilian agencies.	
1.d. (p.525)	The forward deployed NZPRT ambulance should be a vehicle with the appropriate level of force protection measures and equipment as an alternative to tactical AME	Agreed. Health support improvements are intended for NZPRT operations in the NE of Bamyan Province specifically by upgrading the medical element based at FPB ROMERO to provide a stabilisation capability and by the provision of Light Armoured Vehicles (stretcher capable) which will provide protected mobility for the extraction of casualties to FPB ROMERO. NZPRT patrol planning and decision making is to incorporate a greater emphasis on forecast weather conditions and the accessibility of Coalition AME assets.	**Actioned**
1.e. (p.525)	NZPRT develops CONPLANs to facilitate alternate action for delayed AME or no AME.	Agreed. CONPLAN has been developed at PRT and incorporated into SOPS.	**Actioned**
1.f. (p.525)	HQ JFNZ must plan for alternative patient hospitalisation if strategic AME transport is required to stop over or is delayed.	Agreed. Where repatriation involves planned stopovers, transit medical support is arranged as part of the repatriation plan. Unplanned stopovers are usually dealt with on an occurrence basis although options are considered as part of the overall repatriation planning process. Noted for planning consideration and incorporated into Business-As-Usual actions.	**Actioned**
1.g. (p.525)	Conventions preventing NZPRT medics from manning crew served weapons should be reviewed by J1 Hlth and DLS, as this limits patrol effectiveness and affects the medical coverage of patrols.	Agreed. Currently medics wear a 'Red Cross' brassard which identifies the individual as a medic and is a symbol of the 'responsibilities and protections' of the medic under the Geneva Conventions. In addition to a number of medical responsibilities and obligations, the Convention restricts the medic's use of weapons to self-protection and the protection of patient(s). In conventional warfare wearing of a 'Red Cross' brassard is intended to identify the individual as a medic and as such provides some 'protection' for the medic, however there is no evidence to suggest that the 'insurgency' recognise the Convention, in fact some would argue the brassard may identify the medic as an attractive target. Acknowledging that the primary role of the medic is the provision of medical support to the patrol, it is also recognised that NZPRT patrols are typically minimally manned. To optimise patrol security ideally all	**Actioned**

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		members should be able to contribute to the protection of the patrol. The use of medics in this role is precluded by the Geneva Convention requirements (self defence and casualty protection) even if they removed their brassards. Notwithstanding these comments medics will be trained in the use of the support weapons. However, they will only be able to use them operationally when required for self protection or protection of their patients on the basis of a 'last man standing situation'. This has been confirmed by JS01 Legal and recommendations have been sent to J5 for implementation on PDT.	
1.h. (p.525)	The medical staff establishment at NZPRT KB RAP be reviewed to ensure adequate coverage for life support should casualties be required to be held for longer periods.	Agreed. The medical support arrangements for the NZPRT and associated patrols are currently under active review. To be incorporated into CRIB OPORD but noting restrictions due to manning capacity and priorities.	**Actioned**
1.i. (p.525)	The NZPRT KB RAP establishment be accurately reviewed to determine its ability to handle mass casualty at KB, as well as the need to have suitably-qualified key medical staff deployed eg. RMO and NO have appropriate EMST qualifications and experience.	Agreed. The medical support arrangements for the NZPRT and associated patrols were reviewed and included the positioning of suitably qualified medical personnel at FOBs as necessary. The medical officer (MO) job description has been amended to formally reflect the need for the MO to have skills in emergency medicine. The skill-set requirements of the other deployed medical staff will be reviewed as the revised HSS plan is formalised. The personnel cap on the NZPRT prevents the addition of any further medical personnel to the NZPRT, however, the location of some medical staff has been changed to provide senior medical staff in better proximity to patrols in the N.E. districts of Bamiyan.	**Actioned**
1.j. (p.525)	The Combat Lifesaver qualification is a critical capability in the section or patrol. Army units preparing contingents for TU CRIB should seek to maximise the number of Combat Lifesaver qualified personnel, particularly in	Agreed. As part of the review of the medical support arrangements for the NZPRT and in particular the patrols, it is intended that all personnel deployed in 'patrol roles' are combat lifesaver qualified and will form part of the criteria for nomination for deployment. Consequently, more emphasis ihas been placed into ensuring that 2 x Combat Lifesavers are incorporated into patrols, however, to date this has not been fully achieved due to a lack of training capacity.	**Actioned**

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	patrols, during DLOC preparation activity.	9 x Combat Lifesavers will deploy with CRIB (19).	
1.k. (p.526)	HQ JFNZ J1 Br should ensure that casualty NOK, and especially partners of NZDF casualties, receive appropriate and timely psychological support.	Agreed. Psychological support can be delivered by a number of mechanisms, e.g. chaplains, LO's, community welfare officers, etc. The provision of clinical psychological support to civilian NOK is problematic. If NZDF Psychologists (who are not clinical psychologists) intervene and identify possible clinical issues arising, then the NZDF Psychologist becomes obligated ethically to deliver the person to the most appropriate care providers. NZDF policy would require amendment to enable this care to be delivered and funded.	**Actioned**
1.l. (p.526)	The HQ JFNZ SOP 190 regarding the requirement for follow-up NOTICAS procedures by other elements in the evacuation chain should be reinforced to deploying NSE contingents.	Agreed. The recommendation should read Mission SOP 10-51 (located on the HQ JFNZ Mission SOP website). J1 Health SOPs are updated regularly and copies are provided to deploying health personnel on each rotation.	**Actioned**
1.m. (p.526)	ARIKI NSE should develop an SOP for casualty evacuation procedures to fill the gap identified during this incident. The court noted that OC NSE had identified this gap and was taking action to ensure it was resolved at the time of his interview. It is further recommended that incoming contingents receive an adequate handover of existing SOPs, and conduct further analysis to determine potential gaps therein.	Agreed. The conclusion of the Court that the repatriation process was efficient and timely given the circumstances is noted. It is also acknowledged that the repatriation of both the deceased and casualties was dependent on the goodwill and professionalism of our Coalition partners, particularly the US support in BAF, and the Australian and Canadian support The After Action Review process for this incident resulted in the repatriation SOP being improved at all vital points of the chain. In-theatre SOPs were found to be out of date which has now been rectified; confirmed all in-theatre SOPs are current.	**Actioned**

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	Logistics		
2.a. (p.526)	NZ-based Plant and/or Equipment Managers should be instructed to refrain from circumventing HQ JFNZ by engaging NZPRT S4 directly with regard to the action desired for particular equipment return of equipment post-incident administration.	Agreed. NFAR as processes are already in place IAW SOPs.	**Actioned**
2.b. (p.526)	SOPs for repatriation of weapons/non NZDF equipment should reflect the requirements of End User Certification.	Agreed. JAPG conducted and current defence doctrine has been incorporated into SOP 433.	**Actioned**
2.c. (p.526)	The Crisis Management Team is an effective organisation that, led by CoS HQ JFNZ, is capable of coordinating separate branches when handling different aspects of, and substantially different procedures for, repatriation of deceased (J4) and living casualties (J1).	Agreed. The role of the CoS in leading CMT is recognised and in place.	**Actioned**
3.a. (p.526)	Deceased – Single services should identify/recognise that military-issued personal equipment may be significant to deceased family (in this case uniforms/sleeping	Agreed. This issue is governed by extant Defence policy; DFOs prohibit the gifting NZ combat clothing and equipment. Additionally, Coronial, COI and / or MAF may also dictate that such items may not be transferred. Should items be requested it is recommended that the focus be placed on items such as Beret, Corps Belt, etc.	**Actioned**

	bags/packs etc), and therefore procedures for liaising with family on what military equipment they may wish to keep is recommended before its destruction or return to the supply chain.	SOP 433 will require further amendment and any / all Family LOs must be appraised of procedures.	
3.b. (p.526)	Casualties – the return of casualties' personal effects from theatre has been a slow and laborious process, with very little explanation offered except that the contracted civilian company has difficulties with processing the effects through NZ Customs and MAF. It is recommended that J4 Branch investigate alternative options or identify desired improvements with the current system with the contractor to improve the speed of the repatriation of personal effects from theatre.	Agreed. Acknowledged the need for expeditious action by theatre/ NSE staff and advice to contractor WRT priority and time lines. SOP 433 reviewed with current procedures remaining extant.	**Actioned**
4. (p.526)	HQ JFNZ J1 Branch should be tasked with identifying improvements to current policy for medical, psychological and welfare support to LEC that are involved in critical incidents with NZDF elements.	Agreed. This is an in-theatre command issue whereby advice can be sought from J11 Psychologist, but the actual provision of psychological support should be provided through local available mental health agencies. NZDF Psych support was provided to the LEC in the same form as that provided to the patrol. The process will be incorporated into the CRIB (19) OPINST and all subsequent mission OPINSTs.	**Actioned**

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	Mortuary Affairs and Post Mortem		
6.a. (p.528)	Labelling of separate body bags within transit cases IAW SOP 433.	Agreed. NFAR	**Actioned**
6.b. (p.528)	An MOU should be established between NZDF MOU with Coronial Services/MAF/Customs/NZ Police.	Agreed in part. NZDF has extant MOUs with MAF, Customs, and NZ Police. MOU with Coronial Services was reviewed but deemed unnecessary.	**Actioned**
6.c. (p.528)	NZDF supports the NZ Pathology Services' acquisition of a dedicated post-mortem CAT scanner.	Agreed. Although the NZDF would be supportive of this initiative, it is not appropriate for NZDF to take any further action.	**Actioned**
6.d. (p.528)	Auckland is maintained for future use as a transport and post-mortem services hub, as a staging point through Auckland will ensure access to necessary support staff and resources, particularly in the case of mass casualties/deceased.	Agreed. Auckland confirmed as the transport and post mortem hub. SOPs 433 and 10-52 have been updated.	**Actioned**
6.e. (p.528)	The dedication of a suitably qualified HQ JFNZ or medical officer to act as a Coronial escort/LO.	This remains an extant task for J1 Health IAW SOP 433.	**Actioned**
6.f. (p.528)	Retain the practice of involvement of the Coroners Office in operational deaths investigation and procedures.	Agreed. No change to SOP 433 required.	**Actioned**
6.g. (p.528)	Contingency planning should be conducted by HQ	Agreed.	**Actioned**

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	JFNZ CMT, with the Pathologist, in order to consider the problems and actions associated with a Mass casualty Incident, particularly with regard to co-mingling of remains.	To be conducted in conjunction with CRIB (19) OLOC (-) Generation Training (MRE).	
6.h. (p.528)	HQ NZDF acknowledges that the post-mortem process is subject to a number of factors that reside outside of NZDF control that could delay the repatriation process. HQ NZDF should acknowledge that unnecessary haste to this process can create friction and compromise the Coroner's outcomes.	Agreed. Acknowledged; NFAR.	**Actioned**
6.i. (p.528)	HQ JFNZ should attempt to release as much information as possible (with appropriate security classification and privacy considerations noted) from any TSE to the pathologist in order to assist post mortem investigations.	Agreed. Acknowledged; NFAR.	**Actioned**
	NZPRT Equipment and Capability		

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Personal Equipment		

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Other Capabilities

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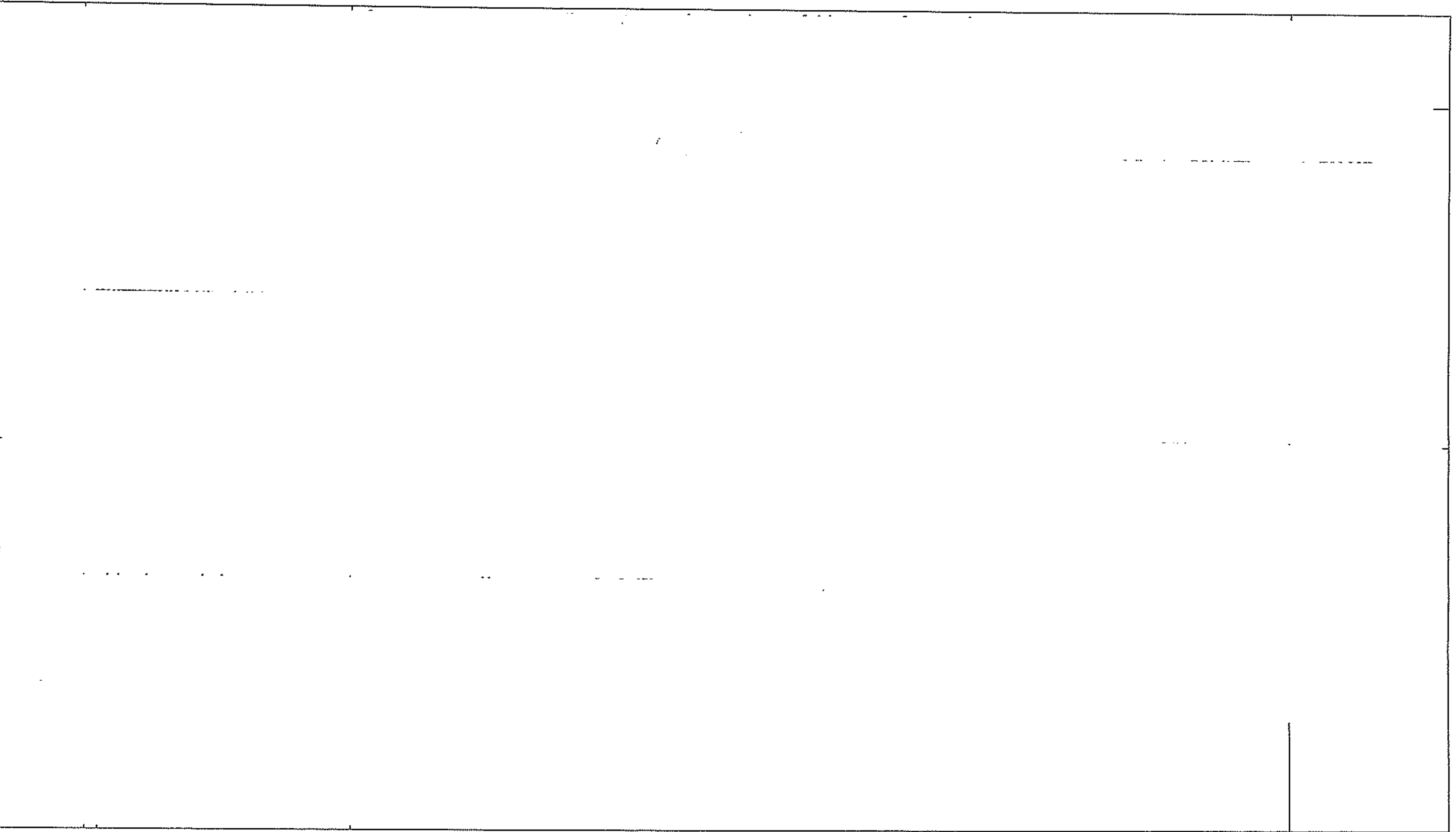

