

Headquarters New Zealand Defence Force Defence House Private Bag 39997 Wellington Mail Centre Lower Hutt 5045 New Zealand

OIA-2023-4652

10 July 2023

@stuff.co.nz

Dear

I refer to your email of 2 March 2023 requesting, under the Official Information Act 1982 (OIA), a copy of the finding, report or similar of the Court of Inquiry Report into the death of Lance Corporal N.R Kahotea.

Apologies for the delay in responding to your request. A copy of the Report of the Court of Inquiry is enclosed. This report has been released to you in accordance with section 200T of the Armed Forces Discipline Act 1971. Where indicated, information has been withheld in accordance with the following grounds of the OIA: section 6(a) where making the information available would likely prejudice the security and defence of New Zealand or the international relations of the Government of New Zealand; section 6(b)(i) where making the information available would likely prejudice the entrusting of information to the Government of New Zealand on a basis of confidence; section 9(2)(a) to protect privacy; section (9)(2)(ba)(i) where making available the information would likely prejudice the supply of similar information and it is in the public interest that such information should continue to be supplied; section 9(2)(h) to maintain legal professional privilege; and, section 9(2)(k) to avoid malicious use of staff information.

You have the right, under section 28(3) of the OIA, to ask an Ombudsman to review this response to your request. Information about how to make a complaint is available at <u>www.ombudsman.parliament.nz</u> or freephone 0800 802 602.

Please note that responses to official information requests are proactively released where possible. This response to your request will be published shortly on the NZDF website, with your personal information removed.

Yours sincerely

AJ WOODS Air Commodore Chief of Staff HQNZDF

Enclosure:

1. Report of the Court of Inquiry into the death of Lance Corporal N.R Kahotea



Headquarters New Zealand Defence Force Defence House Private Bag 39997 Wellington Mail Centre Lower Hutt 5045 New Zealand

OIA-2023-4764

10 July 2023

@nzme.co.nz

Dear

I refer to your email of 23 June 2023 requesting, under the Official Information Act 1982 (OIA), a copy of the Court of Inquiry Report into the death of Lance Corporal N.R Kahotea.

A copy of the Report of the Court of Inquiry is enclosed. This report has been released to you in accordance with section 200T of the Armed Forces Discipline Act 1971. Where indicated, information has been withheld in accordance with the following grounds of the OIA: section 6(a) where making the information available would likely prejudice the security and defence of New Zealand or the international relations of the Government of New Zealand; section 6(b)(i) where making the information available would likely prejudice the entrusting of information to the Government of New Zealand on a basis of confidence; section 9(2)(a) to protect privacy; section (9)(2)(ba)(i) where making available the information would likely prejudice the supply of similar information and it is in the public interest that such information should continue to be supplied; section 9(2)(h) to maintain legal professional privilege; and, section 9(2)(k) to avoid malicious use of staff information.

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AJ WOODS Air Commodore Chief of Staff HQNZDF

Enclosure:

1. Report of the Court of Inquiry into the death of Lance Corporal N.R Kahotea

REPORT OF THE COURT OF INQUIRY

INVESTIGATING THE CIRCUMSTANCES SURROUNDING THE DEATH OF S1019698 LANCE CORPORAL N.R. KAHOTEA, 1ST NEW ZEALAND SPECIAL AIR SERVICE REGIMENT DURING EXERCISE VECTOR BALANCE NET ON 08 MAY 2019.

GENERAL

The inquiry was carried out over the period 10 May 2019 – 29 May 2020. Evidence from 30 witnesses was considered. The court consisted of:

President: s. 9(2)(a)	, RNZA	
Special Operations Board	d Member: s. 6(a)	, NZSAS
Air Safety Board Member	r; s. 9(2)(a)	, RNZAF

Abbreviations, call signs and terms explained:

C/S S13:	LCPL Kahotea's team from A Squadron, 1st NZSAS Regiment.
C/1-1:	C Company, 1 st Battalion, 1 st Special Forces Group, US Special
	Operations Command (Pacific).
160 SOAR:	160th Special Operations Aviation Regiment, US Army.
Hawk 61 / 62:	160 SOAR Blackhawk call signs/air frames involved with the training
	that day.
'Bump':	The Single-Point Wheel Bump is a subcategory of a Helicopter
	Rooftop Single-Point Landing ¹ . In this method the helicopter hovers
	allowing for lateral insertion of troops onto a structure.
MOE House:	The Method of Entry building in Ardmore Military Training Area.
AMTA:	Ardmore Military Training Area.
MWD:	Military Working Dog

In order to maintain operational security the Court will refer to the following personnel by the designations noted below:

SOCC:	COL Rian McKinstry, Special Operations Component Commander.			
CO:	s. 6(a)	, Commanding Officer.		
OC A SQN:	s. 6(a)	, Officer Commanding A Squadron.		
OC SOTC:	s. 6(a)	, Officer Commanding Special Operations		
	Training Ce	ntre and Unit Training Officer.		
TP COMD:	s. 6(a)	, 1 Troop Commander, A Squadron.		
TP SGT:	s. 6(a)	, 1 Troop Sergeant, A Squadron.		
OPSWO:	s. 6(a)	, A Squadron Operations Warrant Officer.		
SAFETY:	s. 6(a)	, Safety Officer.		
GMO:	s. 6(a)	, Papakura Garrison Medical Officer.		
MEDIC:	s. 6(a)	, RNZAMC Medic.		
MP:	s. 6(a)	, Military Police Station Commander.		

¹ Exhibit AT, section 8F, page 4-190; Exhibit AJ.

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s. 6(a), s. 6(b)(i)
s. 6(a)	, Military Working Dog Handler of S13.
LCPL Nichola	as Kahotea, Team Leader of S13.
s. 6(a)	, Team Member 1 of S13.
s. 6(a)	, Team Member 2 of S13.
s. 6(a)	, Team Member 3 of S13.
s. 6(a)	, Team Member 4 of S13.
s. 6(a)	, Team Member 5 of S13.
	s. 6(a), s. 6(s. 6(a), s. 6(s. 6(a), s. 6(s. 6(a), s. 6(s. 6(a) LCPL Nichola s. 6(a) s. 6(a) s. 6(a) s. 6(a) s. 6(a) s. 6(a)

BACKGROUND

Outline briefly the relevant service history of S1019698 Lance Corporal N.R. KAHOTEA ('the deceased').

- 1. LCPL Kahotea's shortened service history is located at Exhibit N and a NZDF Record of Service history, including courses and operations, is located at Exhibit S.
- 2. LCPL Kahotea was a professional soldier and JNCO having served 13 years and 104 days in total on the night of the incident. He joined the NZ Army on 25 January 2006 enlisting as a Sapper in the Royal New Zealand Engineers (RNZE). From 15 December 2008 until 13 August 2013 LCPL Kahotea was posted to 1st New Zealand Special Air Service Regiment (1 NZSAS Regt) as a member of the RNZE Specialist Search Team, including being promoted to LCPL (RNZE) in December 2009. On 01 February 2013 LCPL Kahotea completed the NZSAS Selection Course, completing the NZSAS Cycle of Training (Phase 1) on 11 October 2013, graduating as a Commando in the rank of Private. He completed NZSAS Cycle of Training (Phases 2 and 3) and was subsequently badged as a NZSAS Trooper on 04 December 2014. In April 2017 he was promoted to LCPL (NZSAS).
- 3. Exhibit S shows that LCPL Kahotea had completed at least two Air Mobile courses. These courses include the s. 6(a)

Both of these courses teach a number of different helicopter deployment methods, including the Hover Jump. LCPL Kahotea had also conducted a number of multinational exercises and an operational deployment to Afghanistan, where he would have regularly worked with helicopters of multiple types.

4. LCPL Kahotea has significant experience in working at height, which is a frequent requirement in his role working as a member of NZ Special Forces. Exhibit S shows numerous courses where he has developed the understanding and experience to work at height in various situations with confidence. S. 6(a) s. 6(a)

The suite of NZSOF Counter Terrorism courses included in the NZSAS Cycle of Training (Phase 1) trains operators to work at height with military equipment in dynamic settings, as does the continued training and exercises conducted routinely throughout his career.

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- 5. LCPL Kahotea was a previous NZSAS Military Working Dog (MWD) handler and Instructor. LCPL Kahotea conducted significant MWD training in the UK with UK Special Forces; which included deploying from multiple helicopter types, such as the CH-47 Chinook, the AH1 Wildcat, and the WS-61 Sea King.² He qualified proficient in multiple deployment methods, such as Fast Roping, Rappelling, Hover Jumping and Helo Casting, both with and without a MWD. As a Team Leader and ex-MWD Handler/Instructor he was proficient in the deployment of a MWD, his team members, as well as himself from a helicopter.
- 6. LCPL Kahotea was considered by all of the witnesses as an experienced NZSOF operator having been in the RNZE Specialist Search Team, a NZSOF Commando and subsequently a badged member of the NZSAS. LCPL Kahotea had been a NZSAS operator for approximately five years when he died. His Commanding Officer (CO) described him as making the "transition from mastery of their skills to starting to give back as an assistant instructor" with regards to his tactical and technical skills.³ According to his CO, LCPL Kahotea was about to be promoted to CPL and posted to the Special Operations Training Centre as an instructor in the near future.⁴

What was the nature and purpose of the activity that was being conducted prior to the incident?

 Exercise Vector Balance Net (Ex VBN) was a Counter-Terrorism (CT) Integration Exercise conducted with C Company, 1st Battalion, 1st Special Forces Group (C/1-1). US Special Operations Command Pacific. s. 6(a), s. 6(b)(i)
 ⁵ The

purpose of Ex VBN was to conduct CT integration with C/1-1s. 6(a), s. 6(b)(i)

The design of the exercise allowed for the development of interoperability between the NZ and US force elements ^{s. 6}(a)

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² Exhibit AT, Investigation Report, tab D, page 4, Section I a (1) (e).

³ Witness 4, page 1, para A1.

⁴ Witness 4, page 1, para A1.

⁵ Witness 2, page 2, para A4; Witness 4, page 1-2, para A3.

⁶ Witness 2, interview 1, page 2, para A5-6; Witness 2, interview 3; Witness 3, Interview 1, page 1, para A3; Witness 10, page 1, para A1; Witness 4, page 3, para A4; Exhibit AU.

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Ultimately the purpose of the training for s. 6(a) 1 NZSAS Regt s. 6(a) was to conduct CT integration s. 6(a) .¹³ 1 NZSAS Regt is required to certify tasks mandated under Output 5 s. 6(a) ; to do this the unit has to partner with FVEY Special Forces, s. 6(a), s. 6(b)(i) .¹⁴

- 12. Specific exercise objectives annotated in the Exercise Instruction included:15
 - a. Strengthen Defence relations with regional partners.
 - b. Cooperate to enhance organisational capability and performance in areas of mutual interest.

⁷ Witness 4, page 1-2, para A3; Witness 1, page 3, para A4.

⁸ Witness 2, page 2, para A4; Witness 4, page 2-3, para A4.

⁹ Witness 1, page 2-3, para A4.

¹⁰ Witness 4, page 1-2, para A3; Witness 2, page 1, para A3.

¹¹ Witness 1, page 3, para A4; Witness 4, page 3, para A4; Witness 2, page 2, para A4.

¹² Witness 2, page 2, para A4-5.

¹³ Witness 3, page 1, para A3.

¹⁴ Witness 1, page 3, para A6.

¹⁵ Exhibit E, page 2, para 7.

- c. Conduct intra-theatre air mobility readiness training.
- *d.* Provide DLOC readiness training opportunities in tactical air transport operations including airdrop and tactical air-land techniques.
- e. Conduct deployed operations in a simulated semi-permissive environment.
- f. Conduct specialist training IOT enhance and develop TTP's, equipment and to integrate with FVEY partners.
- g. Conduct platform familiarisation in order to de-risk interoperability on operations.
- 13. The Concept of Operations for Ex VBN was to provide realistic training in a simulated combat environment. The training was provided in such a manner as to best achieve the participant's specific intra-theatre air mobility and ground force tactical operations requirements.¹⁶

Specifically where and when did the incident occur?

- 14. As per the NOTICAS located at Exhibit F, LCPL Kahotea fell at 1947M hrs on 08 May 2019, during hours of darkness.
- 15. The incident occurred within the Ardmore Military Training Area (AMTA), a long established NZDF training area. The specific incident site was located on the roof and western side of the Method of Entry (MOE) House, which is adjacent to the Battle Training Facility (BTF) where the troops were staging that evening (Exhibit U).
- 16. The 160 SOAR Blackhawk helicopter, call sign (C/S) Hawk 61 conducted the 'bump' with LCPL Kahotea's team (C/S S13) onto the western side of the second storey roof of the MOE House as indicated by Exhibit U. There are two rooftop areas on the MOE House seen at Exhibit H – a protruding first storey rooftop on the northern side, and the second storey rooftop where C/S Hawk 61 and 62 were conducting deployments. At this point it is pertinent to note that during the day the helicopters were approaching from the north and releasing the troops onto the northern side of the second storey rooftop, meaning that if someone fell they would have fallen one storey onto the first storey rooftop.¹⁷ After dinner the aircraft still approached from the north but changed deployment location to the western side of the second storey rooftop. The fall from the western side rooftop is two storeys high onto asphalt.¹⁸
- 17. LCPL Kahotea's body was found directly beneath the 'bump' site on the ground, approximately 1-2m out from the western wall of the MOE House. He was found

¹⁶ Exhibit E, page 2, para 8.

¹⁷ Exhibit U; Exhibit H; Exhibit AJ.

¹⁸ Exhibit U; Exhibit H.

lying on his back, body aligned perpendicular to the wall, with his head closest to the building.¹⁹ Note that the CCTV orientated to that aspect was not functioning.

Describe in chronological order the events leading up to the incident, that are, in the Court's view, relevant to the incident.

- 18. Liaison and planning for Ex VBN commenced with an Initial Planning Conference in October 2018 and a US Pre-Deployment Site Survey (PDSS) later that year.²⁰ However, it wasn't until February 2019 that activities started to be agreed upon between 1 NZSAS Regt, C/1-1 and 160 SOAR and exercise objectives confirmed in April 2019.²¹
- 19. As per A Sqn training programme,²² in the week prior to US forces arriving in NZ A Sqn conducted build up training; including Fast Roping, helicopter tower training, and other shooting and breaching skills. The layout of the NZSAS helicopter training tower does not exactly resemble the internal layout of a MH-60M Blackhawk, however US Fast Roping drills were practiced.²³ The USSOCOM M 350-6 training manual, which pertains to helicopter deployment and training such as Fast Roping, was used by A Sqn as a guide to ensure troops were compliant with US standards prior to starting live Fast Roping serials with US forces.²⁴ USSOCOM M 350-6 Series does not include the 'bump' deployment method.²⁵
- 20. US Forces were planned to arrive in NZ in time to open the exercise at 0800 hours on Monday 06 May, commencing live helicopter training (elevators) the following day on Tuesday, running into a second day of live training (circuits) on Wednesday 08 May 2019. US Forces arrived a day late, which compressed the helicopter training window from two days into one.²⁶ Therefore, the objectives set for both Tuesday and Wednesday occurred on Wednesday 08 May 2019.
- 21. On the day of the incident teams from A Sqn, 1 NZSAS, C/1-1 and 160 SOAR met at the rifle range in AMTA. The first activity to be conducted was a USSOCOM M 350-6 aircraft familiarisation brief at the two Blackhawks delivered by the respective crew chiefs of C/S Hawk 61 and 62, which lasted for approximately 40 minutes.²⁷ C/S Hawk 61 CC2 provided the USSOCOM M 350-6 brief on Fast Roping drills, calls and safety considerations prior to handing over to the CC1 who briefed the 'bump' in anticipation of conducting 'bump' serials during that training event.²⁸ The familiarisation brief was

- ²⁴ Witness 20, page 2, para A10.
- ²⁵ Witness 6, page 4, para A7.
- ²⁶ Exhibit Y2; Witness 20, page 2, para A9.
- ²⁷ Witness 20, page 4, para A18 A21; Witness 7, page 1, para A3 and A10; Witness 3, page 5, para A14.
- ²⁸ Witness 9, page 5-6, para A12; Witness 7 page 1-2, para A3.

¹⁹ Witness 10, page 14, para A34; Witness 16, page 11, para A45-48; Exhibit U.

²⁰ Witness 1, page, para A1. Witness 2, page 1, para A3. Witness 20, page 1, para A2, A4. Exhibit A

²¹ Witness 20, page 2, para A7. Exhibit E.

²² Exhibit Y1, Y2.

²³ Witness 3, page 5, para A11.

followed by an opportunity to engage with the Blackhawk crews to discuss anything helicopter related, including deployment methods.²⁹ A conduct brief followed the familiarisation brief prior to the delivery of the activity Safety Brief by the Safety Officer.

- 22. Some members of C/S S13 recall the 'bump' deployment method being discussed during the aircraft familiarisation brief.³⁰ It was briefed by the crew chiefs that individuals could choose their own personal deployment body position if doing the 'bump'.³¹ However, some team members and the Troop Sergeant (TP SGT) do not recall the 'bump' being discussed, which raises the question as to whether the briefs delivered by the two separate helicopter crews contained the same content.³²
- 23. The Exhibit AT Report articulates that upon arriving at the AMTA the US Flight Lead (P1) requested that the Ground Force Commanders consider including the 'bump' into the day's training for the purposes of aircrew proficiency.³³ However, the NZSAS Troop Commander (TP COMD) and TP SGT coordinating the training serials do not recall this activity being agreed to at that time.³⁴ Throughout the interviews the court conducted, there were conflicting accounts as to exactly how and when the 'bump' deployment was inserted into the training. Late in the afternoon of 08 May 2019, 'bump' deployments started to replace the Fast Roping deployments. Of the five NZSAS and C/1-1 teams, three conducted a bump deployment by day before the aircraft reported they needed to return to Papakura Camp to refuel.³⁵

24. s. 6(a)

The TP COMD deemed this was an appropriate training opportunity s. 6(a) , the risk level was acceptable, the participating troops were sufficiently skilled and the Fast Roping serials were reportedly progressing well.³⁶

25. A progressive 'Crawl-Walk-Run' training approach was adopted towards the Fast Roping serials. This is in accordance with DFO(A) Vol 7, Book 3, Chapter 6, Section 2, Para 6.2.1003 Planning Safe Activities.³⁷ Following on from the previous tower descents the training commenced with 'elevator' serials on the rifle range - where the aircraft elevates just metres above the ground, deploys the troops via Fast Rope, and then lands in the same place. Fast Roping drills were conducted in clean fatigue prior to deploying with personal kit and weapons.³⁸ The exercise then progressed to conducting circuits

³⁰ Witness 24, page 9, para A56; Witness 19, page 4, para A20-A23.

³⁸ Exhibit Z Witness 10, page 3, para A1.

²⁹ Witness 9, page 7, para A13; Witness 3, page 5, para A14.

³¹ Witness 7, page 4, para A15.