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	Training		
8.a. (p.530)	Formal training for all NZPRT Patrol members at a minimum, for all non-NZDF weapons used on operations and their maintenance should be conducted on PDT, or at least on a sufficient TIC in-theatre.	Agreed. Training in these skills is largely covered during the TIC. The training consisted of a review of turret operation, Blue Force Tracker, ECM and mounted ops. The TIC was reviewed and a report forwarded to LCC. Key recommendations included training in this area be increased during DLOC, weapons systems used on CRIB to be made available in NZ for training purposes, and NZCTC to be responsible for the co-ordination function rather than in-theatre personnel. Report endorsed by LCC and recommendations now under action.	**Actioned**
8.b. (p.530)	Formal training for all NZPRT patrol members on vehicles used on operations to include tactics, driving (including with NVE),	Agreed. The trainers believe that because the combat elements of CRIB (18) are coming from a vehicle-centric unit, they will have little difficulty in making the transition to the HMMWV. As [part of the TIC Review training in this area is to be increased during DLOC (including LAV). It is assessed that the time currently	**Actioned**

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	maintenance, problem solving, and recovery.	currently allocated to this training on the TIC is sufficient to cover off on other vehicle types not available for training purposes in NZ. Under action by LDTG and NZCTC.	
8.c. (p.530)	A shift in emphasis to long-range marksmanship training on PDT, as opposed to short-range reaction type shooting.	Agreed Has been incorporated into PDT OLOC (-) Generation Training WEF CRIB (18).	**Actioned**
8.e. (p.530)	ECAS procedures should be taught to all patrol members on PDT, not just a minimum of 1 per patrol.	Agreed. NZCTC confirm that all patrol members are revised on ECAS procedures during OLOC (-) Generation Training.	**Actioned**
8.f. (p.530)	NZ CTC should ensure training for all patrol members in LZ procedures including night LZ marking is delivered, IAW theatre procedures.	Agreed. Skill's taught during unit DLOC training and practised during OLOC (-) Generation Training.	**Actioned**
8.g.	Contact point appreciation	Agreed.	**Actioned**

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(p.530)	skills should be taught to patrol members on PDT, particularly focussing on Complex IED/ambush type tactics.	Skill's taught during unit DLOC training and practised during OLOC (-) Generation Training.	
8.h. (p.530)	NZPRT Sup Tech personnel should receive basic mortuary affairs training and an introduction to applicable HQ JFNZ and NZPRT SOP for the handling of deceased personnel and their effects after a critical incident. The conduct of MRE during PDT, including the processing of a deceased serviceperson, is encouraged.	Agreed. NZDF (Sup Tech's) training has been enhanced by the experience with Canterbury quake. 2 LOG conducts specialist MA Training for LOG and other personnel prior to each OLOC (-) Generation Training period and will additionally conduct MA Training during OLOC (-) Generation Training to all deploying personnel. 2 LOG has developed a detailed SOP for the management of deceased personnel as well as developed a 'grab bag' for each patrol vehicle. An application for funding is being staffed by J4 to enable these to be issued to theatre.	**Actioned**
8.i. (p.531)	The lessons identified in this COI are of a time-sensitive nature and should be released as soon as practicable to better prepare CRIB 18.	Agreed. NFAR.	**Actioned**
8.j. (p.531)	CTC personnel are included on the Command Reconnaissance to identify current TTP to be included in OLOC training.	Agreed. NZCTC personnel deployed CRIB (18) Command Recce and this will continue to occur for all rotations; NFAR	**Actioned**

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REPORT FROM THE COURT OF INQUIRY

General

The inquiry was carried out during the period 10 August to 22 October 2010. Evidence from 59 witnesses was considered.

1. What were the circumstances leading up to and surrounding the death of the deceased and the wounding of the casualties?

(R) The TU CRIB 16 OPORD 1/10 dated 24th February 2010 was the overarching Operations Order in force at the time of the KT2 Contact/ IED incident on the 3rd August 2010. This order specified the conduct of operations by TU CRIB 16 within its Area of Operations in Bamyan Province. In conjunction with this OPORD, a Strategic Plan was developed by TU CRIB 16, to ensure adherence to the long-term planning goals for the NZPRT operation. At the tactical level, the NZPRT Effects Conference is a process by which the achievement of a Strategic Plan is coordinated through the identification of desired effects that need to be achieved. The outcome of this process is driven by the CO's Effects Guidance for the NZPRT, which identifies and articulates the effects to be achieved and the measures of effectiveness to be utilised. The patrol programme that was developed and executed by Kiwi Team 2 (KT2) was a direct evolution of the NZPRT Effects Conference Held on 8th July 2010, which outlined the desired effects to be achieved in July and August for the DO ABE area.

There were no indicators or warnings, that identified there was a direct and specific threat to the KT 2 Patrol on the day of the contact.

(R) The investigation by the Court revealed that the outline sequence of events was much as tabled by the After Action Review Report – KT2 TIC 03 Aug 2010 – as submitted by NZPRT, TU CRIB 16 on 09 Aug 10. Most witness accounts and exhibits tend to confirm the timeline of the significant events that occurred immediately prior to the contact, and its subsequent related events. A more detailed account of the actions The narrative below summarises the key events from the morning of 3 Aug 2010 to the morning of 4 Aug 2010:

(R) The objective of the KT 2 patrol conducted on the 3 Aug 2010 was to deliver gabion baskets, fertiliser and agricultural seed to a number of villages in eastern KAHMARD DISTRICT between Forward Patrol Base ROMERO and the isolated village of SARI GULI.

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(S)KT2 conducted their patrol with a mix of 2 x HMMWV[1] and 2 x Hilux.

(S) The mixture of 2 x HMMWV and 2 x Hilux was determined, to have met the minimum Force Protection requirements for both numbers and types of vehicles

(S) The patrol commander and LNO issued a warning order for the 03 Aug 10 task the night before. Final confirmatory orders were given by the patrol commander and LNO with the patrol departing FPB ROMERO at approximately 0830 hours. After a brief stop at the range immediately south of to test-fire the patrol's weapons, the patrol departed for DO ABE. It was noted by the Court that all of the weapons, were serviceable and fired normally at this test-fire.

[1] HMMWV-High Mobility Multi-Purpose Wheeled Vehicle. The NZPRT operates the M1151 variant of the HMMWV which has a heavier chassis and improved engine to allow for the addition of add-on armour.

(S) The patrol moved to DO ABE

The first halt reported by the patrol was that of DO ABE (DT), where it delivered gabion baskets to a local Shura between 1025 and 1043 hrs, it then departed DT heading north to ISH PESTA It was noted by the Court that one witness stated that the original plan was to go straight to the furthest village of SARI GULI first, and then work their way back to ROMERO from there. However, the instability of the load of gabions on the rear HMMWV's trailer obliged them to modify this plan and begin delivering gabions earlier than expected, albeit to the same intended recipients.

(S)KT2 conducted at least one more drop of gabions to the village of CHARTOK, and probably a second drop at KARIMAK, en route to ISH PESTA.

(S) The patrol commander stopped once more before reaching ISH PESTA, at a lone house ; to talk to a local national. When the patrol commander learned that this person was not present, he apparently left a note and continued with the patrol.

(S) After a short halt at the ANP Checkpoint at DAHANE ISH PESTA, the patrol continued north to the main village of ISH PESTA, reporting from that location at approximately 1240hrs. Upon reaching this location, the patrol commander split his patrol into two separate elements. The two Hiluxes, moved north to SARI GULI to deliver gabion baskets, fertiliser and agricultural seed. The two HMMWV remained at the ISH PESTA COALMINES to conduct training and liaison with the ANP in that location. The decision of the patrol commander to split the patrol at the ISH PESTA COALMINES was supported by witness accounts.

This decision did not impact on the incident itself,

(S)The two elements of the patrol rejoined at ISH PESTA COALMINES and departed for FPB ROMERO, via the same route which they had followed . After a brief halt at the DAHANE ISH PESTA ANP Checkpoint again, they continued west toward DO ABE. During the move, the patrol halted again at the house of same LN that the patrol commander had left the note for earlier in the day.

(S)At approximately 1630 the patrol was nearing a critical point across a dry stream bed just south of the village of KARIMAK. This critical point had been formed due to the extensive flooding in the area earlier in May and June, which had destroyed the original road in that location. The critical point consisted of a detour east approximately 100 metres from the main road, onto a roughly-formed ford through the dry streambed. It had been used by KT2 on numerous occasions on previous patrols leading up to the incident. The shape of the critical point was a rough hairpin bend, which obliged the vehicle to slow as it entered the critical point from the north, and descend down into the stream bed. The bend was surrounded by high ground to the north, south and west, and enfiladed by the flood plain of the stream bed to the east.

(S) The patrol members, and in particular the crew of the lead vehicle, confirmed that there was no prior warning that contact may be imminent, nor anything out of the ordinary as the vehicle approached the critical point.
nor did any LN attempt to warn or flag down the patrol.

. There appeared to be widespread agreement between the members of the patrol that the critical point was of concern, but that they had not deliberately cleared it since its creation by flooding some months earlier. It was confirmed by members of the patrol that there was no deliberate or ad hoc attempt to clear the critical point using tactical methods, either dismounted or mounted, as the patrol approached it from the north. It had also not been cleared earlier in the day when the patrol had passed it heading north. Deliberate obstacle crossing procedures had been trained on PDT but it appeared they were not always utilised. The Court agreed with the assertion that the nature of the terrain in the AO,
was such that a patrol could not be expected to stop and check every critical point on that route without severely impairing its momentum and achievement of objectives.

In the absence of a specific threat by IED and ambush to KT2 for that period, it is understood that the patrol believed they were sufficiently protected by its armoured

vehicles,

they were patrolling with a generic threat, but not a specific one.

(S) The remaining vehicles in the patrol were strung out in the same OOM, and were passing an isolated LN house and walled compound approximately 260 metres north of the critical point as the lead vehicle entered the stream bed. At this point, the CW-IED was triggered, immediately immobilising the lead vehicle.

(S) The next vehicle,

observed the lead vehicle enter the critical point and being hit by the IED. conducted the briefed and rehearsed Immediate Action drill for contact front, and immediately reversed the vehicle back the way they had come, calling out the contact to the remaining members of the patrol on his PRR. At this point, the INS were engaging the patrol from the high feature at the 12 o'clock (south) with small arms, PK and RPG fire. It is also likely that INS at the IED firing point followed up the IED with a volley of RPG and small arms fire at the lead vehicle.

(S) The remaining vehicles followed suit, reversing until K2B, the last vehicle, jack-knifed their trailer and could reverse no further.

, the Hilux of K2C emerged from the dust thrown up by an RPG explosion and struck the HMMWV on their right front corner. The K2C Hilux bounced forward and stalled, forcing the crew,

, to evacuate the vehicle to the driver's side along the wall of the LN house. The commander of K2B, the rear HMMWV, gave a target indication to the 12 o'clock enemy position, and then a fire control order to his gunner, who was using a MK19 AGL. The AGL failed to fire immediately, and did not fire after the gunner carried out the misfire drill, obliging the gunner to change to his coaxial MAG 58 MG.

(S) The vehicle commander of K2C regained control of his ANPRC-117 radio handset whilst his vehicle was reversing out of the contact, and managed to send the initial "K2, Contact, contact, wait out" report, which was received by KB CP at approximately 1633 hrs.

. When the crew of K2C debussed their vehicle, they failed to take the ANPRC-117 with them to cover, which precluded the immediate passage of further information to Kiwi Base until it was recovered later in the contact.

a rough location was calculated from their earlier

radio call at 1600 to say that they were departing from ISH PESTA.

(S) The crew of the lead vehicle did not evacuate the vehicle immediately, as they were dazed by the initial explosion.

The gunner,
, was the first member of the crew to evacuate it, realising they were immobilised. He elected to debus the vehicle by jumping over the turret when he discovered the rear passenger compartment was already on fire. The driver of the vehicle was stunned, but realised what had happened and started to check himself for wounds.

He then realised that small arms fire was striking his left armoured window, and elected to sit tight behind what he thought was adequate protection. When he realised the rear compartment was on fire, and the gunner asked him to move to the passenger side of the vehicle to help him extract the patrol commander, he evacuated the vehicle through his driver's side door, under fire facing the side of the contact (east), and moved around the rear of the vehicle to cover on the passenger side (west). The interpreter, sitting immediately to the rear of the driver, evacuated at roughly the same time. The interpreter had not been wearing his personal protective equipment during the patrol, and was not wearing ballistic sunglasses, but only received minor burns to his face and eyes in the initial explosion.

(S) By this time, the gunner had already appeared at the front passenger door to attempt to extract the patrol commander from his seat. The gunner stated that
his door had been thrown open

The gunner and driver alternated several times in their attempt to pull the patrol commander from the vehicle, as the internal fire in the rear of the vehicle intensified and small arms ammunition started exploding. At the same time, they were aware of RPG and small arms fire striking the ground from the front (south) and left-hand side (east) of the vehicle. At one stage an RPG struck the bonnet or armoured windscreen of the HMMWV without penetrating the armour. Despite several attempts, at considerable personal risk from both enemy fire and exploding ammunition inside the vehicle itself, the gunner and driver realised they could not extract the commander without becoming further casualties themselves.

(S) The interpreter had by this stage elected to break from the vehicle and seek better cover from enemy fire. He had remained with the gunner and driver for a period after evacuating the vehicle,
The interpreter, suffering from eye injuries caused by the initial blast and fire, entered the dry streambed to the west, and followed it blindly for some distance before electing to head north in the direction of the remainder of the patrol.

(S) After realising they could not free the trapped patrol commander, the driver and gunner followed the interpreter's route into the stream bed. As both were suffering from lower limb injuries, they could not break contact from that area without assistance, and elected to hide in what they perceived to be the best cover available from the INS fire coming from the east and south.

(S) During the period the gunner and driver from the lead vehicle were attempting to extricate the patrol commander, the remainder of the patrol had reversed into a position north of the lead vehicle's location.

. Most witnesses from the three vehicles reported receiving a significant volume of small arms and RPG fire, All three vehicles were struck by accurate fire, including bullet and RPG strikes, . Although the vehicles were immobilised by their manoeuvre, and not by enemy fire, they allowed the patrol to gain the safety of the only cover available on an otherwise straight stretch of road, dominated by high ground on three sides.

(S) Some witnesses reported that fire was taken from not only the 12 o'clock position (south east), but also from the 9 o'clock (east) and 3 o'clock (West) directions. Anecdotal evidence, in the form of shell casings and RPG strikes on the road surface suggested that the predominant fire came from the main position at 12 o'clock, with additional rounds directed at the lead vehicle from the trigger man location for the IED, approximately 45 metres east of the contact site in the dry stream bed.

(S) After debussing from their vehicle, the crew of K2C, sought cover alongside the wall of the compound to their east. Still taking effective fire in that position, they continued to move to the rear (north) to seek better cover from the heavy enemy fire. K2 B continued suppressing the known enemy position at 12 o'clock

(S) Although some witnesses continued to believe that they were receiving accurate fire from the 3 o'clock (west) direction, no actual firing positions were observed.

(S) The commander and driver of K2B debussed their vehicle at one stage to return fire with their Steyrs, but were forced to remount after accurate small arms fire struck the ground around them.

(S) Witnesses reported that, after the main elements of the patrol sought cover behind and adjacent to the compound wall, the RPG fire noticeably shifted to the lead vehicle

again, with some witnesses stating that the vehicle was struck between 5 and 7 times by rockets. The driver and gunner of the lead vehicle stated that they were in cover by this stage, and did not hear the explosions, or at least could not distinguish them from the other fire directed at the patrol.

(S) The driver and gunner of K2, after reaching the stream bed immediately west of the vehicle, continued to receive accurate fire from the enemy position to their south. They were oblivious to the actions of the remainder of the patrol at this stage, and hoped that they had been seen as they left the vehicle. The remainder of the patrol, however, did not observe the two, as they were in a depression below the line of sight from the compound. The driver and gunner elected to continue moving down the streambed to the west on their hands and knees, to where the bed makes a subtle turn and offers better cover from the northern bank. They decided to stay in this position for the remainder of the contact, as it appeared to offer the best cover from the enemy fire coming from the south.

(S) The remainder of KT2, by this stage, were in cover behind the compound wall, The only exception was the crew of the K2B HMMWV, which maintained its position on the road next to the compound and was returning the only effective fire at this point. A M72 rocket was fired at the enemy 12 o'clock position, , with no observable result. One witness believed the firing from the enemy did noticeably slacken at this point.

(S) When it was discovered by the patrol that the spare 117 radio had been left in the K2C Hilux, the commander of K2B elected to use the HMMWV to move forward far enough to allow the driver to recover this item from the cab of the Hilux.

This was done, and the radio returned to the remainder of the patrol behind the wall. Communications were unable to be established with Kiwi Base using this radio, The driver of K2B, whilst retrieving the radio, noticed that a MAG 58 MG remained in the K2C vehicle, along with ammunition and day bags, but neglected to retrieve them at the same time. After informing his vehicle commander, it was decided that they would use the same method to retrieve these items. At least another two trips were made to the vehicle, using the HMMWV's armoured doors and body as cover from small arms fire.

(S) At an undetermined time, but early in the contact, the remainder of the patrol observed the interpreter from the lead vehicle running in their direction in a field to their west. He was apparently running blindly, and did not immediately realise that

they were to his right (east). Although the interpreter states he did not hear their calls, he did observe their vehicles, and ran over to join them behind the compound wall.

(S) At some time between 1645 and 1700, the driver and gunner from the lead vehicle managed to establish communications with the commander of K2B . They informed the K2B commander that they were out of the vehicle and in the dry stream bed to its west, that the patrol commander was dead, and that they were both injured. They requested the patrol to come forward to retrieve them. The K2B commander requested permission to go forward, but this was refused, as the enemy fire remained heavy and accurate. After repeated requests to go forward, K2B was permitted to move forward after the spare MAG58 had been deployed and the enemy fire had stopped completely.

(S) During the period they were in cover in the streambed, the driver and gunner from K2 stated that they heard a distinct explosion from their vehicle.

The driver stated that he was certain this explosion occurred after the enemy fire had stopped, because the explosion was distinct from the firing they had heard earlier. The gunner stated that he believed some enemy fire was still occurring when this single explosion occurred, but that it was still distinct from the enemy fire, as it came from within the vehicle. They both stated that various types of small arms ammunition had been exploding with the heat of the fire in the vehicle, both while they were attempting to extract the patrol commander and after they had sought cover in the stream bed. Neither witness could be sure about what had caused this particular explosion,

(S) At approximately 1645L at Kiwi Base, CO NZPRT requested the acting PCOP BAMIYAN to deploy elements from DO ABE as the NZPRT had received a report that KT2 was in contact and we were having difficulty raising comms with KT2. This request was apparently acknowledged by the ANP PCOP, and elements were despatched as requested.

(S) At approx 1650L, the CO NZPRT ordered his Quick Reaction Force, the KT5 patrol, to move from Kiwi Base
KT5 deployed from KB at 1700L with four HMMWV

(S) There were no further communications with KT2 until 1656L when they attempted to send a contact report through. For an unknown reason, the NZPRT CP could hear KT, but KT2 could not hear the NZPRT.

(S)
two US F-16 aircraft,
were despatched to K2's assistance at 1657.

(S) At 1701L communications were established with KT2

KT2 reported that one vehicle had been hit by an IED and destroyed, and they had received one x RPG and SAF.

(S) At 1706L KT2 reported that it was their patrol commander's vehicle which had been hit by the IED, that the convoy had received a minimum of five RPG, and one other vehicle had also been disabled. They informed the KB CP that they were moving forward to extract the casualties from the IED vehicle.

(S) At some time after 1705, K2B moved forward to retrieve the gunner and driver of K2 from their position in the dry river bed. Although the enemy fire had apparently stopped by this time, the gunner of K2B maintained a suppressive rate of fire at the 12 o'clock enemy position as the HMMWV drove up to the destroyed K2 vehicle. Upon reaching it, the commander of K2B ordered the pair to stand up to show their position. When they were sighted, K2B commander ordered his driver to turn right and drive along the northern edge of the dry stream bed to where the two were waiting. He ordered the pair to get themselves to the vehicle, rather than ordering his crew to dismount and help them. Once the pair had got into the vehicle, K2B quickly extracted them back to the remainder of the patrol and unloaded them. One of the patrol members, who was a Combat lifesaver, began providing them with first aid.

(S) At 1719L the KB CP was informed that there was one KIA and one vehicle immobilised.

(S) At 1725L, KT2 reported that the INS were located 900 meters SE of their loc at an altitude of approx 2200 metres. At this time KT2 were asked for an update on the state of the casualties. At 1727L it was reported

again that there was 1 x KIA, 1 x Pri 2 with cuts to lower legs and 1 x Pri 3 with a broken foot. KT2 reported that the INS had disappeared and that the patrol had adopted all round defence. KT2 were informed at this time that there was a patrol heading to DO ABE

(S) At 1742, KT5, the QRF, had reached its initial objective Upon reporting this to Kiwi Base, they were ordered by CO NZPRT to continue through SHIKARI VALLEY to DO ABE.

(S) At 1755L KT2 were told that there were NDS and ANP on their way to their location from DO ABE. At 1757L KT2 reported that they had the ANP in sight. The ANP dismounted and moved directly through the contact site to where the patrol was behind the compound, and began liaising with the patrol

Shortly after the arrival of ANP from DO ABE, a further group of ANP arrived from the ISH PESTA COALMINES security element from the north. They began clearing the open fields to the west of the patrol up to the contact site.

The group cleared the road either side and secured the contact site in due course.

(S) During the clearance of the contact site by the ANP, one policeman apparently observed a LN running east up the dry stream bed away from the contact site in the gloom. The NZ soldier with the ANP told the ANP not to fire, as the person was running away and could not be positively identified as hostile. The Court believed that this decision showed considerable presence of mind on the behalf of the NZ soldier.

(S) At 1800, a further update was requested on the casualties. At this time there were no changes to the previous report.

(S) At 1816L ; an ad hoc reserve patrol , with 2 x HMMWV and the NZPRT 1300 UNIMOG ambulance, deployed from KB to DO ABE. This decision was made by the NZPRT CO when it began to appear that AME helicopters may not be able to reach KT2 because of poor weather.

(S) At 1821L the KB CP was informed that a CASEVAC was approximately 45 mins from the contact site. By 1837L the CASEVAC was still unable to fly in to the AO due to bad weather.

the RMO at Kiwi Base indicated he was comfortable that the CLS with KT2 was providing sufficient medical support to the casualties.

(S) Between 1848 and 1855, KT2 was again informed that an AME was in the air and en route. They were requested to mark an LZ

(S) During the wait for KT5 to arrive, K2B's driver changed a tyre of his vehicle which had been punctured by a burst of PK machine gun fire during the contact.

. The remainder of KT2 continued to secure their position, tend to the

(S) At 1911, Kiwi Base was informed that one of the AME elements had turned back because of bad weather.

(S) At 1916, KT5 reported that they had reached the CITB at DO ABE and married up with KT2 ROMERO there. KT5 were ordered to move forward to the contact site from DO ABE, and reinforce KT2,

(S) At 1952L KT2 were briefed on the plan for the actions that would occur after KT5 had married up with them at the contact site:

(S) At 2022L NZPRT were made aware that there was an injured LN interpreter who had been in the vehicle that had been hit by the IED. The interpreter's injury was unknown but it was reported that he was resting in the back of one of the vehicles. There had been some confusion as to whether the interpreter had been evacuated to ISH PESTA with ANP,

(S) , KT5 arrived at the contact site and RV with KT2.

Both the KT2 medic, who had joined the KT5 patrol at DO ABE, and the KT5 medic started tending to the casualties and prepared them for evacuation. KT5 commenced destruction of the Hilux of K2A, which had been found by KT2 to have significant damage from small arms fire to both its radiator and engine block, and was unusable.

(S) At 2126L the remaining KT2 vehicles, K2B and the K2C Hilux, together with KT5, moved to DO ABE away from the contact site. The casualties had been loaded into KT5's HMMWV, which although limited with space, proved sufficient for the drive to DO ABE.

(S) At approx 2200L KT Jackhammer arrived at the CITB and went firm, awaiting the arrival of KT5 and KT2. At 2211L KT5 and KT JH rendezvoused at CITB and commenced cross-loading the 2 x WIA into the ambulance. Lt O'Donnell's remains were loaded into a KT JH HMMWV for the return journey to KB. At 2218L KT JH commenced their return to KB (including the WIA and KIA). KT5 and KT2 settled down to secure themselves at the CITB for the night.

(S) CO NZPRT departed Kiwi Base at 1000L 04 Aug 10 to move north with KT3 and marry up with KT5 and KT2 at DO ABE,

(S) Over the period 04 – 07 Aug 10 KT5, EOD and Engr Offr completed the TSE and clearance of the destroyed vehicles from the contact site, and arranged for the destroyed vehicles to be back-loaded to KB. Due to unseasonable rain and flash flooding LN transport assets could not reach the site until 07 Aug 10, at which time the wrecks were recovered to KB. Over the period 04 – 05 Aug 10 the RNZMP NCO and conducted interviews at FPB ROMERO with KT2 in regards to the contact.

Other Comments by the Court

(S) The ambush by an INS group was assessed to be most likely one of opportunity. The group may have been present in the area in search of targets including but not limited to NZPRT patrols, GIRoA representatives and NGO/ OGA vehicles. The time spent by the patrol in ISH PESTA and SARI GULI (from approx 1240 to 1600 hrs on 03 Aug 10) was assessed as allowing the INS to decide to conduct the opportunity attack, emplace their IED and prepare their ambush IVO KARIMAK.

(S) The conduct of the ambush essentially proved to be the MDCOA as identified in the NZPRT S2 Weekly Assessment 30 Jul-06 Aug.
believed they were "rolling green" is most likely testament to a degree of complacency

The MDCOA assessment had existed for a significant period, and is likely to have become just another factor when planning a patrol in the area. Had the threat been more specific, it is likely that the patrol commander would have cancelled activity to that part of the AO;

(S) The battle procedure and patrol training carried out by KT2 prior to its task on 03 Aug 10, and in particular the orders given by the Patrol Commander for actions-on and reaction to ambush, appear to have been adequate and appropriate. The execution of the Contact Drill by KT2 as a reaction to the initial IED and small arms fire extracted the bulk of the callsign from the immediate killing area and allowed

it to seek protection offered by the nearest structure. It was noted by the Court that the decision to stop and go firm at this location,
was predicated by two factors: the immobilising of the rear vehicle by it's jack-knifed trailer, followed by the collision of the third vehicle and the rear vehicle, causing the crew of the former to abandon the vehicle; and the understanding that two wounded members of the patrol remained in the vicinity of the destroyed lead vehicle, and were unable to extricate themselves.

(S) The protected mobility offered by the HMMWV and Hilux,
saved the occupants of the remaining vehicles from small arms fire casualties, and also from RPG shrapnel and blast. The extra firepower offered by the turreted support weapon in the HMMWV was the factor that allowed the remainder of the patrol to protect itself and suppress further small arms fire from INS. The current vehicles available to NZPRT are assessed as a balance between force protection requirements and mobility on poorly constructed roads in the AO.

(S) The preclusion by weather of aero-medical evacuation
has demonstrated the fallibility of relying solely on aviation support for casualty evacuation, particularly in seasons of poor weather conditions. The decision

The provision of ECAS support has been consistent and timely in both KT2 contacts during Crib 16's deployment.

Given the site of the explosion in relation to the Patrol Commander, , it is the opinion of the Court that it is highly likely that he was killed by the multiple injuries sustained in the initial explosion. The Court cannot ascertain the exact time that death occurred, however the Pathologist's Report states that death could have been instantaneous. In the opinion of the Court, the inability of the gunner and driver to extract him from the vehicle was unavoidable, and would have required specialist equipment and medical assistance, support which was impractical and unfeasible in the middle of a particularly heavy contact. The gunner and driver risked sustaining further wounds, and possibly death themselves, by electing to remain at the vehicle for as long as they did, noting that the vehicle was already well-alight and was sustaining hits from small arms fire and RPGs.

2. Were the deceased and the casualties on duty at the time they were injured, and if so, what were the nature of those duties?

(S) Lt O'Donnell, and LEC were all on duty at the time of the incident on the 3rd August 2010. Lt O'Donnell held the appointment of Platoon Commander, was the Patrol 2 Sig/Dvr and

was the vehicle IC. At the time of the incident the deceased and injured were in the lead HMMWV, Lt O'Donnell was in the right front passenger seat, was driving, was standing in the HMMWV cupola and LEC was sitting in the left rear passenger seat behind the driver. Lt O'Donnell was the Kiwi Team Two (KT2) Patrol Commander, was KT2 Signaller/Driver and was manning the .50 Cal in the lead HMMWV. LEC was the KT2 interpreter.