³² Witness 20, page 5, para A21; Witness 21, page 4, para A30; Witness 19, page 2, para A9.

³³ Witness 6, page 1-2, para A1, A3; Exhibit AT, tab D, page 5.

³⁴ Witness 20, page 2-3, para A10, A14-16.

³⁵ Witness 3, page 8, para A18.

³⁶ Witness 3, page 8, para A18.

³⁷ Exhibit AB. Witness 11, page 6, A20. Witness 10, page 3, para A1.

deploying initially onto the old Method of Entry 'tyre' house then onto the second storey roof of the new MOE House.³⁹ The training programme as A Sqn had planned it was to conduct Fast Roping serials only.⁴⁰

- 26. The two teams that were unable to conduct a daytime 'bump' deployment were C/S S13 (LCPL Kahotea's team) with C/S Hawk 61, and the TP COMD team utilising C/S Hawk 62, which was behind C/S Hawk 61 in the sortie rotation during the day.⁴¹ At approximately 1630 hours the TP COMD requested that the remaining two teams be afforded the opportunity to conduct a day-time 'bump', however this did not occur as the aircraft were required to return to Papakura Military Camp (PMC) to refuel.⁴²
- 27. Whilst aircraft were being refuelled the Ground Forces returned to PMC for the evening meal and a meeting to discuss night training iterations. Prior to returning to PMC the Safety Officer and the TP SGT discussed debrief points from the day's training iterations and safety considerations for the upcoming night training iterations.⁴³ The Safety Officer left the exercise to conduct a task that had been organised prior to him being appointed as the Safety Officer. He subsequently handed over Safety Officer duties to the TP SGT, who was also the designated Alternate Safety Officer. The Safety Officer was not present for any collective briefs at PMC. At PMC the TP SGT conducted a collective debrief for all participants to cover points from the day's training.⁴⁴ At that debrief there was discussion around the level of comfort the participants had with the 'bump' deployment and the impression that it was safer than fast roping.⁴⁵ Additionally, a meeting occurred between the commanders and team leaders of both NZ and US Ground Forces, as well as the US aircrew, to confirm the night training iterations. That group agreed to conduct a further two to three fast rope iterations and a further two to three 'bump' iterations onto the MOE House commencing at 1835 hours.⁴⁶

Detailed description of specific activities directly leading up to the incident.

28. Following dinner C/S S13 conducted Fast Roping serials as planned. Prior to taking off on C/S Hawk 61 for the first 'bump' iteration of the evening LCPL Kahotea briefed his team on the expected activity, which was initially planned to be a starboard-side 'bump' deployment – exiting from the right-hand side of the airframe. After the team embarked they were informed by the CC2 that there was a change and it would now be a port-side 'bump' deployment out of the left-hand side of the airframe, at which time LCPL Kahotea

44 Witness 20, page 7, para A37.

³⁹ Witness 10, page 4, para A1.

⁴⁰ Witness 20, page 3, para A15-16.

⁴¹ Witness 3, page 8, para A18.

⁴² Witness 3, page 8, para A18.

⁴³ Witness 10, page 4, para A1.

⁴⁵ Witness 3, page 10-12, para A23-A26; Witness 18, page 5, para A29; Witness 17, page 4, para A23, page 7, para A47, page 8 para 48.

⁴⁶ Witness 20, page 7, para A37; Witness 6, page 2, para A3; Exhibit AT, Report Mishap Narrative, Section 1, page 8.

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made some minor changes to the positioning of some team members.⁴⁷ LCPL Kahotea had his team re-positioned as per Figure 1:



- 29. Daytime 'bump' approaches consisted of a North to South approach onto the northern edge of the MOE House roof, which requires a 90 degree turn to present the aircraft's cabin door opening to the rooftop.⁴⁸ This places the aircraft above the first storey with an approximate fall height of 5m. The medic was located on the first storey rooftop for this purpose noting that any fall from this approach would be limited to a single story fall.⁴⁹ The Safety Officer was located on the upper stairwell where he could observe the serial but avoid the downwash.⁵⁰
- 30. For the first night 'bump' serial to minimise manoeuvring of the helicopter under NVG and to avoid the ambient light presented by the BTF, the approach path remained direct North to South changing to a port-side exit onto the western aspect of the MOE House rooftop.⁵¹ s. 6(a)
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 5. 6(a)

53 s. 6(a)

⁵⁴ The Safety Officer had pre-positioned the medic on the rooftop of the first story for the night approaches with the expectation that the deployment site would remain the same.⁵⁵ This change in deployment location increased the fall height from approximately 5m to 10m and negated the extant safety plan.

- 50 Exhibit U.
- ⁵¹ Witness 8, page 2, para A5; Witness 6, page 2, para A3; Witness 10, page 10, para A23.
- 52 Witness 8, page 3, para A5.
- ⁵³ Exhibit AT, Report, Tab D Mishap Narrative, page 11.
- ⁵⁴ Witness 10, page 10, para A23; Witness 8, page 3, para A5.
- 55 Witness 10, page 10, para A23.

⁴⁷ Witness 21, page 6, para A49; Witness16, page 6, para A21; Witness 19, page 5, para A31-A32.

⁴⁸ Witness 8, page 2, para A5. Exhibit U.

⁴⁹ Witness 22, page 2, para A7 and A8. Exhibit U.

- 31. After C/S Hawk 61 settled into its deployment location on the western aspect of the MOE house CC2 dispatched the troops with a hand signal. The first two troops off the airframe were TM1, the MWD handler followed by the MWD itself. Both report the approach, settling of the airframe, and individual deployment were uneventful.⁵⁶ MWD does not recall the dog being caught up or any noticeable tension on his dog restraint. This leads the court to believe that the dog did not pull LCPL Kahotea off the airframe as it exited.⁵⁷ The RNZAF Air Safety representative on the US Air Safety Investigation, recalls seeing the aircraft location and tail boom orientation data, and concluded that aircraft movement was within normal tolerances.⁵⁸ This leads the Court to believe that the airframe was stable and did not significantly deviate from its settled position on the building. Both TM1 and MVVD deployed themselves easily from the seated position on the edge of the Blackhawk floor, and neither saw LCPL Kahotea fall.⁵⁹
- 32. After issuing the dispatch 'Go' hand signal and reporting this to the pilot, CC2 had his head out of his window as can be seen in Exhibit AJ. He observed TM1 and MWD deploy onto the roof whilst monitoring the gap between the airframe and the roof's edge. At this time he moved his head inside to check that the remainder of the troops were repositioning to deploy.⁶⁰ There is a section of fuselage between the Crew Chief's window and the door the troops exit from, which impedes his view of the aircraft cabin.⁶¹ CC2 observed the next pair (this would have been TM2 and LCPL Kahotea) initiating their exit from inside the cabin, so moved his head back out of his window. It was as CC2 looked back out of his window that he noticed movement low in his field of view. As he looked down to confirm the movement he saw a soldier (LCPL Kahotea) falling down the side of the building.⁶² CC2 observed LCPL Kahotea falling next to the western-side of the MOE House rooftop, in a vertical position.⁶³ facing the building, his head at the height of the rooftop, with his arms in a raised posture.⁶⁴ Following this CC2 moved into the cabin to stop further troop deployment whilst informing the pilot that a soldier had fallen.⁶⁵
- 33. LCPL Kahotea was the fourth man to exit the Blackhawk. He was sitting on a cooler which was located in a central location at the front of the cabin,⁶⁶ facing rearwards as demonstrated in Exhibit X. The height of the cooler would have placed LCPL Kahotea in a slightly higher body position than those sitting on the seat at the rear of the cabin. It has been noted that LCPL Kahotea was at some point orientated towards the port door

- ⁶¹ Witness 9, page 13, para A28.
- ⁶² Witness 9, page 13, para A28.
- 63 Witness 9, page 14, para A29.
- 64 Witness 9, page 15-16, A35-A36.
- 65 Witness 9, page 13, para A28.

⁵⁶ Witness 16, page 7, para A21; Witness 24, page 3, para A17.

⁵⁷ Witness 16, page 8, para A31.

⁵⁸ Witness 28, page 2, para A1.

⁵⁹ Witness 16, page 8, para A27; Witness 24, page 5, para A33.

⁶⁰ Witness 9, page 13, para A28.

⁶⁶ Exhibit V2; Witness 16, page 6, para A21; Witness 17, page 5, para A28.

as he was also assisting with the deployment of the MWD.⁶⁷ LCPL Kahotea had two options to exit the airframe; Option 1 would be to take a seat on the floor of the aircraft and shuffle across to the door before exiting from a seated position, or Option 2 to remain on one knee, or a crouched position, before directly exiting on his feet in a dynamic manner as demonstrated by other operators in Exhibit AJ video and stills. s. 6(a), s. 6(b)(i)

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- TM2 was located on the bench seat at the rear of the cabin, next to the port door facing 34. forward. He was the third man planned to deploy and would have exited at about the same time as LCPL Kahotea, if not slightly before. TM2 recalls last seeing LCPL Kahotea in a kneeling position, beside the cooler in the centre of the cabin, looking out of the port door as the Blackhawk was on its final approach.⁶⁹ TM2 personally moved from the bench seat to a seated position on the floor vacated by TM1 to exit.⁷⁰ He assessed the horizontal gap between the airframe and the rooftop to be approximately one foot with a vertical distance of approximately 1 1/2 feet71 - he was able to touch the rooftop with his foot whilst seated on the Blackhawk floor.72 TM2 recalls discussing how he and LCPL Kahotea would debus - which would be one after the other, likely from the seated position.⁷³ Once TM2 had deployed across the roof he does recall looking back at the Blackhawk and saw it still hovering there, but thought nothing of it.⁷⁴ He then continued across the rooftop and down the stairs to stack with TM1 and MWD on a door ready to enter. He did not notice LCPL Kahotea was missing until he reached TM1 and MWD on the stairs.75
- 35. TM3 was located on the rear bench seat, on the right-hand side, and was planned to be the fifth man to deploy. He had a backpack and breaching charges on his back, so he was mindful of his height. As a result, when it was his turn to debus he shuffled across the rear bench seat, and took up a seated position on the floor of the aircraft. It was once he was in the door that he saw the gap between the airframe and the rooftop had opened up to approximately 1 m.⁷⁶ It was also at about that time that the CC2 placed a fist into his chest ensuring he did not attempt to debus.⁷⁷ The Court believes this gap is a result of the pilot being made aware of LCPL Kahotea's fall and the pilot was already

- 72 Witness 17, page 6, para A36.
- 73 Witness 17, page 10, para A62.
- 74 Witness 17, page 7, para A39.
- 75 Witness 17, page 4-5, para A26.
- 76 Witness 19, page 5, para A30-A32.
- 77 Witness 9, page13, para A28; Witness 19, page 6, para A32.