(S) The duty status of the deceased and casualties was confirmed by both the CO and S3 NZPRT. This was supported by the S1, who produced the NOTICAS for the deceased and injured. The duty status of was confirmed by the CSM NZPRT, who is responsible for coordinating LEC interpreter support.

3. What was the nature and extent of the injuries sustained by the deceased and the casualties?

4. **What was or were the cause(s) of those injuries?**

Lt O'Donnell
(S) The mechanism of injury that caused the death of Lt O'Donnell could not be confirmed by the Court,

Given the extent of the injuries described it is likely that death occurred as a result of the initial explosion

5. Was or were any property, equipment or stores destroyed, damaged, or lost during the incident, and if so what was the nature of the property equipment or stores and its or their value, and how was it destroyed damaged, or lost?

(R) The NZPRT S4 has compiled a list of property, equipment and stores that was destroyed, damaged or lost during the incident on the 3rd Aug 2010. This list was supported by the AFNZ164s, Loss and Damage reports, and MD311s for specific items that were lost, damaged, destroyed or otherwise rendered unserviceable as a result of the incident. The latest version of this list was entered as an exhibit by the J43-2 on 06 Oct 2010. At that time, the approximate value of items destroyed, lost or damaged was An amended total value was provided by the J43-1, due to an item of equipment that was formerly identified as lost being located by NZPRT since 06 Oct 10 .

(R) The Court determined that all of the items annotated on the Exhibit were destroyed, lost, damaged or otherwise rendered unserviceable as a result of the initial IED, the subsequent fire in the HMMWV, or as a result of the break-contact drill undertaken by the patrol members of KT2 and its subsequent fire fight with the

insurgents.

6. Were the personnel involved in the incident, including the deceased and the casualties, qualified and sufficiently trained to perform their duties?

(R) The personnel involved in the incident, including the deceased and casualties, had all qualified to meet the prerequisite standards to be nominated to deploy on CRIB 16. Additionally, all personnel had completed and passed CRIB 16 OLOC training, which was certified by CO NZPRT and OC NZCTC. All personnel had participated in the CRIB 15 coordinated Theatre Indoctrination Course (TIC) upon arrival in theatre. Patrol members had also conducted regular patrol rehearsals, cross-training and live firing of weapons on a range.
Numerous witnesses have stated that the trained state of the patrol members was at a high level given the frequency of in-theatre training that was directed by the KT2 Patrol Commander. This has also been mentioned as a possible reason for the limited number of casualties after the initial contact.

(S) The Court has identified that although OLOC training was completed by all patrol members, the content of that training did not include training or familiarisation on a number of theatre-specific capabilities that the patrol was expected to use to perform their duties once in theatre. It appeared that the mitigation for this deficiency was the conduct of familiarisation training on the TIC at KIWI BASE prior to conducting handover with CRIB 15. However, from witness accounts and CRIB 16 Four-week reporting, it is apparent that the TIC that was delivered by TU CRIB 15 did not cover all of the equipment in sufficient depth or breadth required for OLOC to be achieved prior to deployment on patrol. This was determined to be as a result of the TIC being constrained by the timings for movement imposed on the RIP of the incoming and outgoing contingents. This constraint appears to be driven exclusively by the adherence to HQ JFNZ-imposed NZDF strategic air movements for the RIP operation. Therefore, an inadequate period of time was available to conduct formal training on the equipment that was not available for OLOC generation in New Zealand. Even if there was time, there were apparently insufficient numbers of qualified CRIB 15 instructors to conduct this training. These gaps in training were addressed through on-the-job training during actual operations, and during patrol administration in the form of rehearsals and range practices. The COI believed that this is not acceptable given the potential for patrols being contacted before completing all of its formal training with theatre-based equipment and capabilities, or at best achieving an acceptable level of familiarity with their equipment. It should be noted that this situation occurred on the handover patrol of KT2 with CRIB 15 on the 9th April 2010. The COI team believed that the gap in OLOC could significantly affect NZDF reputation and more importantly presents a substantial risk to NZDF personnel on OP CRIB. The following gaps in OLOC were identified by the COI:

(R) Driver Training on HMMWV The first time patrol members drove a HMMWV was on the TIC. There was no formal driver training

conducted in the vehicle or formal training on vehicle maintenance on the TIC. At the completion of the TIC KT2 patrol members drove to ROMERO. Effectively, they were conducting on the job training on operations.

(R) Formal weapons training on the AGL. Patrol members were not given formal operator training on the Mk 19 AGL during the TIC. Statements from KT2 patrol members show that they developed their own weapons drills and maintenance procedures based on trial and error and seeking advice .

(R) Weapons training on the .50 Cal machine gun. The patrol members of KT2 felt that not enough time or ammunition was dedicated to live firing the .50 Cal machine gun. In one statement given, the OLOC training apparently consisted of firing half a belt from a dismounted weapon at a dirt bank. It was felt by this witness that this was not effective training or a realistic method of OLOC evaluation, especially as the weapons in-theatre are all mounted on HMMWV. There was also comment made on the limited value of all CRIB personnel, in particular those personnel unlikely to conduct patrols soon after arrival in theatre, to fire the weapon system, particularly if ammunition and time was short, and given that this gap could have been picked up in theatre.

(R) ECAS training for all patrol members.

During the incident in question, there was no qualified JTAC on the patrol,

Although Witness 12 had conducted JFO training in Waiouru and was qualified to conduct All Arms Call for Fire, he was not formally trained on the in theatre ECAS 'nine liner' procedure. He had familiarised himself with the in theatre procedures through informal conversations with the attached JTAC in the preceding weeks. If he had been incapacitated and unable to coordinate the ECAS, it is unlikely that any of the other KT2 patrol members were sufficiently trained or familiar with ECAS procedures. The Court also identified that the lack of formal ECAS training had a significant impact on the ground to air communications procedures during the incident. Witness 15 identified in his statement and provided a transcript from his involvement in the TIC that there was a 30 minute period when ECAS aircraft were above the contact site, but could not establish communications with KT2. This undoubtedly denied KT2 the ability to assist it to neutralise the INS, protect the exposed casualties from callsign K2, and confirm INS movement and intentions. Statements indicate that a lack of awareness of what channels were available to communicate directly affected this delay.

(R) Lack of experience in long-range live firing. Witness 13 mentioned in his statement that he felt the focus of live firing did not reflect the type of shooting expected on CRIB. He noted that the majority of live fire shooting practices were conducted at short range and concentrated on reaction shooting. The range the KT2 personnel were firing out to during the incident was approximately 600 metres. This is supported by observations made in the NZPRT AAR dated 9 Aug 10.The Court supports these comments and believes that close range reaction shooting, although important, does not effectively prepare personnel for the most likely shooting ranges expected in a contact in Bamyan.

7. What orders, standard operating procedures or other procedures including Rules of Engagement were in place or were being followed by the element of which the deceased and the casualties were part at the time of the incident, and are their any changes required to such orders, procedures or practices?

Orders

(R) The overarching order for the conduct of operations by KT2 on the day of the contact was the TU CRIB 16 OPORD 1/10 dated 24 Feb 2010. This OPORD provided the CO NZPRT's intent for the Bamyan Province AO to all key appointments within the NZPRT, particularly the KT patrol commanders and liaison officers (LNO).

(R) CO NZPRT also produced a Strategic Plan for the NZPRT's operations in Afghanistan during TU CRIB 16's deployment. This provided amplification of the Lines of Operations for the NZPRT in Bamyan Province, and clarified responsibilities once the NZPRT transitioned from military to civilian leadership.

(R) deliberate orders for the tasks on 03 Aug 10 were given by both the Patrol Commander and LNO on 02 Aug 10. In addition to this, it was normal procedure for the patrol commander to issue confirmatory orders, including actions-on, for the day's activity before the patrol left these orders were given at 030800 Aug 10, before the patrol departed The patrol had been in the AO and conducting operations for an extensive period prior to the contact, and the orders were assessed as providing adequate detail and intent for the task to be carried out, and allowed the patrol to take the appropriate action if it was contacted or attacked.

(S) The objectives for KT2 for 03 Aug 10 were noted by the Court as differing significantly from those indicated by the patrol commander in his daily patrol SITREP of 02 Aug 10. The intent for 03 Aug 10 in that SITREP indicated that the patrol would

be undertaking a Key Leadership Engagement, or meeting, at CHARTOK village north of DO ABE. However, the patrol instead delivered gabion baskets, fertiliser and seed to villages from DO ABE to SARI GULI, and therefore exploited much further north than expected by the NZPRT S3. The deviation between the patrol commander's intent and his actual task on 03 Aug 10 did not prompt any conversation or inquiry by the KB CP at the time. This lack of independent check was highlighted by the Court to CO NZPRT at the time. However, the objectives and tasks for KT2's patrol on 03 Aug 10 were considered to be within the humanitarian assistance and development lines of operation, and whilst not specifically annotated in the KT2 SITREP of 02 Aug 10, were considered to be consistent with the CO NZPRT's intent, and he stated that he would have approved the task had it been forecast by the preliminary Patrol SITREP regardless.

Standard Operating Procedures

(R) The NZPRT SOPs consist of a number of operational, administrative, logistic and communications chapters. It is not considered a TTP, although some tactical procedures and drills are included in it. The TTP currently taught on PDT reflects information provided from theatre and brought back by the next TU CRIB Comd Recon team.

(R) NZPRT SOPs serve to provide guidance and reference for mandatory actions and procedures, but exact patrolling routine appears to have been a mixture of PDT-based training and TTPs, personal experience of the leadership of the patrol (and particularly the motorised infantry background of its commander), a hand-over of TTPs from the TU Crib 15 patrol that it replaced, and those that KT2 had developed as a result of its own experience of its AO and the operating environment.

(S) The patrol's reaction to contact was considered appropriate and in accordance with SOPs for mixed patrols of HMMWV and Hilux. The patrol extracted its mobile elements from the immediate engagement area to the nearest cover before becoming immobilised, without further casualties. The evacuating of vehicles was based on an appreciation that the vehicles were immobilised, and the fact that other members of the lead vehicle may still require mutual support in order to break contact themselves. The patrol's subsequent actions were considered a result of individual initiative and reaction to contact by key members.

(S) The force protection minimum requirements for the area of the patrol's operations on 03 Aug 10 required investigation by the Court. It appeared that TU CRIB 16 was in the middle of rewriting its SOPs at the time of the incident, and that two versions existed, one version being the extant copy and the second version being a copy in the process of being amended.

(S) The immediate RATEL procedure followed by KT2 when contacted was the normal call of "*Kiwi Base, this is KT2, contact, wait out.*" This is a standard RATEL call that any member of the NZ Army becomes familiar with. However, as a result of the subsequent communications difficulties,

the initial contact call should be modified to include at least the location of the call sign, in order to allow the direction of air support to the right place.

(R) The Court noted that the NZPRT SOPs did not explain the ISAF procedures for marking LZ.

(S) The ECAS mission directed by KT2 late in the incident showed that an untrained operator can, with the assistance of the aircraft pilot, select an appropriate type of task in order to support the tactical situation.

Rules of Engagement

The primary ROE guidance in force and applied by the element of which the deceased and the casualties were a part of at the time of the incident is the standard ROE Card – NZFOR ISAF (Afghanistan) The patrol returned fire at the observed enemy firing points at the 11-12 o'clock direction in accordance with their issued ROE. The provision of suppressing fire towards this location as the K2B HMMWV moved forward to extract the two casualties from K2, after it appeared the enemy fire had stopped, was considered an appropriate application of tactical judgement by the K2B commander.

This was considered consistent with ROE. the prevention of an ANP policeman from engaging a fleeing LN in the vicinity of the contact site by the K2B driver was considered a well-judged application of ROE principles, in that the LN could neither be assessed as presenting a threat or in fact was armed.

(S) The patrol's overall application of fires was considered acceptable by the Court, in view of the weight of the insurgent attack, the requirement to adequately suppress further enemy fire and enable it to extract casualties to a place of safety.

8. Was the equipment issued to the element of which the deceased and the casualties were part at the time of the incident functional and functioning; and if not, why not?

(S) The weapon appears to have failed to operate when required due to an accumulation of dust coupled with the burred action rails which provided excessive resistance to the weakened return springs, preventing the bolt from moving forwards hard enough to release the firing pin and initiate the round. This was exacerbated by the use of the incorrect grease lubricant on the weapon.

(S) The K2B gunner did not receive any formal training on the Mk19 AGL other than his familiarisation firing during Theatre Induction Training. The weapon system is not available in New Zealand for instruction during PDT so must be mastered by users on arrival in theatre. As there were no formally trained and qualified instructors on this system available to KT2, the patrol members were developing their own drills for the operation of this weapon. Furthermore, the armourer has had no formal training or experience with this weapon system, receiving a 15 minute brief from the outgoing

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the Ops Log of the 3rd August does not show an increase in the number of LOCSTAT reports made by KT2 while moving around the AO. The Ops Log does show that other patrols were calling in their LOCSTAT on a far more regular basis than KT2. Further, the previous night's SITREP submitted by KT2 forecast a KLE at CHARTOK and made no mention of the plan to move to ISH PESTA or SARI GULI. As such, the first time the CP became aware of the intended move to ISH PESTA was when KT2 called from DO ABE to say they were leaving for the ISH PESTA checkpoint. Although the patrol's actual task for 03 August was not seen as a problem, because this change is still within the CO NZPRT Effects Guidance issued, the fact that the KB CP was unaware of the patrol's location at all times is of concern.

(S) In this case, the patrol reported their LOCSTAT by radio when they arrived at ISH PESTA, albeit some two hours after leaving DO ABE. KT2 reported when they eventually left ISH PESTA after 3 hours and 20 minutes. There were no communications between the patrol and KB during this period updating their situation or location, nor was there any explanation as to why the journey had taken two hours when it should have taken one. No action was taken to establish the state of KT2 in

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the two hour period between leaving DO ABE and arriving in ISH PESTA on the outward leg or during the period that KT2 remained at ISH PESTA.

9. Was the equipment issued to the element of which the deceased and the casualties were part at the time of the incident suitable for the tasks that the element was conducting; and if not, in what way was it unsuitable?

Individual Weapon Sights.

(S) KT2 deployed on patrol on 3rd August 2010 with the full range of weapons available to them on that day.

The majority of contacts in the Afghanistan theatre of operations are at ranges of between 300-600 metres, in some cases greater.

Rocket 66mm HEAT M72

(R) The M72 rocket is primarily designed for penetration of armoured targets, but may be used effectively against bunkers and other light field fortifications. They are a man portable, lightweight direct fire weapons consisting of a launcher and a rocket. The weapon has a maximum operational range of 350 metres and a maximum achievable range of 1350 metres (depending on model).

5.56mm Weapon Systems.