⁶⁷ Witness 16, page 6-7, para A21; Witness 17, page 5, para A28; Exhibit X.

⁶⁸ Witness 7, page 4, para A15; Witness 9, page 10, para A22.

⁶⁹ Witness 17, page 6, para A31.

⁷⁰ Witness 17, page 4, para A25.

⁷¹ Witness 17, page 6, para A37.

pulling away from the building to land. TM3 recalls last seeing LCPL Kahotea S. 6(a)

still seated on the cooler at that time.⁷⁸ TM3 wasn't aware of LCPL Kahotea's fall until the Blackhawk had landed and he had got out to speak with other NZSAS members.⁷⁹

- 36. TM4 and TM5 were both seated in the starboard-side door opening of the airframe and were planned to be sixth and seventh men to deploy. Neither man saw LCPL Kahotea fall and did not observe him immediately prior to his exit. Neither of these men were able to debus as their path across to the port-side door opening was blocked by TM3.⁸⁰ TM4 told the court that he intended to exit the aircraft on his feet in a crouched position after having adopted a kneeling position in the airframe.⁸¹ TM5 was unable to recall how he intended on exiting the aircraft, but noted that he would apply what naturally came to him at that time.⁸² Neither of these men knew that LCPL Kahotea had fallen until the aircraft had landed and they had exited and reunited with other teams.⁸³
- 37. Upon considering all of the witness statements, observations and experience that related to the movement of troops from a Blackhawk to a rooftop via a 'bump' deployment, broadly there are two methods of exiting the aircraft from a seated position on the airframe floor, or from a crouched position on one's feet. The court's opinion is that it is more likely that LCPL Kahotea attempted to exit the airframe from a crouched position on his feet as he was last seen in a kneeling position, facing out the door, whilst next to the cooler.⁸⁴ However, his actual exit from the aircraft was not observed by anyone.

Potential Hazards in and around the aircraft and incident site.

- 38. Generic helicopter hazards are identified in DFO (A) Volume 7, Book 1, Chapter 5 Section 11 Annex A, the Unit Activity Hazards Register (UAHR), are discussed in the USSOCOM M 350-6 familiarisation brief, and taught during the NZSAS Air Mobile courses. The hazards the Court deemed of most relevance to this incident are discussed below.
- 39. There are potential trip and snag hazards inside the aircraft cabin, the most obvious being the Troop Restraint System and the Fast Rope Insertion Extraction System (FRIES). The Troop Restraint System is a strap connected to the floor and is what the Ground Force can hook their personal restraints to during transit.⁸⁵ CC1 states that he

- 84 Witness 17, page 6, para A31.
- 85 Witness 9, page 10, para A24. Exhibit V2.

⁷⁸ Witness 19, page 6, para A34, A36.

⁷⁹ Witness 19, page 6, para A32.

⁸⁰ Witness 18, page 6-7, para A36; Witness 21, page 7, par A65.

⁸¹ Witness 21, page 7, para A62

⁸² Witness 18, page 8, para A45.

⁸³ Witness 18, page 7, para A36.

has never seen anyone trip on it during a bump serial.⁸⁶ The Court can confirm that LCPL Kahotea correctly stowed his personal restraint lanyard⁸⁷ which removes this as a potential snag hazard. The FRIES is the system used to attach the Fast Rope to the aircraft. The FRIES bar and release cables are potential snag hazards.⁸⁸ CC2 states that he has no experience of people snagging on the rope however, in previous activities, some people have said that they have hit their head on the FRIES bar.⁸⁹ All cabin hazards are identified and briefed to participants in the USSOCOM M 350-6 aircraft familiarisation brief.⁹⁰

- 40. There are trip hazards on the roof of the MOE House. Those hazards are sections of pipe that house the MOE House rooftop safety rails. They protrude approximately 7cm above the level of the rooftop and are interspaced along the edge of the rooftop, approximately 8cm from the edge of the roof.⁹¹ These stanchions are not usually a hazard when the safety rails are installed. For this activity the safety rails had to be removed to allow troops access and not present a hazard to the aircraft.⁹² TM2 recalls seeing these stanchions through his Night Vision Googles (NVG), and that he was familiar with their presence having worked with the safety rails removed whilst conducting previous rappelling training.⁹³ There is potential for a trip to occur if an individual comes into contact with one of these stanchions as they exit the aircraft.
- 41. No evidence was provided which led the court to believe that LCpl Kahotea tripped or snagged on any object. However, the court cannot rule it out.

Vision, Communications and Situational Awareness.

42. NZSAS Operators can chose from two variants of NVG, that being the current in-service s. 6(a) and s. 6(a) ⁹⁴ 1 NZSAS Regt regularly trial different items of equipment to inform future acquisition, and issue this equipment out to personnel to use and evaluate. During the early stages of the COI interviews the Court was informed that LCPL Kahotea was in possession of, and used, a trial set of s. 6(a) , which is a more modern and capable set of night vision goggles than both types of in-service NVG.⁹⁵ This information was subsequently corrected; LCPL Kahotea had in fact been in possession of

- 90 Witness 9, page 3-4, para A11.
- 91 Exhibit W3-W5.
- ⁹² Witness 10, page 4, para A1.
- 93 Witness 17, page 12, para A80.
- ⁹⁴ Witness 26, page, para A5. Exhibit AQ.
- 95 Witness 26, pages 1-2, para A3, A5-A7.

⁸⁶ Witness 7, page 8, para A26.

⁸⁷ Exhibit AF, page 3.

⁸⁸ Witness 7, page 5, para A17. Exhibits AJ, V2.

⁸⁹ Witness 9, page 11, para A26.

s. 6(a) ⁹⁶ s. 6(a) NVG.⁹⁷

are a notable enhancement on the current in-service

- All members of NZSAS are experienced in the use of NVG. Regardless of experience, 43. there is still depth perception and peripheral vision issues that can impact a user's situational awareness. Some users remove the NVG evecups in order to provide some unaided peripheral vision, which some of the team members of C/S S13 had done.⁹⁸ The NZ Police Report contains a Forensic Imaging Report which shows LCPL Kahotea's helmet and NVG at the scene. It is evident from the images that LCPL Kahotea did not have the NVG cups fitted⁹⁹ - meaning that there is potential for LCPL Kahotea to be able to have some unaided peripheral vision. Most team members recall using their NVG but did not observe LCPL Kahotea using his specifically in the aircraft.¹⁰⁰ However, two team members observed LCPL Kahotea with his NVG down whilst the aircraft was on the ground prior to take off.¹⁰¹ The Court believes that on the balance of probability, as indicated by the other team members, LCPL Kahotea was using his NVG at the time he exited from the airframe. If this was the case his vision could have been impacted by the associated periphery limits or depth perception restrictions. However, when compared with the other team members that impact would have been less than those wearing the in-service NVG.102
- 44. The experience of wearing NVG is similar to that of looking through a set of binoculars, in that it focuses and concentrates your vision. C/S S13 team members note that if you are focussed on an activity in front of you, such as deployment of other team members, and do not make the conscious decision to look down at your immediate footing you could move forward without being fully aware of the hazards directly in front of you.¹⁰³ S. 6(a)
- 45. Team members are able to communicate between themselves via radio, but the noise of the aircraft would have made this extremely difficult. As a consequence, while inside and exiting the aircraft communication between team members and aircraft crew is mostly via hand signals and drills. Due to his service history and experience LCPL Kahotea was familiar with communicating in helicopters.

96 Witness 26, page 1, para A1, A9.

- 98 Witness 21, page 9, para A77.
- 99 Exhibit AE, Tab 27, page 12.
- 100 Witness 17, page 6, para A38.

¹⁰¹ Witness 24, page 7, para A41; Witness 3, page 19, para A38.

- ¹⁰² Witness 16, page 10, para A40.
- ¹⁰³ Witness 16, page 9, para A32.

⁹⁷ Witness 26, page 2, para A5-A7.

PLANNING AND CONDUCT OF THE ACTIVITY

Was the exercise and specific activity appropriately authorised, and by whom?

- 46. Ex VBN had been in planning for at least one year prior to its commencement in May 2019. The court received a number of authorisation documents that had been staffed through the NZ Special Operations Component, elements of HQ Joint Forces NZ (notably the Air Component Commander) and 1 NZSAS Regt HQ.¹⁰⁴ The exercise was authorised by the SOCC, the Air Component Commander (ACC) and the 1 NZSAS Regt CO, which is appropriate for a training exercise of this nature.¹⁰⁵
- Authority to operate on a United States Department of Defence aircraft is contained in DFO 36, Volume 1, Chapter 5, Operational Movements Section 4 - Air Transport, paragraph 5.34.d (4); which states:

Military aircraft owned or authorised for use by the Ministry of Defence United Kingdom, **United States Department of Defence**, Canadian Armed Forces, and Australian Defence Force meet the NZDF airworthiness standards and require no safety assessment by approval authorities.

- 48. The 'bump' deployment is not an approved NZDF insertion technique. It was not included in the exercise documentation described above as it was not a planned activity, nor was it included in the related training documents produced by 1 NZSAS Regt. Therefore, the 'bump' was not formally approved by SOCC or the CO.
- 49. The senior commander on the ground during that day's activities was the TP COMD, who was acting under the authority of his OC and appointed as Ex VBN Officer in Charge (OIC VB19) by SOCC.¹⁰⁶ The TP SGT was allocated the task of planning and coordinating this particular training phase.¹⁰⁷ On arrival at AMTA that day the lead pilot of C/S Hawk 61 (P1) made a request to the NZ and US ground force Troop Commanders and Troop Sergeants to conduct 'bump' training, and came away from the conversation with the impression that approval had been given.¹⁰⁸ It is not uncommon to have training opportunities presented to Special Forces teams when training with other nations¹⁰⁹ and there is an appropriate process to obtain approval. The change in training activity from Fast Roping to 'bump' deployments was supported by the TP COMD once he became aware they were occurring, in that he requested NZSAS teams be able to conduct daytime 'bump' serials. Following the coordination briefs back at PMC all Ground Force Commanders present had given their approval to conduct 'bump' training by night,

¹⁰⁴ Exhibit A, B, C, D and E.

¹⁰⁵ Exhibit B, C and E.

¹⁰⁶ Exhibit D, para 4.

¹⁰⁷ Witness 20, page 1, para A1.

¹⁰⁸ Exhibit AT, Report tab D, page 5.

¹⁰⁹ Witness 25, page 8, para A29.

including agreement from the relieving Safety Officer (TP SGT). The assigned Safety Officer was absent from the evening coordination briefs and unable to be a part of the 'bump' approval discussion.¹¹⁰ The 'bump' deployment is not specifically covered in either the DFO (A) Volume 7 Safety in Training or the USSOCOM M 350-6,¹¹¹ however was covered as a part of the initial aircraft familiarisation briefs conducted by the US aircrew.

- 50. The 'bump' deployment was considered by both the 160 SOAR pilots, and the US and NZ Ground Forces as a safer activity than the Fast Roping serials. It was considered a skill that was easily transferrable as 'you are just stepping off the air frame', as many of the team communicated during interviews.¹¹² This goes some way to highlighting the thinking of those participants and commanders involved.
- 51. s. 6(a), s. 6(b)(i)

Was the activity conducted in an authorised location?

- 52. AMTA is NZDF property, and designed and authorised for this type of complex training – that being the incorporation of ground troops, aircraft, complex activities, including live firing and explosives. The AMTA is where the Special Operations Training Centre, NZSAS Squadrons and the Regiment itself conduct courses and unit training activities, so it is very familiar to 1 NZSAS Regt members.¹¹⁵
- 53. The use of the AMTA facilities and buildings for this type of activity was appropriate in terms of safety and training options.¹¹⁶ AMTA is considered to provide world class training facilities and is governed by AMTA Standing Orders. AMTA Standing Orders 01/15 Part 3, Chap 1, Section 1, paragraph 3105 (g) authorises helicopter Fast Roping, Hover Jumping, Rappelling and extraction practices. AMTA Standing Orders do not specifically mention 'bump' deployments as a method of insertion but could be considered for future Standing Orders. AMTA Range Standing Orders 01/15, Part 3, Chapter 1, Section 4, MOE House Range Standing Orders, paragraph 3556 states that:

¹¹⁶ Witness 11, page 4, para A12, A14.

¹¹⁰ Witness 10, page 4-5, para A1.

¹¹¹ Exhibit AT; Witness 6, page 4, para A7; Witness 7, page 2, para A5; Witness 11, page 5-6, para A18-A19.

¹¹² Witness 3, page 10, para A23; Witness 25, page 5, para A19; Witness 19, page 3, para A13, A16; Witness 6, page 4, para A7.

¹¹³ Witness 25, Page 2-3, A7-A10.

¹¹⁴ Witness 10, page 10, para A23.

¹¹⁵ Witness 11, page 4, para A12-A13; Witness 1, page 6, para A15.

Helicopters may be used to assault the MOE house by fast roping, hover jumping, winching or rappelling...onto either level.

Was the activity authorised, executed and controlled in accordance with Defence Force Orders and publications and technical authority? Was an appropriate exercise instruction issued?

- 54. Ex VBN as planned was authorised at appropriate levels and in accordance with Defence Force Orders, publications and technical authority. This is evidenced by Exhibits A-E. However, the 'bump' training was not identified in advance in any of these planning documents. With this in mind the Court considers that the 'bump' serials were not conducted in accordance with current Defence Forces Orders, nor was dispensation requested. This was primarily due to the impromptu nature of the training request, the compressed timeframe, and the inadequate appreciation of the associated risks.
- 55. The applicable chapter at DFO (A) Volume 7 Book 3, Chapter 6 Special Operations Training is currently in draft. This is still being validated, but provides the necessary guidance and is being applied as directed by the 1 NZSAS Regt CO.¹¹⁷ This is being applied in draft form as the current Standing Orders for Training (SOTs) are being transferred into the DFO format.
- 56. The current Section 9 Air Mobile Operations located in the draft DFO (A) Volume 7 predominantly covers Fast Roping from the NH-90 as the current primary helicopter insertion method. It no longer comprehensively covers Hover Jumping which was a previous deployment method employed on the UH1H Iroquois helicopter and not currently available with the NH-90. The Hover Jump is still taught on the NZSAS Cycle of Training from a ground mock-up to Training Level 2 for potential employment in the South-West Pacific. Hover Jumping was described by interviewees as the closest transferable skill currently held in 1 NZSAS Regt.¹¹⁸ The 'bump' deployment is not a traditionally taught drill and is not included in the DFO (A) Volume 7.
- 57. Exhibit AB shows DFO (A) Volume 7 Book 3, Chapter 6, Special Operations Training, Section 2 Planning Safe Training which covers the need for progressive training, in order to fully prepare individuals prior to proceeding to more complex activities by day and night. Paragraph 6.2.1003 (f) Safe Training Rules lists the following training rules to be adhered to by the Regiment:
 - a. All training is to have a clear training objective and this objective is the primary focus;
 - b. All training is to adhere to relevant policies and procedures;
 - c. Those responsible for training are to be suitably qualified and authorised;

¹¹⁷ Witness 11, page 5, para A18-A19.

¹¹⁸ Witness 11, page 6-7, para A21; Witness 4, page 6, para A13.

- d. All participants are to be provided a safety brief prior to the commencement;
- e. Participants, instructors and safety staff are to practice correct training techniques and procedures;
- f. Training is to be progressive to ensure participants are capable of building on previously learned skills;
- g. All equipment is to be checked and approved for service;
- h. If non-military issue equipment is to be used or worn it must be approved by a suitably experienced and qualified safety officer;
- Medical support is to be tailored to suit each training activity and 'actions on' in the event of an accident are to be briefed as part of the safety brief; communications links are to be tailored to suit each training activity and briefed to all participants;
- j. If at any point during a training activity a participant, instructor or safety staff member feels safety is being compromised they have a duty to immediately raise the issue with an appropriate authority; and
- k. Participants are not to consume alcohol or drugs within twelve hours of training activities.
- Authority to operate on a United States Department of Defence aircraft is contained in DFO 36, Volume 1, Chapter 5, Operational Movements Section 4 - Air Transport, paragraph 5.34.d (4); which states:

Military aircraft owned or authorised for use by the Ministry of Defence United Kingdom, **United States Department of Defence**, Canadian Armed Forces, and Australian Defence Force meet the NZDF airworthiness standards and require no safety assessment by approval authorities.

59. When training on foreign aircraft, including the US MH-60M Blackhawk, NZ troops must follow the appropriate US regulatory requirements and fall under the control of the US aircrew whilst in the airframe. NZSAS troops adopted the USSOCOM M 350-6 procedures inside the aircraft and for deployment procedures such as Fast Roping serials.¹¹⁹ Knowing this, the USSOCOM M 350-6 procedures and calls were taught during the build-up training by an A Sqn member who had worked recently with the US Special Forces and had trained using the US calls and procedures for employment.¹²⁰

¹¹⁹ Witness 3, page 5, para A12; Witness 11, page 8, para A28; Witness 10, page 7, para A12.

¹²⁰ Witness 3, page 4-5, para A11.