(S) The contact on 3rd August was initiated by the use of a CWIED, fired by an unknown number of INS at a range of approximately 45m. Other elements of KT2 reversed out of this immediate area and were then involved in a firefight with numbers of INS on high ground at a range of approximately 600m equipped with 7.62mm weapons, probably AK47 variants and PK, and RPG.

(R) The IW Steyr 5.56mm is capable of a high rate of accurate rapid fire at ranges up to 300 metres and effective section fire at ranges up to 500 metres. The patrol also had the C9 Light Support Weapon, also of 5.56mm calibre and with an effective range of 600 metres.

HMMWV Trailer

(S) The final vehicle in the KT2 patrol, HMMWV Bravo, was fitted with a trailer as they needed to be able to carry large quantities of gabions to distribute as part of a humanitarian aid task. Once the ambush had been initiated by the IED the driver of Bravo vehicle immediately reversed out of the contact area. He managed to cover approximately 15 metres before the trailer jack knifed and the vehicle was unable to reverse further. The next vehicle in line in the patrol was an up-armoured Hilux, vehicle Charlie. As RPGs were exploding on both sides of the reversing vehicles

Whilst stationery an RPG impacted the front of the vehicle but failed to function. The driver then pulled the vehicle forward and the crew debussed using the vehicle as cover. The trailer was now preventing Bravo from moving further to the rear. Also, when it became clear that there were survivors from the lead vehicle who needed to be extracted, the trailer had to be manually cleared from the rear of the vehicle while under fire.

(S) 40mm Grenade Launcher

The MK19 AGL 40mm Grenade Launcher is fitted into the turret of one of the M1151 HMMWV utilised by KT2. On the 3rd August KT2 had the HMMWV equipped with the AGL as the last vehicle in the patrol.

(S) Body Armour

The latest issue RBAV body armour was worn on the day by all members of KT2 less interpreters. In the lead vehicle the gunner, driver and vehicle commander were all wearing the issue equipment, including helmet, when the device functioned. The driver and gunner have both stated that the body armour performed well, they were happy with the fit and adaptability of the pouch arrangement.

(S) Both the driver and gunner received multiple small fragmentation penetration, to varying degrees, during the initial blast. Neither had any injury to areas covered by the body armour nor did they have head injuries.

(R) Evidence from the remainder of the PRT shows that the equipment is comfortable and sufficiently adaptable to be tailored by each individual to their own specific role and requirements.

(S) Communication Equipment

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SECRET

(R) Gloves

The current combat glove issued to all members of KT2 in Afghanistan is the Glove Combat Nomex. When the lead vehicle hit the IED and caught fire the gloves were

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being worn by the gunner but not the driver.

(R) The gloves are effective and all personnel should be encouraged to wear them at all times while on patrol.

(S) Machine Gun, 7.62mm, MAG 58

The Machine Gun 7.62mm is a belt fed weapon and was coaxially mounted on HMMWV Bravo on 03rd August. the gunner immediately transited to the MAG 58 in order to suppress the enemy at a range of approximately 620 metres. He continued to use the MAG 58 throughout the contact,

A second MAG 58 was used by another member of the patrol to provide security to the rear.

(S) The MAG 58 has an effective range of 900-1100 metres and a maximum range of 1500 metres. In this contact the weapon was used to good effect to suppress the enemy

(R) HMMWV

The M1151 High Mobility Multipurpose Wheeled Vehicle (HMMWV) is an improved version of the standard HMMWV in that it has a heavier chassis and an improved engine that allows for the addition of heavier armour protection. It is equipped with ballistic windows that are more resistant to spalling and has seats that are designed to absorb energy from a blast beneath the vehicle.

(S) On 3rd August KT2 were utilising two HMMWV M1151 variants in their patrol. The lead vehicle in the patrol, a HMMWV, was struck by an IED as it slowed to enter a river wash out.

. The blast from the explosion appears to have penetrated the crew compartment of the vehicle and has distorted the body causing the doors on the right side to pop open. The vehicle then caught fire.

(S) Of the four personnel within the vehicle when it struck the IED, three were able to extract themselves from it and move away, albeit with injuries, under their own power. The fourth, the front right passenger of the vehicle, was unable to be extracted from the vehicle, and may have died as a result of the explosion.

(S) Accepting the injuries caused to the front right passenger, it should be noted that all four occupants of the vehicle were within 2 metres of high explosives functioning. Three personnel survived and are likely to recover from their injuries.

(S) According to witnesses this vehicle was also struck by multiple small arms rounds and RPG.

Toyota Hilux

The NZPRT makes extensive use of the Toyota Hilux in patrolling the AO. Immediately prior to the contact of 3rd August KT2 were utilising two of these

vehicles to transport humanitarian aid.

(S) Unimog Ambulance

on 3rd August the CO NZPRT made the decision to send KT JH North to DO ABE with the NZPRT Unimog ambulance as it appeared that the air MEDEVAC was unlikely to get into the location due to weather.

(S) The primary role of the Unimog ambulance is casualty transport within the AO. It is also used to provide support for range shoots, and other local taskings.

. There were at least two separate attempts by coalition MEDEVAC assets to reach KT2, both were turned back by adverse weather conditions at or near the contact site.

10. Were the prescribed reporting procedures followed after the incident, in accordance with TG CRIB, and HQ JFNZ procedures?

(R) The reporting procedure followed immediately after the contact was found to be appropriate and timely by the Court. The first notification of the incident was by the CO NZPRT using secure telephone direct to HQ JFNZ, which was followed by verbal updates throughout the course of the incident.

(R) The first summary of events was drafted by the NZPRT S3 and released by CO NZPRT to HQ JFNZ by email on 04 Aug 10. It was compiled as the incident unfolded and supported by information from the Ops Log.

(S) As soon as was practicable
, an After Action Review was conducted by all of the NZPRT elements involved with the contact,

(R) An MP investigation was convened by CO NZPRT using the RNZMP SNCO, to conduct that investigation. The Court was provided with the investigation details at the time of its interview with the RNZMP SNCO

numerous reports and statements were compiled with regards to the deceased and the casualties after the incident, as per HQ JFNZ SOP and NZPRT SOP

(S) The Police reports and Coronial documentation for the deceased were taken by safe-hand to BAF by the escort officer, and submitted to HQ JFNZ

(R) The NZPRT compiled a Media Release document for HQ JFNZ PRO on 04 Aug 10.

(S) From the time they arrived in BAF until they departed for the OC NSE was responsible for submitting regular updates to HQ JFNZ on the progress of the casualties and the status of the arrangements for the move of both them and the deceased. It was noted by the Court that NOTICAS were not used to follow-up medical progress of the three casualties. This may have led to some of the confusion regarding their status and movement requirements noted by the Court in other parts of the inquiry. It was noted by J1 Health that liaison between HQ JFNZ and the NZDF rep at BAF was problematic, and this led to a lack of medical-specific information about the two casualties during the preparation for their evacuation to NZ.

(R)

It was deemed by the Court that all necessary documentation and reporting by the Crib S4 was completed for HQ JFNZ J4 purposes, for the destruction, write-off, refurbishment and replacement of equipment and stores that were damaged

or destroyed as a result of the incident, as quickly as possible, noting the retention of some items temporarily for the purposes of the Inquiry. Emails submitted to the Court by witnesses confirmed that significant liaison between theatre and HQ JFNZ, and associated NZ-based logistics experts, and was critical in confirming the correct action to be taken in respect of specific equipment or stores.

(R) After Action Reviews were also completed by HQ JFNZ for the repatriation process and by 2/1 RNZIR from a unit perspective for the procedure followed for the handling of the deceased and ceremonial aspects for the funeral in NZ.

11. What actions were taken to treat the injuries sustained by the casualties and were these in accordance with established medical practice?

(S) The actions taken to treat the injuries to were deemed appropriate, and the evidence from those who received the casualties at each stage of the evacuation does not indicate any concerns about their medical treatr. ent. However, given the operational circumstances and directions given by HQ JFNZ, some of the procedures followed were not in accordance with established medical practice as planned and trained. The following actions were taken to treat the injuries sustained by the casualties:

(S) The initial treatment at the scene of the contact was provided by a rifleman in KT2 and one of their two trained Combat Lifesavers. He attended to first, and then . His treatment of consisted of following the MARCHH procedure, which included assessing injuries, checking his vital signs, and then treating them as best he could with the resources available.

Treatment included the administration of Penthrox to decision to treat first was based on his initial assessment of the two casualties, and also the fact that told him to deal with first. Once he had treated then treated This also involved an initial assessment of his injuries, checking vital signs and stabilising the patient. then concentrated on injuries, again following the MARCHH procedure.

The treatment provided to LEC consisted of an assessment which identified that his eyesight was impaired. These were washed out by water and then covered. also mentally prepared a handover for both casualties to the next medical provider. This handover followed the MIST format, although he stated he did not prepare a written MIST handover.

(S) The next medical treatment was provided by the KT2 medic, and the KT5 medic, who had both travelled with KT5 to the contact site. KT5 arrived in KT2's location at 032016 Aug 2010 local time. treated and r treated l assessed and based on this assessment and the actions of did not take any further action, apart from preparing him for evacuation by HMMWV. then assisted insert an IV into take his blood pressure and prepare him for evacuation by HMMWV. The patents were then evacuated by HMMWV to DO ABE at 032126 local, where they were cross loaded onto an Unimog ambulance which was part of C/S Jack Hammer at 032211. KT Jackhammer then departed DO ABE for KIWI BASE via the SHIKARI VALLEY at 032218 local. stabilised and observed the three casualties. On at least two occasions she stopped the patrol in order to administer pain relief and re-bandage the wounds of On arrival at KIWI BASE, handed over the casualties to the RMO, at the RAP. This handover included the following information

(S) On arrival at KB RAP at approximately 040308L, the RMO, , was responsible for the medical care of the casualties. This involved an initial assessment, observation and preparation of the patients for evacuation to BAGRAM (BAF). The RMO completed MD 907 documents for which was a summary of his findings and the patients' state when they left KIWI BASE. The RMO states that an MD 907 was completed for LEC but he was not able to produce a copy at the time of the interview. The casualties were then held at the RAP until they were able to be evacuated by C130 to BAF at approximately 041900 local.

(S) The three casualties arrived by C130 at BAF at 041925 local. On arrival in BAF the casualties were taken to the CF hospital where a full assessment was conducted by the medical staff there.

. LEC spent three nights under observation in the Local National Ward, after which he was released and stayed at KIWI LINES BAF before returning to KB on a flight.

. From there the focus of the medical staff was on preparing the NZDF casualties for evacuation to Germany. However, on advice from HQ JFNZ and NSE, the BAF Hospital staff began assessing them for the possibility of evacuation to NZ, and preparing them for that move. At this stage it became clear that the evacuation of the casualties would need to be via in order to marry up with the NZDF flight that had been despatched by HQ JFNZ to recover the remains of Lt O'Donnell.

the Nursing Officer to accompany the two casualties on the C-17 that was also transporting the remains of the deceased. The discharge summary for was completed by . a medical officer at BAF Hospital.

The C-17 departed BAF at 06 0305L.

A RNZAF Boeing 757 was used to transport the body of Lt O'Donnell and the casualties.

(S) When the casualties arrived at 06 0557 local they were cross-loaded onto the RNZAF 757 after viewing a ramp ceremony for Lt O'Donnell.

During the transfer the patients were assessed by the NZ Aeromedical Evacuation Team (AME Team). The RNZAF 757 departed at 06 0705 local. On the RNZAF 757 the patients were seated in the business class seats and medical supervision was conducted throughout the flight. An additional medic NCO joined the flight at a scheduled stop at Perth, Western Australia, after pre-positioning by commercial travel. The flight arrived in Whenuapai on the 7th August where the patients were met by RNZAMC, who took over

their management. He assisted their transfer to North Shore Hospital. On the 8th August was transferred to Christchurch Hospital. He has subsequently been released and has returned to duty at his parent unit at 2/1 RNZIR in Burnham. His primary medical provider is now the RMO 2/1RNZIR, but is the senior medical officer in Burnham, and as such has retained overall responsibility for him. remained in North Shore hospital until he was discharged on the 10th August 2010. He has returned to duty at his parent unit 1 NZ Sig Regt. His medical coverage is provided by 2 HSB in Linton and his primary medical provider is , a Medical Officer at 2 HSB.

The following issues were identified that prevented established medical practice being followed:

(S) The initial treatment to the casualties was provided by , who is a trained Combat Lifesaver and not the patrol medic, , who was the best-trained medical practitioner available to the patrol. The patrol medic was conducting another task, specifically providing medical training to the ANP at Romero Forward Patrol Base. stated she had no concerns about the treatment the casualties received or with the detail of the handover. This is supported by the RMO, who conducted more advanced assessment and treatment of the casualties at KB upon their arrival.

(S) The primary means for casualty evacuation for CRIB 16 is via AME assets provided by the NZPRT's parent tactical HQ, in this case that of
The reliance on AME as the primary means of casualty evacuation is a key assumption in any NZPRT tactical and, more specifically, Health Service Support planning. This did not occur, despite numerous attempts and Regional Command North assets, due to unusually poor weather conditions. As result of the failure of AME to reach the incident site, CO NZPRT made the decision to recover the casualties by HMMWV to DO ABE, then by Unimog ambulance to KB. Although this means of evacuation was not ideal in terms of patient treatment, comfort, speed of evacuation and security, it was the only guaranteed means by which the evacuation could have been completed at the time. It was also identified by that the ambulance did not have the required medical equipment to conduct an evacuation by land as stated in NZ PRT SOP

(S) Both the RMO and Nursing Officer identified that they did not have enough medical staff to deal with the patients. This was mitigated by using other personnel to assist in the RAP. The current number of medical staff in the NZPRT establishment is below that outlined in the NZ PRT SOP Medical.

(S) The delay in evacuating the casualties from KB to BAF due initially to poor weather and then unavailability of air transport meant that the normal evacuation process was prolonged. Again this did not adversely affect the treatment or health of the casualties in this incident, but it does raise concerns if urgent medical care at BAF is necessary due to the type of injuries. The RMO identified that the medical facilities at KB are not able to stabilise and treat casualties if this scenario eventuates.