- 60. An appropriately detailed exercise instruction was signed by the CO and distributed on 30 April 2019.¹²¹ It provides the necessary authority for sub-units and unit staff to develop more detailed supporting plans and annexes; as well as Direct Liaison Authority (DIRLAUTH) between exercise participants, visiting forces and supporting agencies.¹²²
- 61. The training programme and associated sorties board was appropriately detailed and depicted a progressive 'Crawl-Walk-Run' approach to Fast Roping.¹²³ However, the training programme and exercise instruction did not account for the impromptu 'bump' deployment serials as it was a late addition to training on that particular day.
- 62. S. 9(2)(h) the Exercise Instruction states Ex VBN was not a declared operational activity for the purpose of Section 7 of the Health and Safety at Work Act 2015. The Court believes this is an error as the training conducted was CT in nature.¹²⁴ S. 9(2)(h)

unaware of the content of the A SQN OPORD and relied solely on the IPC Report and Exercise Scoping Document. Both of these documents provided less detail than the OPORD. It was also apparent that due to **s**. 9(2)(h) relatively junior experience they did not have a full understanding of SOF employment contexts.¹²⁵ This meant that, in the absence of the detailed A SQN OPORD, the task of **s**. 9(2)(h) as being subject to an operational exemption was a complex task. **s**. 6(a), **s**. 6(b)(i)

.¹²⁶ Equally, 1 NZSAS Regt hold New

Zealand's Expeditionary CT capability. The A Sqn OPORD for the exercise appropriately identifies the intent of the exercise at paragraph 4. (a)¹²⁷ which states:

Intent:

- (1) Purpose. To prepare and deliver immediate readiness forces to conduct special operations in support of national objectives.
- (2) Method. Conduct collective training focussing on combined arms integration with FVEY partners within a non-permissive CT-centric environment.
- (3) End-State. A Sqn has conducted integrated training with USSOF, certifying our ability to coalition with s. 6(a)

¹²¹ Exhibit E; Witness 4, page 6, para A11.

122 Exhibit E, para 32-33 and Annex N.

¹²⁴ Witness 2, page 2, para A4-A6.

¹²³ Exhibit Y1-Y2, Z

¹²⁵ Witness 31.

¹²⁶ Witness 4, page 2, para A3.

¹²⁷ Exhibit AW, page 1, para 4.

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s. 6(a) Full mission profiles have been executed and the SOTG is accredited for HAF operations.

63. s. 6(a)

This saw the exercise participants training to an operational level of capability and achieving a high degree of readiness. For these reasons the Court believes Ex VBN was subject to the existing CT Response exemption of the day. This conclusion is supported by witness statements of command elements of 1 NZSAS Regt and NZDF doctrine¹²⁸.

Was an appropriate risk management plan in place? Did it identify the risks, and if so, what steps were taken to mitigate or eliminate those risks? (including relevant PPE and safety officers).

- 64. 1 NZSAS Regt utilise a Unit Activity Hazard Register (UAHR) which is a database of anticipated risks and associated treatments by activity. It is a self-imposed, bespoke, Risk Management System. The risks are prepopulated, which in turn produces a computer generated UAHR. The relevant hazards are able to be selected and the risk is subsequently assigned, however if a new hazard or risk factor needs to be introduced this can be a complex task to insert into the system.¹²⁹ The UAHR system identifies the risk and the mitigation, and as such provides the Safety Officer and activity managers a framework of risk to be addressed and monitored during the conduct of the training. For Ex VBN it produced a 44 page UAHR. By comparisonS. 6(a), S. 6(b)(i) the respective RMP produced by the RNZAF were 1 page each.¹³⁰ PPE was appropriately worn for this activity.
- 65. 1 NZSAS Regt Minute 6641/1 NZSOF Unit Activity Hazard Register Scope of Implementation dated 10 Sep 18 signed by the CO 1 NZSAS Regt states that all activities that result in a mitigated risk of CRITICAL, or HIGH where the high risk is associated with Personnel or Live Firing, are to be approved by the CO. All other HIGH risk and below activities are to be approved by an OC. If a single hazard is required to be signed by the CO the entire UAHR must be approved by the CO.¹³¹
- 66. As per Exhibit AB showing DFO (A) Volume 7, Book 3, Chapter 6 Special Operations Training, Sect 2 Planning Safe Activities, Paragraph 6.2.1010 -1011, outlines that activity managers are responsible for ensuring that hazards are identified prior to any training being conducted. The Unit Activity Hazard Register (UAHR) is to be drafted, printed and signed when conducting:

¹²⁸ Witness 2, page 2, para A5, Witness 3, page 1, para A3, Witness 4, page 3, para A4, Witness 10, page 1, para A1, Exhibit AW, NZDDP 3.12, New Zealand Special Operations para 3.14.

¹²⁹ Witness 1, page 16, para A50.

¹³⁰ Exhibit AH; Exhibit AU; Exhibit AV; Exhibit R.

¹³¹ Exhibit AD; Witness 11, page 15, para A49.

- a. All 1 NZSAS Regt collective training activities;
- b. Activities involving personnel or assets from outside of 1 NZSAS Regt.
- 67. Three versions of the UAHR were submitted to the Court. Version 2 was dated 03 May 2019, Version 3 was dated 10 May 2019, and Version 4 was dated 17 May 2019 and signed by the CO on 19 May 2019. All versions required the CO's signature due to containing CRITICAL risk profiles. Throughout the iterations the CO required further refinement and improvement as the exercise progressed.¹³² The respective UAHR were constructed by the A Sqn OPSWO and checked by multiple people in the unit, including OC SOTC and the CO.
- 68. Version 2 of the UAHR dated 03 May 2019 was the version in use the day of the incident. Although Version 2 was not signed by the CO it was applied to the training events, including the Safety Officer who was briefed on the document prior to the activity.¹³³ Version 2 did not include a risk specific to 'bump' deployments as it was an impromptu activity, but it was included on later versions to be applied for the remainder of Ex VBN. Version 2 identified numerous hazards and associated means to mitigate those hazards, and whilst not specifically designed for the 'bump' many hazards could be applied, for example under the Air Mobile Operations section:¹³⁴
 - a. Fast Roping from Aircraft or Tower Falling from Height has an Uncontrolled Hazard Score of HIGH and a Residual Hazard Score of MEDIUM.
 - b. Night Vision Goggles Slips trips bumps and falls has an Uncontrolled Hazard Score of HIGH and a Residual Hazard Score of MEDIUM.
- 69. If the above examples were attributed to 'bump' training the resulting mitigation would have included measures such as 'ground training conducted prior to moving to height', 'teach correct techniques' and 'maintain solid points of contact whilst moving around at height'. The Court believes a disconnect exists given witnesses state that they viewed the 'bump' as a variation of a normal landing or Hover Jump as opposed to a new technique. As a result the commanders did not fully appreciate the risk profile; therefore did not associate it with the similar hazards annotated in the UAHR.
- 70. Post incident the 'bump' was added to the UAHR (Version 4) and resulted in an Uncontrolled Hazard Score of MEDIUM and a Residual Hazard Score of MEDIUM. With the benefit of hindsight, this means that the OC, or the TP COMD acting as OC/OIC was the appropriate level to authorise the activity if a standalone UAHR was drafted for that day's activities. The TP COMD did not have Version 4 of the UAHR available to him to refer to, therefore in lieu of such guiding documentation

¹³² Witness 15, page 2, para A7-A8; Witness 4, page 6, para A12; Witness 11, page 14-15, para A49.

¹³³ Witness 15, page 4, para A16.

¹³⁴ Exhibit AG, page 3, 5.

he could have sought guidance from training experts or command at 1 NZSAS Regt.

- 71. Ultimately a comprehensive Risk Management Plan (UAHR) was in place. That Risk Management Plan is the established Risk Management process in place at 1 NZSAS Regt. Version 2 of the UAHR was the current document in use on the day of the incident. This version was not signed. Ordinarily it is signed by the CO. On this occasion the CO had reviewed the document and asked for amendments; specifically the addition of foreign troops driving NZ roads and vehicles, civilian helicopter crash or collision impacts and A109 carriage of restricted items.¹³⁵ For this reason the UAHR remained unsigned at the time of the incident, however the existing content of the UAHR remained applicable having been subject to review by the CO. The CO signed Version 4 of the UAHR subsequently in the anticipation of future Ex VBN activities, however due to the nature of this system if anyone needed to make further amendments to suit future activities this could be done.
- 72. C/1-1 completed the US DD Form 2977 Deliberate Risk Assessment Worksheet on 03 March 2019. The mission description assigned is 'Fast Rope Insertion/ Extraction System (FRIES) Training, Vector Balance Net, 19-5516'. It identifies risks, hazards and controls for Fast Rope Operations and it emphasises the need for utilising a 'Crawl-Walk-Run methodology'. It does not include the 'bump'.¹³⁶ The fact that the 'bump' is not included further reinforces the likelihood that this training was not pre-planned but introduced on the day; had it been included it is more likely that a 'Crawl-Walk-Run Methodology' would have also been applied to that type of insertion.
- 73. 160 SOAR did not complete an additional helicopter specific risk assessment. Instead they reference the creation of the US SOF Ground Force risk assessment (Exhibit R) and indicate that it is sufficient. 160 SOAR were responsible for other mission briefings and documents, including the Aircraft Familiarisation Brief.¹³⁷ s. 6(a)

¹³⁵ Exhibit AH, UAHR Version 3.

- 136 Exhibit R.
- ¹³⁷ Exhibit AT, Report tab D, page 4-5.
- 138 Exhibit AT, Report tab C, page 4.
- 139 Witness 29.

- 74. Exhibit D is a minute from SOCC to the ACC requesting that CO 3 Sqn "collate a Risk Management Plan and manage all risks associated with the FTX VB19 Air Operations".¹⁴⁰ The Engagement Scoping Document FTX refers to the Field Training Exercise (FTX), encompassing all phases of Ex VBN.¹⁴¹ These initial scoping documents articulate a request from SOF elements for the RNZAF, notably 3 Sqn, to oversee the Risk Management of all air operations for Ex VBN. Witnesses 29 and 30 stated that due to resourcing constraints they believed they could not provide risk management of air operations for the entire exercise. Witness 30 stated he had subsequent discussions with ACC's staff about this and it was agreed that 3 Sqn would only support those phases that utilised NZ airframes;¹⁴² which were the Aerial Gunnery and the FMP activities.¹⁴³ This resulted in 1 NZSAS Regt, 3 Sqn, PTSU and C/1-1 each constructing separate unit Risk Matrices; which is also reflected in the 1 NZSAS Regt Exercise Instruction.¹⁴⁴
- 75. The Court has identified that with multiple Risk Management Plans in place there is potential for duplication or gaps to appear in certain areas. There were differing opinions as to which entity owned certain areas of risk. This saw the Risk Assessment of the aerial deployment of NZ Ground Forces by foreign aircraft, employing foreign procedures, on an exercise hosted in NZ, being conducted without collective oversight.
- 76. General Orders for NZDF Military Aviation Operations (Aviation Orders) provide a process to be followed when foreign military aircraft are being hosted in NZ. Specifically, it states that the NZDF has a duty of care to ensure that foreign crew members are appropriately briefed while in NZ, their flight intentions are understood and where possible their flying activities do not result in flight safety incidents.¹⁴⁵ Further, it provides a specific paragraph regarding foreign aircraft risk management. In that paragraph it states that NZDF members involved in planning or hosting foreign military aircraft should consider any additional flight safety risks that are particular to the visit, and raise those to the host Military Air Operator (Representative) via the Base Flight Safety Officer for consideration and action. This includes where a planned sortie profile by foreign forces aircraft does not conform to NZDF Aviation Orders.¹⁴⁶ This implies a sound knowledge of applicable aviation orders is required to make such assessments.
- 77. 1 NZSAS Regt was the hosting unit for Ex VBN, however was not organically resourced with the subject matter expertise to make the assessments described above. With this in mind Exhibit D requests 3 Sqn support to provide this expertise

¹⁴⁶ Aviation Orders Part 1, Chapter 2 – Command Leaflet E38 Hosting Foreign Military Aircraft, para 38.17.

¹⁴⁰ Exhibit D, page1, para 3(f).

¹⁴¹ Exhibit B, page 2, para 2b.

¹⁴² Witness 29; Witness 30.

¹⁴³ Witness 30.

¹⁴⁴ Exhibit E, page 5, para 19; Witness 1, page 6, para A14.

¹⁴⁵ Aviation Orders Part 1, Chapter 2 – Command Leaflet E38 Hosting Foreign Military Aircraft.

via the allocation of RNZAF aircraft and personnel.¹⁴⁷ Due to resourcing conflict within 3 Sqn the full suite of support requested by SOCC was not able to be delivered, nor was that request fulfilled by another appropriately qualified unit. This resulted in Phase 1 training not being appropriately understood or managed in a manner that could mitigate the risk associated with air operations as required by Aviation Orders.

78. Both Witness 29 and Witness 30 state they did not see benefit in 3 Sqn being present for activities that didn't involve them, however a NZSAS commander has articulated a Subject Matter Expert may have been helpful.¹⁴⁸ The technical aspects of Air Operations described above illustrate the requirement to employ a collaborative approach to the hosting of foreign force elements outside of single service/component areas of expertise. This was not fully realised for Ex VBN.

Was a safety brief given prior to the activity? If so by whom?

- 79. On arrival at AMTA the 160 SOAR Crew Chiefs gave an aircraft familiarisation brief which covered the aircraft safety aspects required for the conduct of Fast Roping and the 'bump'. There is potential that the two familiarisation briefs did not cover all techniques and procedures of the two deployment methods, but covered those aspects of aircraft safety required by the USSOCOM M 350-6.¹⁴⁹ Following the aircraft familiarisation brief the aircrew remained in place available for questions from the Ground Forces. The brief last approximately 40 minutes.¹⁵⁰
- 80. A conduct brief followed the aircraft familiarisation brief and was delivered by Witness 3. The conduct brief is not a Safety Brief in its own right, however it does lay out the range of activities to be conducted that day and how they will be organised. Witness 3 issued the brief along with the Sorties Board constructed by Witness 20. This shows the allocation of troops to airframes and sequencing of the progressive training serials.¹⁵¹ The 'bump' deployment was not included in the conduct brief, nor was it included in the Sorties Board. Witness 20 states that had he known about the intention to conduct 'bump' training he would have included it in that day's activities, including the Sorties Board.¹⁵²
- 81. The Safety Brief was delivered by the Safety Officer after the conduct brief and prior to live helicopter training commencing. The delivery of this brief was in accordance with DFO(A) Volume 7, Book 3, Chapter 6 Special Operations Training, Sect 2 Planning Safe Activities, paragraph 6.2.1003 Safe Training Rules.¹⁵³ The NZSAS Generic Tower

¹⁴⁷ Exhibit D, para 1.

¹⁴⁸ Witness 29; Witness 30; Witness 2, third interview.

¹⁴⁹ Witness 10, page 3, para A1.

¹⁵⁰ Witness 10, page 5, para A2.

¹⁵¹ Witness 10, page 3, para A1.

¹⁵² Witness 20, page 2-3, para A10, A16.

¹⁵³ Exhibit AB.

Brief¹⁵⁴ was used to brief the safety aspects of the Fast Roping planned for that day, which was deemed by 1 NZSAS Regt as being appropriate.¹⁵⁵ However, as the 'bump' was not a planned activity it was not included in the content of the brief.

Were there appropriate supporting agencies in place to support the activity?

82. No external agencies were required to support this specific activity.

Were extant Unit SOPs followed correctly (in planning and execution)? If not, why not?

- 83. 1 NZSAS Regt used the correct SOPs for the purpose of planning and conducting Ex VBN. Those SOPs did not extend to a 'bump' deployment as a 'bump' deployment is not currently a recognised technique. The 'bump' was not included in SOPs prior to the activity as it was not anticipated.
- 84. 1 NZSAS Regt equivalent of training SOPs were Standing Orders for Training (SOTs), which had been superseded by the draft DFO (A) Volume 7, Book 3, Chapter 6 Special Operations Training. These are still being validated and converted to DFO format. Paragraphs 54 – 58 of this document describe what is contained in this DFO.

Was a medical plan in place? If so, was it appropriate and in accordance with relevant orders, policies and procedures? If not, why not?

- 85. The exercise instruction included the medical plan, which was reviewed and signed by Witness 12, the Garrison Medical Officer.¹⁵⁶ The medical plan is contained in Exhibit E and is further described in paragraphs 121 124 of this document. The medical plan is in accordance with DFO (A) Volume 7, Book 3, Chapter 6 Special Operations Training, Section 2 Planning Safe Operations, paragraph 6.2.1008 Medical Plan.¹⁵⁷
- 86. Furthermore, the medical plan is in order with the AMTA Standing Orders 01/15 Part 1 Chap 1 Section 2 Medical Support. It clearly outlines the level of medical support provided; the primary, alternative and contingency methods of evacuation; the anticipated response times for each, and contact details of all key medical personnel and medical establishments in the vicinity of the activity.

¹⁵⁴ Exhibit T.

¹⁵⁵ Witness 11, page 22, para A71.

¹⁵⁶ Witness 12, page 2, para A7.

¹⁵⁷ Exhibit AB.

Were personnel involved in the activity suitably qualified and empowered for the roles and responsibilities they undertook during the activity?

- 87. Exhibit AT confirms that the 160 SOAR aircrew held the appropriate qualifications and currency requirements to plan and conduct their respective roles and responsibilities for this particular activity.¹⁵⁸
- 88. The Court has not received any evidence to suggest that members of C/1-1 were not appropriately qualified and trained to conduct Fast Roping as dictated by the USSOCOM M 350-6.
- 89. NZSAS Ground Force personnel were appropriately qualified and current to conduct Fast Rope deployments. NZSAS Ground Force personnel undertaking Fast Rope serials conducted the appropriate progressive build-up training on the Papakura Helicopter Tower¹⁵⁹ in accordance with DFO (A) Volume 7, Book 3, Chapter 6 Special Operations Training;¹⁶⁰ as well as the 'Crawl-Walk-Run' training serials on the day.
- 90. Due to 'bump' deployments not being a currently recognised helicopter deployment method taught on NZSOF courses, none of the NZSAS Ground Force could be deemed gualified to undertake that activity. S. 6(a), s. 6(b)(i)
- 91. Witness 10 and Witness 20 are qualified to be Air Mobile Safety Officers, as they have conducted the NZSOF Air Mobile course as part of the Cycle of Training, the NZSOF Air Mobile Dispatchers Course, and hold the appropriate rank.¹⁶² This meets the requirements outlined in DFO (A) Volume 7 Book 3, Chapter 6 Special Operations Training, Section 9 Air Mobile Operations paragraph 6.9.1007.¹⁶³
- 92. The Garrison Medical Officer confirmed that the RNZAMC Medic was qualified to conduct his duties.¹⁶⁴

Was the deceased appropriately qualified to undertake the activity? Had he received sufficient training to enable him to complete the activity safely?

93. Paragraphs 2 – 6 of this document and Exhibit S show that LCPL Kahotea was appropriately qualified to conduct Fast Roping having completed at least two

¹⁵⁸ Exhibit AT Report, tab D, page 2-4.

¹⁵⁹ Witness 3, page 4, 5, 9, para A11, A21.

¹⁶⁰ Exhibit AB.

¹⁶¹ Witness 6, page 4, para A7; Witness 5, page 2, para A5-6; Exhibit AT

¹⁶² Witness 10, page 1, 8, para A1, A19; Witness 11, page 13, para A31.

¹⁶³ Exhibit AB.

¹⁶⁴ Witness 12, page 7, para A37.

These

NZSOF Air Mobile courses. These courses include s. 6(a)

paragraphs also discuss LCPL Kahotea's experience working at height as well as with numerous helicopter platforms.