(S) The following issues were identified with the RTNZ by RNZAF 757.

i. The RNZAF 757 did not have recommended medical equipment or supplies available.

ii. Casualties were reviewed by medical staff on the tarmac as there was no arrangement made to use CF medical facilities.

iii. Casualties had to be assisted on foot on to the RNZAF 757 via stairs, rather than be carried on in the stretchers that they had travelled on from BAF via C-17.

iv. No stretchers in the RNZAF 757 meant that the casualties travelled in business class seats.

v. Medical staff sent from NZ to provide medical supervision and treatment in the RNZAF 757 did not carry necessary medical equipment, and had to procure this informally from Coalition partners

vi. Medical Staff flew at short notice in economy class from NZ and then boarded the RNZAF 757 with no opportunity to conduct a formal patient handover and assessment, nor adequate rest prior to departing for NZ. They were then effectively on duty for the RTNZ flight, which was approximately 40 hours. This meant the medical staff were not sufficiently rested or equipped to deal with possible medical issues that could have arisen during the RTNZ flight.

vii. There was a risk that the RTNZ would be delayed due to flying-hour restrictions if the C-17 had not arrived in time. This would have meant that the patients would have to be admitted to the Coalition Force hospital, an occurrence which had not been anticipated during evacuation planning by HQ JFNZ.

viii. Any delay or maintenance failure of the aircraft between and NZ would more than likely required the patients to be hospitalised in an appropriate facility at the location of the aircraft at the time. HQ JFNZ evacuation planning does not appear to have catered for this possibility.

ix. The evacuation of the casualties appears to have been influenced by the desire of strategic leadership in NZ to RTNZ the deceased, as a priority, and the two wounded, as soon as practicable and with the greatest economy of effort and resources. The haste with which the aircraft was despatched from a

prior task meant that it was not configured adequately for the AME role, and its flight schedule was sufficiently tight as to have presented significant risk if crew flight hours were compromised. This in turn compromised patient comfort and AME team accessibility and preparedness for treating potential in-flight emergencies, such as deep vein thrombosis, which although unlikely, presented a risk nonetheless. The desire to present a positive public affairs statement by bringing home the deceased and the casualties appears to have compromised the most effective, comfortable and safest options for patient care, which could have included an extended stay in a suitable hospital in either BAF. or elsewhere, followed by evacuation by a dedicated AME aircraft with suitable numbers of AME team personnel, with relief, to NZ. As mentioned previously, this appears to have been made without either the BAF Medical staff understanding the lack of the RNZAF 757 capability to perform the AME task, and NZDF medical advisors and planners not fully understanding the casualties' status.

12. Will their injuries cause, or are likely to cause, permanent ill effects impairing the future employment and efficiencies of the casualties?

(R) The Court noted that the recovery of both NZDF casualties was still at an early stage when the respective medical officers for each were interviewed. As such, the assessment of the likelihood of recovery for each casualty is based on the best information available at the time of the Court's proceedings

(M-I-C) The MO for commented that,

should regain full employability in approximately a year from the time of the interview. remained on light duties at his parent unit at the time of the interview.

(M-I-C) The MO for noted

that will likely be troubled by ongoing pain and stiffness in the foot,

The MO stated that it was difficult to predict exactly how limited would be in his employability.

(S) The Court noted that the recovery of the interpreter involved in the incident, had been given much less consideration by the NZDF than had the NZDF casualties. Although this was more than likely due to the relatively minor wounds he received when compared to the latter, it was noted by the Court that NZDF currently lacks a policy toward ongoing medical and psychological support to its locally-employed civilian staff in Afghanistan. This was passed to J1 Health, who noted it for review in their own AAR from the incident.

(S) stated in his interview that he had recovered and returned to work already. He was released from the BAF Hospital after three days of treatment, although he stated that he was free to leave at any time after his injuries were found to be slight. The NZPRT RMO did not indicate any particular concern about recovery, simply stating that he had returned to work as normal.

13. Has the appropriate documentation, including Police, coronial, ACC, and VANZ documentation, been completed regarding the injuries to the deceased and the casualties?

Police Documentation

(R) The Court identified that all of the required NZ Police documentation for the deceased was completed by the appropriate individual in-theatre as per HQJFNZ SOP and returned to NZ for processing in an acceptable manner. The NZ Police Form 265, Deceased Person Certificate, was completed by the NZPRT RMO on 04 Aug 10. The NZ Police Form 265A, Deceased Person Identification, was also completed by the NZPRT RMO and witnessed by an NZ Police Officer deployed with the NZPRT.

In addition to these two forms, an Initial Report for the Coroner was prepared, and all three forms were duly despatched by the NZ Police Officer to NZ.

Coronial Documentation

(R) A coronial brief was initiated as per NZPRT SOP and HQJFNZ SOP but was not complete when provided to the Court by the NZPRT S1. The Coroner's report was not complete at the time of the interview with the Chief Coroner and Pathologist. This report was requested by the Court upon its completion. The confirmation of identification of the deceased was completed by J1 Health and submitted to the Coroner in order for him to complete the overall report. A copy of this document was also given to the Court. It was not confirmed by the Court as to who issued the Death Certificate for the deceased back in NZ, but is likely to have been generated by the pathologist, and issued by the Chief Coroner.

ACC Documentation

(R) The NZPRT RMO confirmed that an ACC form for each of the two NZDF casualties was generated at the NZPRT RAP during the period the pair was in their care.

VANZ Documentation

(R) The HQJFNZ J1 directed the J133 to establish contact with VANZ. The details of deceased and injured were not given to VANZ at that stage, and it was agreed that this would not occur until the deceased and casualties were repatriated to NZ. The details concerned the contact details of the deceased's NOK for arranging a plaque/ headstone, and contact details for the injured. The HQ JFNZ J133 was then informed by the GSO2 HR Policy from Army General Staff, that Army would take responsibility for VANZ reporting. The J133 noted that this staff officer then initiated action by respective parent units to provide this information. A copy of the VANZ documentation was not acquired by the Court.

(R) The GSO2 HR Policy established contact with VANZ, and confirmed what information was required. GSO2 HR Policy then directed Adjt 1 Sig Regt and S1 2/1 RNZIR to provide the necessary POC information GSO2 HR policy confirmed that with VANZ that all information requirements were met on 13 Oct 10.

(R) It was clear from the Court's investigation that NZDF has little in the way of documentation to complete for VANZ procedures, instead it provides the required POC information to VANZ and maintains a supervisory role only. VANZ were not

requested by the Court to provide details on procedures, documentation or actions taken by them subsequent to receiving the information from NZ Army. GSO2 HR Policy did comment that DFO3 policy with regards to VANZ matters was being rewritten at present, and should provide greater clarity on actions and responsibilities of NZDF staff in future.

Other Documentation

In addition to the documentation identified above the following documents were submitted as part of the reporting process for the deceased and the casualties:

NOTICAS
(R) NOTICAS were raised IAW HQ JFNZ SOP for the deceased and the two casualties by S1 NZPRT. These were followed by follow-up NOTICAS reporting until the casualties reached BAF Hospital, from which time ARIKI NSE took over responsibility for subsequent reporting.

Media Release
(R) A media release was drafted by S1 NZPRT to the HQ JFNZ PRO on 04 Aug 10 with the appropriate detail.

Medical documentation
(S) Form MD907 were completed for the two NZDF casualties and submitted via PROFILE. Copies of handwritten MD907 were provided to the Court, and accompanied the casualties to BAF Hospital. The MD907 completed for the LEC interpreter was not able to be produced to the Court by the NZPRT RMO at the time of his interview. In addition to NZDF medical reporting, discharge summaries were provided by BAF Hospital for the two NZDF casualties when they were evacuated from BAF to on 06 Aug 10.

Critical Incident Reporting
(R) The NZPRT S1 was responsible for drafting a critical incident report for CO NZPRT, and this was submitted at 032052Z Aug 10. This was followed by an Incident Report at 040343Z Aug 10.

Court Comments

(R) The only exception to the documentation required to be produced for the deceased and the casualties concerned the Communicable Disease Statement that was required to be produced by the NZPRT RMO to accompany the deceased's documentation back to NZ, , given the nature of the injuries to the deceased, as well as the resources available at the NZPRT in Bamian, to determine whether a communicable disease was present in the remains or not, or in the environment in which the death occurred. The Court concurs with the impracticality of this requirement, and it is recommended that HQJFNZ J1 Health review the requirement for this statement, as well as the practicality for forward-deployed MO to do so in limited facilities.

14. What procedures were used to recover and transport the body of the deceased? Were the procedures appropriate to ensure the efficient and timely repatriation of the deceased?

(R) The operational circumstances such as the complex terrain, security concerns and weather issues influenced the decisions made by the NZPRT with regard to the initial repatriation of the deceased. The Court also noted that the unique situation of Lt O'Donnell being the first KIA on operations since 2000 influenced the procedures taken to repatriate his body. The following is the sequence of events for the repatriation of Lt O'Donnell.

(S) At 2211L Lt O'Donnell's remains were loaded into a KT JH HMMWV at CITB for the return journey to KB. At 2218L commenced their return to KB with the remains and WIA.

A security detachment was placed outside for the duration that the remains were kept. Once secured the Police and RMO conducted an identification process. It was during this time that prepared the remains for transport. The S4 stated that the primary procedures followed by the NZPRT for the repatriation of Lt O'Donnell were detailed in HQJFNZ SOP Deceased Personnel – Repatriation of Remains to NZ. TG CRIB SOPs were consulted and amendments identified.

(S) At 04 1000L CO NZPRT and the TSE party departed KB to move north with KT3 and marry up with KT5 and KT2 at DO ABE, to commence TSE of the contact site

(S) The MP NCO, EOD and Engr Offr with CO NZPRT conducted the TSE of the contact site

. Prior to departure a Ramp Ceremony was conducted and then Lt O'Donnell's remains were placed onto the aircraft. The S3 was appointed the Escort Officer.

. The plane departed Bamian at 1900L for BAF. NSE BAF was informed of the departure time and flight manifest. OC NSE and CSM NSE escorted the remains to the BAF Mortuary Affairs Collection Point (MACP).

(S) The repatriation of Lt O'Donnell's remains from BAF was coordinated by OC NSE BAF. OC NSE stated that he was unaware of any NSE SOPs. He has subsequently identified NSE SOPs and is re-writing them. This move was facilitated by the use of a USAF C-17. Initially the plan was to move only the remains however after direction from HQ JFNZ the plan was amended to evacuate the casualties on the same C-17 flight in order for the WIA and KIA to RTNZ together on a RNZAF flight.

the Nursing Officer to accompany the two casualties on the C-17 that was also transporting the remains of the deceased. The flight departed at 06 0305L

Prior to departure a Fallen Comrade

Ceremony was conducted which had been coordinated by CSM NSE and his counterparts at Brigade and Division.

(S) The repatriation flight arrived at 06 0557L. CO and CSM TG TROY coordinated all activity CO TG TROY stated that the SOPs followed were the HQ JFNZ SOPs, although these did not specifically refer to TG TROY. He has subsequently drafted SOPs for TG TROY and identified this issue in his AAR

. A Ramp Ceremony was conducted with representation from all Coalition Forces The casket was then secured The RNZAF 757 departed at 061055L for NZ via Perth.

(S) The RNZAF Boeing 757 arrived at Whenuapai on the 7th August 2010. At Whenuapai Lt O'Donnell's casket was met by his brother and sister, members of 2/1 RNZIR and various NZDF personnel. The clearance of the casket and remains of Lt O'Donnell through NZ Customs and MAF was coordinated by the JMCO Movements Operator. Once cleared, Lt O'Donnell's remains were placed under the Jurisdiction of the Chief Coroner for New Zealand. The arrangements for an autopsy and other coronial procedures were coordinated between him and the J1 Health. This involved the movement of remains from Whenuapai to Auckland for an autopsy, liaison with the O'Donnell family, then release of the remains to allow them to be then transported by Undertaker to Whenuapai. Lt O'Donnell's remains were then flown by RNZAF C130 to Ohakea on the 8th August 2010. At Ohakea Lt O'Donnell's body was met by his family, and a Ramp Ceremony was conducted by members of 2/1 RNZIR. He was then transported to Feilding and lay in state at his family's house. On the 9th August 2010 he was moved to 1 RNZIR, and lay in state for the night there. On the 10th August 2010 a military service was conducted at Linton for Lt O'Donnell. He was then returned to his family and stayed with them until the funeral which was held on the 11th August 2010 in Feilding. Once the funeral service was complete, he was taken to the crematorium, where a small service was held.

(S) The following issues are raised by the Court as they affected the repatriation and should be taken into consideration in the event of a similar situation:

(S) Personnel deployed to the NZPRT need to be trained and equipped to provide basic Mortuary support at KB for an extended period. There also needs to be ice generating equipment to ensure that remains can be kept at the recommended temperature in storage and for transportation to the MACP. Transit cases are also required at KB for secure storage and repatriation of remains.

(S) The Court understands that the reasons for repatriating the WIA and KIA together were to allow the WIA to attend the funeral, maximise the efficient use of RNZAF resources, and the belief that it was in the best interests of the WIA.
that there was also pressure from HQ NZDF. This decision did create an administrative burden for those coordinating the repatriation of the deceased. The Court acknowledges that the repatriation of the deceased from Afghanistan to NZ in the time frame of five days was a reflection of the flexibility and the determination of all involved to achieve the task. However this approach did create a potential risk to the standard of medical care to the WIA.

(S) The Court has identified that the repatriation process worked successfully for an individual but recommends contingency planning is done for mass casualty repatriation and the possibility of co-mingling of NZDF, Local National, or Coalition Force casualties.

(S) The decision to RTNZ via Auckland to Ohakea allowed for the necessary Customs, MAF and Coronial processes to take place. This expedited the process and enabled all the relevant stakeholders to complete their respective responsibilities. The appointment of the J1 Health to the Chief Coroners Office and SMO Burnham as the NZDF Medical POC enhanced communication and liaison between the NZDF, Coroners Office and the O'Donnell family. It is recommended that this procedure is followed in the future. The Court also identified that the Pathologist, was instrumental in this process. To ensure that the relationship is maintained it is recommended an MOU between the Coroner's Office and the NZDF is drafted and agreed. One of the recommendations from the Pathologist was that Auckland Hospital purchases a dedicated CAT scanner for autopsies. This would alleviate the need to share the CAT scanner at Auckland Hospital that is used for patients and avoid the cultural issues surrounding its post mortem use. The use of Auckland as a hub for NZDF repatriation purposes would support this.

(R) The AAR from 2/1 RNZIR identified a number points relating to ceremonial support. The Court agrees with these points and recommends that an SOP is created to identify HQ NZDF, HQJFNZ, Single Service, Formation and Unit ceremonial responsibilities.

(R) The Court believes that the procedures taken by the all those involved in the repatriation process of the deceased were done with the interests of the O'Donnell family and deceased foremost. The Court has identified that the repatriation process was efficient and timely given the circumstances. The recommendations above have been made to assist with contingency planning for incidents of a similar nature in the future.

15. Has an inventory of the personal effects of the deceased been completed?

(R) An inventory of Lt O'Donnell's personal effects was completed by the CRIB S4 on the 7th Aug 2010. On the 4th Aug 2010 Lt O' Donnell's personal effects were collected and an inventory completed
These were returned to KB in Bamian, where the remainder of personal effects were

collected and added to the Inventory of Personal Effects. With regard to Lt O'Donnell's personal effects that were left in New Zealand for his deployment an inventory was also made. This inventory was completed by 2/1 RNZIR

16. What has been done with the personal effects of the deceased?

(R) The RTNZ of effects was coordinated by the JMCC from theatre to his unit 2/1 RNZIR. Once LT O'Donnell's personal effects arrived at 2/1 RNZIR from CRIB 16 military equipment that had not been requested by his family was removed. A list of this equipment was provided by the Adjutant 2/1 RNZIR as well as a revised list of his personal equipment from CRIB 16. His family were advised of this action. An inventory was also made with regard to Lt O'Donnell's personal effects that were left in New Zealand during his deployment. This inventory was completed by 2/1 RNZIR and the Adjutant provided a copy of it to the COI. All of Lt O'Donnell's personal effects as identified in the combined inventories have been returned to his NOK. This was achieved by sending them to 1 RNZIR, who tasked a unit LO to deliver them to the O'Donnell family in Feilding.

(R) The Adjutant 2/1 RNZIR identified that some personal effects were still to be found as Lt O'Donnell had lent these items to his peers who deployed on CRIB 16 or other operations. 2/1 RNZIR has informed Lt O'Donnell's family and will continue to gather these items and maintain liaison with his family on this matter.

17. Was the handling of the personal effects of the deceased in accordance with applicable orders and established procedures?

(R) The procedure used by NZPRT S4 followed and complied with the direction given for the repatriation of effects of deceased personnel as detailed in HQ JFNZ SOP and NZPRT SOP All of the effects were organised into specific groups and placed in separate bags, and returned to NZ in a single consignment. Once receipted by JMCO, they were despatched to the parent unit, for action by Q Store staff, prior to the personal effects being returned to the next of kin.

18. What procedure or procedures were used to recover, transport and treat the casualties?

(S) The two NZDF casualties were initially recovered from near the K2 vehicle, which they had abandoned after failing to extract the patrol commander, approximately 30 minutes after the initial contact Due to the tactical situation, and the threat of further enemy action, the K2B commander directed them to recover themselves the few metres from the dry stream bed, in which they had taken cover, to the rear passenger door of the HMMWV, and get in as quickly as possible. The casualties were immediately driven back to the remainder of the patrol's position approximately 400 metres to the north of the contact site.

(S) The other casualty, the LEC Interpreter made his own way back to the

patrol after abandoning the vehicle earlier in the contact. His injuries were only slight compared to the driver and gunner of the K2 vehicle, and he was mobile enough to run back the 400 metres to the rest of the patrol.

(M-I-C) The initial treatment of the casualties at the scene of the contact was provided by the driver of K2C, who was a rifleman and a trained Combat Lifesaver. He attended to the K2 driver first, and then the gunner. His decision to treat the driver first was based on his initial assessment of the two casualties, and also the fact that the gunner had told him to deal with the driver first, as his injuries were more significant than his own. His treatment of the driver consisted of following the MARCHH procedure, which included assessing the driver's injuries, checking his vital signs, and then treating them as best he could with the resources available.

. Treatment included the application of a pressure bandage to the driver's right leg laceration, and the administration of Penthrox.

(M-I-C) Once he had treated the driver, the combat lifesaver then treated the K2 gunner. This also involved an initial assessment of his injuries, checking vital signs and stabilising the patient. The Combat lifesaver concentrated on the gunner's injuries, again following the MARCHH procedure.

(M-I-C) The treatment provided to the interpreter consisted of a brief assessment which identified that his eyesight was impaired. These were washed out by water and then covered.

(R) The combat lifesaver also mentally prepared a handover for both casualties to the next medical provider. This handover followed the MIST format, although he stated he did not prepare a written MIST handover.

(S) The casualties were stabilised as much as was possible for the remainder of the period until KT5 rendezvoused with KT2 at the contact site

The next medical treatment was provided by the KT2 medic and the KT5 medic, who had both travelled with KT5 to the contact site. The KT2 medic treated the gunner, and the KT5 medic treated the driver. The KT2 medic assessed the gunner, and based on this assessment and the actions of the combat lifesaver, determined that no further action was immediately required, apart from preparing him for evacuation by HMMWV. The KT2 medic then assisted the KT5 medic to insert an IV into the driver, take his blood pressure and prepare him for evacuation by HMMWV.

(S) The patients were then evacuated by HMMWV It was acknowledged that the HMMWVs were not entirely suitable for evacuation of wounded, however the tactical situation and the urgency of evacuating the casualties and the remainder of KT2 from the contact area precluded bringing the ambulance further forward.

(S) the casualties were cross

loaded onto an Unimog ambulance, which had come forward from Kiwi Base that evening under the escort
After ensuring the patients were prepared for the move, KT departed DO ABE
, and moved directly back to KB. Throughout the trip, the KT2 Medic, who had been instructed to remain with the ambulance, continued to stabilise and observe the three casualties. On at least two occasions she stopped the patrol in order to administer pain relief and re-bandage the wounds of the K2 driver.

(R) On arrival at KB, the KT2 medic handed over her care of the casualties to the NZPRT RMO. The casualties were unloaded from the ambulance and taken into the RAP. Inside the RAP, only one bed was available, so an improvised care area was created in the waiting area. Two teams of personnel assessed the casualties, cleaned wounds as best possible, administered pain relief when necessary, and prepared them for eventual MEDEVAC to BAF.

(R) The RMO completed MD 907 documents for the driver and gunner, which was a summary of his findings and the patients' state when they left KB.
that an MD 907 was completed for the interpreter, but was not able to produce a copy. The casualties were then held at the RAP until they were able to be evacuated
to BAF at approximately 041900 Aug 10. The delay in this stage of the evacuation process was due to a combination of poor weather and aircraft serviceability.

(R) On arrival in BAF, the casualties were immediately taken to the CF hospital, where a further full assessment was conducted. the NZPRT interpreter
was admitted to the Local National ward. He spent three nights under observation in the Local National Ward, after which he was released and stayed at KIWI LINES BAF before returning to KB

(M-I-C) Upon admittance to the CF Hospital, the driver and gunner underwent CAT scans and a number of surgical procedures to clean their injuries and provide initial treatment. From there, the focus of the medical staff was on preparing the two NZDF casualties for evacuation to Germany. This is a standard ISAF procedure, and the expectation was that they would be evacuated on the next available air ambulance flight scheduled to leave BAF. However, at the request of both HQ JFNZ and NSE, the BAF Hospital staff were requested to provide an assessment on both casualties, with a view to the possibility of evacuation to NZ. The casualties were cleared to be evacuated by NZDF means to NZ, and the BAF Hospital staff subsequently prepared both with further minor surgical procedures to clean their wounds prior to that move.

(S) At this stage it became clear that the evacuation of the casualties would need to marry up with NZDF flight that had been despatched by HQ

JFNZ to recover the remains of Lt O'Donnell. This meant that NSE staff had to request that casualties could be evacuated on the same flight as the remains of Lt O'Donnell.

This request was approved, and also allowed the Nursing Officer to accompany the two casualties on the C- 17 that was also transporting the remains of the deceased.

(R) The casualties were given their final preparation for the flight and discharged from the hospital at BAF. They moved under the care of the Nursing Officer to the flight line, where they observed the ramp ceremony for Lt O'Donnell before being stretchered aboard the aircraft.

(R) . The C-17 was delayed by 95 minutes and as a result departed BAF at 06 0305 Aug 10.

(S) When the casualties arrived , they were cross-loaded onto the RNZAF 757 after viewing a ramp ceremony for Lt O'Donnell.

The casualties had been stretcher-borne since leaving BAF Hospital, but there was no capability to load them on to the RNZAF 757 in this manner. They both had to be supported on their feet up the stairs and into the aircraft, During the transfer the patients were assessed by the NZ Aero-medical Evacuation Team (AME Team) on the tarmac, in considerable heat.

The AME team had to acquire medical stores from Coalition resources, which was duly and generously provided

The RNZAF 757's flight schedule precluded the opportunity to use the hospital facilities to administer patient care in a more hospitable environment before beginning the RTNZ phase.

(R) On the RNZAF 757 the patients were seated in business class seats, with their feet and legs supported by improvised boxes. This was assessed as an unsuitable arrangement, as it complicated access by the AME team to both patients in-flight. The AME team provided medical supervision throughout the flight. An additional medic NCO joined the flight at a scheduled stop at

Perth, Western Australia, after pre-positioning by commercial travel.

(M-I-C) The flight arrived in Whenuapai on the 7th August, where the patients were met by RNZAMC, who took over their management. He assisted with their transfer to North Shore Hospital. On the 8th August, the K2 gunner was transferred to Christchurch Hospital. He has subsequently been released and has returned to duty at his parent unit, 2/1 RNZIR. His primary medical provider is now the RMO 2/1RNZIR, but the Senior Medical Officer in Burnham has retained overall responsibility for him. The driver remained in North Shore hospital, until he was discharged on 10th August 10. He has subsequently returned to duty at his parent unit 1 NZ Sig Regt on light duties. His medical coverage is provided by 2 HSB in Linton and his primary medical provider is a Medical Officer at 2 HSB.

Comments by the Court

(S) The decision to evacuate the casualties to NZ was made by HQ JFNZ based on what would appear to be direction from HQ NZDF. A RNZAF Boeing 757 was used to transport the body of Lt O'Donnell and the casualties. On the surface the decision would appear to be a good one as the deceased and casualties were returned to NZ in a relatively short time. However this did mean that the medical care for the casualties was compromised. The decision meant that a RNZAF 757 was diverted the medical evacuation without having the time to refit the aircraft for this task.

(S) The primary means for casualty evacuation for CRIB 16 is via AME assets provided by the NZPRT's parent HQ, The reliance on AME as the primary means of casualty evacuation is a key assumption in any NZPRT tactical and, more specifically, Health Service Support planning. This did not occur, despite numerous attempts due to unusually poor weather conditions. As result of the failure of AME to reach the incident site, CO NZPRT made the decision to recover the casualties by HMMWV , then by Unimog ambulance to KB. Although this means of evacuation was not ideal in terms of patient treatment, comfort, speed of evacuation and security, it was the only guaranteed means by which the evacuation could have been completed at the time. The NZPRT did comment that, after reviewing the decision to use the ambulance, he considered that a HMMWV could have been used in place of the Ambulance to provide a higher level of protection, albeit with a significantly reduced degree of patient comfort and care. It was also identified by the KT2 Medic that the ambulance did not have the required medical equipment to conduct an evacuation by land as stated in NZPRT SOP

(S) The delay in evacuating the casualties from KB to BAF meant that the normal evacuation process was prolonged. Although this did not adversely affect the treatment or health of the casualties in this incident, it does raise concerns if in the future casualties with more significant injuries are required to be held for prolonged periods at the NZPRT.

(S) The following issues were identified by witnesses and the Court with the RTNZ plan by RNZAF 757:

i. The RNZAF 757 did not have adequate medical equipment or supplies available.

ii. Casualties were reviewed by medical staff on the tarmac as there was no time available to use CF medical facilities. These could have been arranged through TG TROY personal and professional contacts, had there been flexibility in the flight schedule.

iii. Casualties had to be assisted on foot on to the RNZAF 757 via stairs, rather than be carried on in the stretchers that they had travelled on from BAF

iv. No stretchers in the RNZAF 757 meant that the casualties travelled in business class seats.

v. Medical staff sent from NZ to provide medical supervision and treatment in the RNZAF 757 did not carry necessary medical equipment, and had to procure this informally from Coalition partners

vi. Medical Staff flew at short notice in economy class from NZ and then boarded the RNZAF 757 with no opportunity to conduct a formal patient handover and assessment, nor adequately rest prior to departing for NZ. This resulted in them effectively being on duty for the RTNZ flight, which was approximately 40 hours. This meant the medical staff were not sufficiently rested or equipped to deal with possible medical issues that could have arisen during the RTNZ flight.

vii. There was a risk that the RTNZ would be delayed due to flying-hour restrictions if the C-17 had not arrived in time. This would have meant that the patients would have to be admitted to a Coalition Force hospital, an occurrence which had not been anticipated during evacuation planning by HQ JFNZ.

viii. Any delay or maintenance failure of the aircraft between and NZ would more than likely required the patients to be hospitalised in an

appropriate facility at the location of the aircraft at the time. HQ JFNZ evacuation planning does not appear to have catered for this possibility.

ix. The evacuation of the casualties appears to have been driven exclusively by the desire by strategic leadership in NZ to RTNZ the deceased, as a priority, and the two wounded, as soon as practicable and with the greatest economy of effort and resources. The haste with which the aircraft was despatched from a prior task meant that it was not configured adequately for the AME role, and its flight schedule was sufficiently tight as to have presented significant risk if crew flight hours were compromised. This in turn compromised patient comfort and AME team accessibility and preparedness for treating potential in-flight emergencies, such as deep vein thrombosis, which although unlikely, presented a risk nonetheless. bringing home the deceased and the casualties appears to have compromised the most effective, comfortable and safest options for patient care, which could have included an extended stay in a suitable hospital in either BAF, or elsewhere, followed by evacuation by a dedicated AME aircraft with suitable numbers of AME team personnel, with relief, to NZ..

x.

19. Has an inventory of the personal effects of the casualties been completed?

(R) On the 4th Aug 2010 personal effects were collected and an inventory completed by members of KT2. An inventory of personal effects was completed by the CRIB S4 on the 7th Aug 2010. These were returned to KB in Bamian where the remainder of personal effects were collected and added to the Inventory of Personal Effects.

20. What has been done with the personal effects of the casualties?
(R) The personal effects were despatched from Kiwi Base to ARIKI NSE at BAF at the same time as the deceased's effects. The NZPRT S4 compiled three separate inventories for each respective soldier's equipment, consisting of personal equipment, military equipment, and FET returnables. Upon reaching NSE, they were prepared for consignment to NZ

(R) The arrival date of the bags in NZ was unable to be confirmed. However, on 13 Sep 10 the JMCO NCO requested an update on the status of the consignment. On 14 Sep 10 replied to say that they had been delayed by NZ Customs action, and that they should be delivered to JMCO at Whenuapai on 15 Sep 10. This apparently occurred, and effects were despatched to 2/1 RNZIR Q Store at the same time as the deceased's effects, by JMCO on 15 Sep 10.

(R) he had received his effects on approximately 24 Sep 10. The delay between consignment by JMCO on 15 Sep and the arrival of the effects at home is unable to be explained, but was likely due to processing of the baggage for removal of FET items.

(R) effects had still not reached him at the time of his interview The JMCO NCO was unable to provide an MD462 at the time of her interview, as it had not yet been consigned to parent unit. The JMCO Cpl responsible informed the Court that they were awaiting despatch, and would be physically moved to Ohakea by RNZAF on 24 Sep 10. An MD462 confirming this movement was provided to the Court The delay in despatch by JMCO to 1 Sig Regt was not explained to the Court. It was not confirmed by the Court if physically received his effects when the Inquiry was completed.

21. Was the handling of the personal effects of the casualties in accordance with applicable orders and established procedures?

(R) The procedure used for the return of the unaccompanied effects of the two casualties tended to follow that used for the effects of the deceased. The procedure used by NZPRT S4 followed and complied with the same direction given for the repatriation of effects of deceased personnel as detailed in HQ JFNZ SOP

All of the effects essentially were returned to NZ in a single consignment, whereupon they were separated and despatched to parent units, and thence to the individuals themselves.

(R) The return of effects appeared to meet the required endstate. The Court noted particular concerns with the timeliness of the processing of the consignment for all three personnel which was identified by both JMCO witnesses as a common occurrence. This delay, in the order of nearly a month, was considered an unsatisfactory arrangement, but is governed by the NZDF contract

(R) The delay in the return of the effects to individuals was not explained, but the likely cause was the movement times and subsequent action by unit Q Stores to process and remove military items and returnable equipment as necessary.

22. Comment of any others matters the Court considers relevant to the purpose of the Inquiry?

(R) The performance of KT2 during the contact on 03 Aug 10 was selected for particular comment by the Court. The actions of the patrol, after losing its commander and a significant portion of its firepower in the initial IED, displayed determination and tactical competence, even at the most junior soldier level. The patrol's initial reaction to contact was swift and decisive, and ensured further casualties were prevented. In particular, the actions of the following individuals were selected for specific mention:

i. The Patrol LNO, in coordinating the patrol's actions maintaining situational awareness during the post-contact period.

ii. The Vehicle Commander/ Ptl Section 2IC of K2B, who simultaneously fought his vehicle, attempted to establish communications made effective decisions during the fire-fight and coordinated the retrieval of his patrol commander's remains in a dignified manner after the contact.

iii. The Combat lifesaver and driver of K2C, who applied a level-headed approach to dealing with the three casualties during the contact.

iv. The actions of the driver and gunner of K2, who placed themselves at considerable risk from further injury and/or death by attempting to extract their patrol commander from their stricken vehicle, whilst under fire from the enemy and the fire from their own exploding ammunition.

(R) The Court noted the stoic attitude of the KT2 patrol during its visit . which reaffirmed the characteristics of the NZ serviceperson and their ability to cope with times of great stress.

(S) The Court noted the contribution to the repatriation of the NZDF's deceased and casualties by the goodwill of Coalition members,

It is assessed that significant shortcomings in NZDF capability to cope with the task were mitigated by Coalition support, largely engendered by personal contacts between NZPRT and NSE staff, and these should be acknowledged by NZDF and the NZ Government.

(R) The NZPRT's conduct after the contact and the loss of one of their own is commendable, particularly given the requirement to sustain effort into the higher threat areas by its personnel in the weeks immediately following the incident.

(R) The Court has identified that the approach to training and preparing NZDF personnel for CRIB deployments needs to be reviewed. In particular deploying personnel must be trained on the capabilities they will be using in theatre. The Court found that OLOC and DLOC training was not guided by the current TTPs and situation in theatre. The Court also noted that OLOC training is not resourced to prepare deploying personnel for CRIB. The practice of conducting training in theatre on unfamiliar or non NZDF weapon systems and equipment is not recommended.

(R) The complexity of the task faced by the Court of Inquiry was mitigated by the honesty and frankness of all those interviewed in connection with the Terms of Reference.

Recommendations

The Court noted the following recommendations from its investigation:

1. **(R) J1 Health/ Health Service Support Considerations:**

   a. HQ JFNZ standardise the use of Business Class travel arrangements for any future AME team deployed forward, to meet anticipated rest requirements.

   b. Best medical practice takes precedence.

   c. Dedicated use of RNZAF 757 for Strategic AME should have a mandatory air ambulance fit suitable for the carriage of stretcher-borne patients, with appropriate stocks of medical stores and equipment.

   d. The forward-deployed NZPRT Ambulance should be a vehicle with the appropriate level of force protection measures and equipment as an alternate to tactical AME.

   e. NZPRT develops CONPLANs to facilitate alternate action for delayed or no AME.

   f. HQ JFNZ must plan for alternate patient hospitalisation if Strategic AME transport is required to stop over or is delayed.

   g. Conventions preventing NZPRT medics from manning crew served weapons should be reviewed by J1 Hlth and DLS, as this limits patrol effectiveness and affects medical coverage of patrols.

   h. The medical staff establishment at NZPRT KB RAP be reviewed to ensure adequate coverage for life support should casualties be required to be held for longer periods.

   i. The NZPRT KB RAP establishment be accurately reviewed to determine its ability to handle mass casualty at KB, as well as the need to have suitably-qualified key medical staff deployed e.g. RMO and NO have appropriate EMST qualifications and experience.

   j. The Combat Lifesaver qualification is a critical capability in the section or patrol. NZ Army units preparing contingents for TU CRIB should seek to maximise the number of Combat Lifesaver-qualified personnel, particularly in patrols, during DLOC preparation activity.

UNCLASSIFIED

k. HQ JFNZ J1 Br should ensure that casualty NOK, and especially partners of NZDF casualties, receive appropriate and timely psychological support.

l. The HQ JFNZ SOP regarding the requirement for follow-up NOTICAS procedures by other elements in the evacuation chain should be reinforced to deploying NSE contingents.

m. ARIKI NSE should develop an SOP for casualty evacuation procedures to fill the gap identified during this incident. The Court noted that OC NSE had identified this gap and was taking action to ensure it was resolved at the time of his interview. It is further recommended that incoming contingents receive an adequate handover of existing SOPs, and conduct further analysis to determine potential gaps therein.

2. **(R) J4 points and considerations:**

a. NZ-based Plant and/or Equipment Managers should be instructed to refrain from circumventing HQ JFNZ by engaging NZPRT S4 directly with regard to the action desired for particular equipment return of equipment during post-incident administration.

b. SOPs for repatriation of weapons/ non NZDF equipment should reflect the requirements of End User Certification.

c. The Crisis Management Team is an effective organisation that, led by CoS HQ JFNZ, is capable of coordinating separate branches when handling different aspects of, and substantially different procedures for, repatriation of deceased (J4) and living casualties (J1).

3. **(R) Personal Effects points:**

a. Deceased – Single services should identify/recognise that military-issued personal equipment may be significant to deceased family (in this case uniforms/sleeping bags/packs etc), and therefore procedures for liaising with family on what military equipment they may wish to keep is recommended before its destruction or return to supply chain.

b. Casualties – the return of the casualties' personal effects from theatre has been a slow and laborious process, with very little explanation offered except that the contracted civilian company has difficulties with processing the effects through NZ Customs and MAF. It is recommended that J4 Branch investigate alternative options or identify desired improvements with the current system with the contractor to improve the speed of the repatriation of personal effects from theatre.

4. **(R) Spt to LEC.** It was noted by the Court that NZDF policy with regard to providing post-traumatic support, and even basic considerations for ongoing support, to LEC, in particular interpreters employed with NZPRT, is particularly poor. HQ JFNZ J1 Br should be tasked with identifying improvements to current policy for medical, psychological and welfare support to LEC that are involved in critical incidents with NZDF elements.

5. **(S) Patrol TTPs and training matters.** The Court identified the following improvements that could be made immediately to patrol training, preparation and conduct in-theatre:

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6. **(R) Mortuary Affairs and Post-Mortem Considerations.** The following specific recommendations are made by the Court with regard to mortuary affairs and post-mortem planning and conduct:

a. Labelling of separate body bags within transit cases IAW SOP

b. An MOU should be established between NZDF MOU with NZ Coronial Services/MAF/Customs/NZ Police.

c. NZDF supports the NZ Pathology Services' acquisition of a dedicated post-mortem CAT scanner.

d. Auckland is maintained for future use as a transport and post-mortem services hub, as a staging point through Auckland will ensure access to necessary support staff and resources, particularly in the case of mass casualties/ deceased.

e. The dedication of a suitably qualified HQ JFNZ or medical officer to act as a Coronial escort/ LO.

f. Retain the practice of involvement of the Coroners Office in operational deaths investigation and procedures.

g. Contingency planning should be conducted by HQ JFNZ CMT, with the Pathologist, in order to consider the problems and actions associated with a Mass Casualty Incident, particularly with regard to co-mingling of remains.

h. HQ NZDF acknowledge that the post-mortem process is subject to a number of factors that reside outside of NZDF control that could delay the repatriation process. HQ NZDF should acknowledge that unnecessary haste to this process can create friction and compromise the Coroner's outcomes.

i. HQ JFNZ should attempt to release as much information as possible (with appropriate security classification and privacy considerations noted) from any TSE to the Pathologist in order to assist post mortem investigations.

7. **(S) NZPRT Equipment and Capability.**

8. **(R) Training.**

a. Formal training for all NZPRT Patrol members at a minimum, for all non-NZDF weapons used on operations and their maintenance should be conducted on PDT, or at least on a sufficient TIC in-theatre.

b. Formal training for all NZPRT patrol members on vehicles used on operations to include tactics, driving (including with NVE), maintenance, problem solving and recovery.

c. A shift in emphasis to long range marksmanship training on PDT, as opposed to short-range reaction type shooting.

e. ECAS procedures should be taught to all patrol members on PDT.

f. NZ CTC should ensure training for all patrol members in LZ procedures including night LZ marking is delivered, IAW theatre procedures.

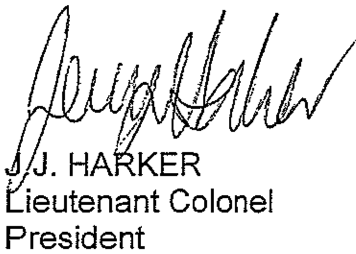
g. Contact point appreciation skills should be taught to patrol members on PDT, particularly focussing on Complex IED/ ambush type tactics.

h. NZPRT Sup Tech personnel should receive basic mortuary affairs training and an introduction to applicable HQ JFNZ and NZPRT SOP for the handling of deceased personnel and their effects after a critical incident. The conduct of a MRE during PDT, including the processing of a deceased serviceperson, is encouraged.

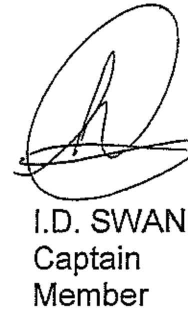
i. The lessons identified in this COI are of a time-sensitive nature and should be released as soon as practicable to better prepare CRIB 18.

j. CTC personnel are included on the Command Reconnaissance to identify current TTP to be included on OLOC training.

Dated at Trentham this 11th day of November 2010


J.J. HARKER
Lieutenant Colonel
President

C.M. KELLY
Major
Member


I.D. SWAN
Captain
Member

ACRONYM LIST

A

AO	Area of Operation
ANP	Afghan National Police
ANPRC-117	Patrol Radio
AME	Aero-medical Evacuation
AFNZ	Armed Forces New Zealand
AAR	After Action Report

B

BAF	Bagram Air Force Base

C

CP Ops Log	Command Post Operations Log
CO	Commanding Officer
CW-IED	Command Wire – Improvised Explosive Device
COMMS / comms	Communications
CITB	Cop in the Box
CLS	Combat Lifesaver
CASEVAC	Casualty Evacuation
C/S	Call Sign
CF	Coalition Forces
CSM	Company Sergeant Major
COI	Court of Inquiry
CoS	Chief of Staff

D

DLS	Defence Legal Services
DLOC	Deployed Level of Capability
DFO	Defence Force Order

E

ECM	Electronic Counter Measure
EOD	Explosive Ordinance Disposal
Engr Offr	Engineering Officer
ECAS	Emergency Close Air Support
EMST	Medical Assessment Procedure

F

FPB	Forward Patrol Base

G

GIRoA	Government Islamic Republic of Afghanistan

H

HMMWV	High Mobility Multi-Purpose Wheeled Vehicle

I

IED	Improvised Explosive Device
INS	Insurgents
IVO	In Vicinity Of

J

JMCO	Joint Movement Control Officer
JAPG	Joint Action Planning Group
JTAC	Joint Tactical Air Controller

K

KB	Kiwi Base
KT2	Kiwi Team 2
K2B / K2C	Kiwi 2 Bravo / Kiwi 2 Charlie (patrol teams)
KLE	Key Leadership Engagement
KT JH	Kiwi Team Jackhammer
NZFOR ISAF	New Zealand Formation ISAF
KIA	Killed in Action
KB CP	Kiwi Base Command Post

L

LNO	Liaison Officer
LOCSTAT	Location Statement
LN	Local National
LZ	Landing Zone
Loc	Location
LEC	Locally Employed Civilian
LDTG	Land Development Training Group

M

MK19 AGL	Automatic Grenade Launcher
MAG 58 MG	Machine Gun
MDCOA	Most Dangerous Course of Action
MIST	Mnemonic for Providing Information on a Casualty
MACP	Mortuary Affairs Collection Point
MARCHH	Mnemonic for a Process for Assessing a Casualty
MRE	Meals Ready to Eat

N

NZPRT	New Zealand Provincial Reconstruction team
NDS	National Directorate of Security (Afghanistan)
NGO/OGA	Non-Government Agency / Other Government Agency
NOTICAS	Notification of Casualty
NFAR	No Further Action Required
NVE	Night Vision Equipment

O

OPORD	Operations Order
OOM	Order of March
OLOC	Operational Level of Capability

OC NZCTC	Officer Commanding New Zealand Collective Training Centre
OC NSE	Officer Commanding National Command Element
OPINST	Operational Instruction

P

PK	7.62mm Machine Gun
PDT	Pre-Deployment Training
PRR	Patrol Radio
PCOP	Provincial Chief of Police
PROFILE	Health Database

Q

QRF	Quick Reaction Force

R

RPG	Rocket Propelled Grenade
RMO	Regimental Medical Officer
RNZMP NCO	Royal New Zealand Military Police Non-Commissioned Officer
RV	Rendezvous
RIP	Replacement in Place
RATEL	Radio Telephone Procedures
ROE	Rules of Engagement
RAP	Regimental Aid Post

S

Sit Rep / SITREP	Situation Report
SAF	Small Arms Fire
SOP	Standard Operating Procedures

T

TU	Task Unit
TSE	Tactical Site Exploitation
TIC	Theatre Indoctrination Course
TTP	Tactics Techniques and Procedures

U

V

VANZ	Veteran's Affairs New Zealand
VP	Vulnerable Points

W

WIA	Wounded in Action