- 94. As discussed previously, the 'bump' deployment is not a current recognised helicopter deployment method taught on NZSOF courses, therefore LCPL Kahotea could not be considered appropriately qualified to conduct or lead a 'bump' deployment. Noting LCPL Kahotea likely received information on how to conduct a 'bump' during the initial aircraft familiarisation brief delivered by 160 SOAR crew, the Court considers this an acceptable start point towards certification. However, the next reasonable step in this process would have been for C/1-1 to lead progressive training. On the completion of that training it would have been for C/1-1 to validate that NZ Ground Forces are at an acceptable trained state, and for NZ Ground Force Commanders to authorise the advancement of the activity. This would have been the process for C/1-1 members conducting training on 3 Sqn aircraft. This would be consistent with DFO (A) Volume 7, which states that a progressive training methodology should be applied to meet the intent of safe training.
- 95. Witness 11 explains what a progressive approach to SOF training could look like for an activity such as a 'bump' deployment. It could include the following progression:¹⁶⁵
 - (a) Conduct ground familiarisation and dry rehearsals.
 - (b) Live serials by day in clean fatigue/light order at a safe height.
 - (c) Live serials by day in full equipment.
 - (d) Live serials by night in light order or full equipment.
 - (e) Incorporated into FMP activity.
- 96. The degree at which personnel could accelerate or consolidate training would be dependent on observed competence levels, initial trained state of participants, associated risk profile and the opinion of an appropriately experienced trainer. In this case that would include both NZSAS and C/1-1 trainers.
- 97. The Court acknowledges that even if the progressive approach noted in paragraph 95 was applied on the day it may not have had any bearing on the outcome of the incident.
- 98. A number of witnesses state that other deployment methods exist that provide transferrable skills, and that the repetitive nature of the training that day provided a level of familiarity with the MH-60M Blackhawk. The Court believes that this familiarity led to a level of confidence that allowed the team members to provide

¹⁶⁵ Witness 11, page 10, para A29.

feedback to their command that a night insertion in equipment could be conducted without further progressive training. The Court accepts that team members were confident in their ability to conduct this task by night. However, they had lost an opportunity to test and adjust how they deploy and other benefits of repetitive training by not conducting day serials.

POST-INCIDENT ACTIONS

Where and who were the personnel involved in the incident?

99. The units involved in the activity on the day of the incident include 1 NZSAS Regt, C/1-1 and 160 SOAR. A detailed list of individuals who were involved with the incident is included at Exhibit M.

What are the relevant policies, orders, or procedures that are applicable to the conduct of the activity?

- 100. This question has been answered during previous sections of this document. Pertinent orders that have been relied on in this report include the following:
 - (a) DFO(A) Volume 7, Book 3, Chapter 6.
 - (b) DFO(A) Volume 7, Book 1.
 - (c) DFO 36, Volume 1, Chapter 5, Operational Movements.
 - (d) USSOCOM Manual 350-6.
 - (e) General Orders for NZDF Military Aviation Operations Part 1, Chapter 2 Command, Leaflet 38 Hosting Foreign Military Aircraft.
 - (f) Ardmore Military Training Area Range Standing Orders 01/15 Part 3 (current on the day of the incident; now superseded).

Were there any deficiencies or weaknesses in any of the policies, orders or procedures identified above, that led to the incident?

101. The USSOCOM M 350-6 is used as a framework to govern the conduct USSOCOM SOF Rotary Wing training. It provides policy, procedures and a consolidated reference for SOF infiltration and exfiltration training. It was relied on by NZ Ground Forces, **s**. 6(a) , to provide the procedural framework required to govern Air Mobile training on US aircraft. It covers numerous techniques, including Fast Roping and Rappelling; however it does not cover the 'bump'. **s**. 6(a)

s. 6(a), s. 6(b)(i)



102. This view was a consistent theme throughout all of the witness interviews. The 'bump' was consistently described as 5. 6(a) where you 'just step off the aircraft'.¹⁶⁷ For these reasons it was considered a preferred method over Fast Roping. It is the Court's opinion that this led to the 'bump' being overlooked as a potentially dangerous deployment method, and was not allocated the full consideration it deserves. This perceived simplicity potentially led to individuals and commanders not conducting a full risk appreciation.

What reporting actions, both internal and external, were taken following this incident?

- 103. Immediately after the evacuation of the casualty the Safety Officer informed the 1 NZSAS Regt Orderly by cell phone. He secured the scene at the MOE House with two NZSAS operators until NZ Police could arrive. The Safety Officer moved all participants to the BTF and advised them as to what had occurred, and then instructed them to relocate and concentrate back at A Sqn hangar at Rennie Lines, PMC. The Safety Officer then went to Regt HQ to brief the CO.¹⁶⁸
- 104. Reporting from HQ 1 NZSAS Regt was initiated on notification from the Safety Officer, with the CO being at work when advised. Regt HQ informed SOCC and the Special Operations Component J3 verbally utilising the 5W's format. Incident Reporting and NOTICAS were subsequently sent to key NZDF staff and senior Commanders as per Exhibit F. An initial storyboard and subsequent updates were sent as per Exhibit G.
- 105. The sequence of informing family was initiated as follows:
 - (a) Primary Next of Kin as per NZDF SAP records and the unit Family Support Plan was LCPL Kahotea's current partner.¹⁶⁹ She was informed of LCPL Kahotea's incident and admittance to Auckland Hospital by the TP COMD from the Emergency Department.
 - (b) Alternate Next of Kin as per NZDF SAP Records was LCPL Kahotea's ex-partner s. 9(2)(a) She was informed of LCPL Kahotea's death in person by the CO and RSM.¹⁷⁰

¹⁶⁶ Exhibit AT, Report tab C, page 4.

¹⁶⁷ Witness 3, page 6, para A15; Witness 6, page para A7; Witness 16, page 4, para A13; Witness 17, page 6, 11, para A34, A72; Witness 24, page 2, para A14; Witness 19, page 3, para A18.

¹⁶⁸ Witness 10, page 11, para A23.

¹⁶⁹ Exhibit AM; Exhibit AL; Witness 4, interview 2, page 2, para A1.

¹⁷⁰ Exhibit AM; Witness 4, interview 1, page 12, para A25; Witness 4, interview 2, page 2, para A1.

- (c) Alternate Next of Kin as per the unit Family Support Plan differs from SAP Records and names LCPL Kahotea's mother as the alternate. The CO contacted her in s. 9(2)(a) ¹⁷¹
- (d) Casualty Next of Kin as per unit Family Support Plan was LCPL Kahotea's brother s. 9(2)(a) LCPL Kahotea's brother was contacted by the CO over the phone.¹⁷²
- A key role of the Casualty NOK is to support the informing of the Primary NOK and family. s. 9(2)(a)

COMD personally knew the Primary NOK and organised for her to be informed in order to get her to the Emergency Department quickly.¹⁷⁴

the TP

- 107. The NZDF Chief Medical Officer was consulted later that night by the CO to seek advice on matters of process regarding NZDF responsibilities relating to Coronial Inquiry.¹⁷⁵
- 108. The Papakura Military Police (MP) Station Commander was informed by 1 NZSAS Regt HQ of the incident at 2135 hours. The MP Station Commander then notified the NZ Police who had not yet been contacted. Of note, the NZ Police were not informed of the incident as part of the emergency call to 111. The MP arrived on the scene at approximately 2200 hours taking over from two sentries placed there by the Safety Officer. He maintained the cordon until NZ Police arrived to commence their scene examination.¹⁷⁶ S. 9(2)(ba)(i)

Witness 13 and the MP Station Commander were useful when coordinating actions between NZDF MP's, NZ Police, and exercise participants.

¹⁷⁷ Witness 13, page 1, para A1.

¹⁷¹ Exhibit AL; Witness 4, interview 1, page 12, para A25; Witness 4, interview 2, page 2, para A1.

¹⁷² Exhibit AL; Witness 4, interview 1, page 12, para A25; Witness 4, interview 2, page 2, para A1.

¹⁷³ Witness 4, interview 2, page 2, para A1.

¹⁷⁴ Witness 3, interview 1, page 17, para A33.

¹⁷⁵ Witness 4, interview 2, page 2, para A1.

¹⁷⁶ Witness 14, page 1, para A1.

INJURIES

What were the injuries sustained by the deceased?

109. Exhibit AS is the Coronial Autopsy Report submitted by the Pathologist. That report lists the injuries in detail. Broadly those injuries include: catastrophic head injuries and multiple bone fractures.

110. s. 9(2)(a)

The Pathologist noted that a primary impact to the skull can transfer energy along the middle structures causing injuries to the neck, vertebrae and ribs.¹⁷⁸

What was the direct cause, if any, of death?

- 111. The Coroner will ultimately determine the cause of LCPL Kahotea's death. However, the Pathologist identified the direct cause of death to be blunt force head and neck injury.¹⁷⁹ In the opinion of the Pathologist this is consistent with falling from significant height and hitting the ground head first and coming to rest.¹⁸⁰
- 112. There is no evidence in the Pathologist report that alcohol or drugs contributed to death.¹⁸¹ Other than the injuries sustained from the incident LCPL Kahotea was deemed healthy.¹⁸²

Who provided medical treatment to the deceased and where did this treatment take place?

- 113. No less than seven medically trained personnel attended to LCPL Kahotea from the time of the incident to the time he was handed over at Auckland Hospital. Upon finding out that LCPL Kahotea had fallen TM1, MWD and TM2 tended to LCPL Kahotea immediately where he lay. TM1 and MWD are NZSAS Patrol Medic qualified.¹⁸³
- 114. TM1 and MWD were shortly joined by TM5, additional NZSAS Patrol Medics from A Sqn, the RNZAMC Medic, the C/S Hawk 62 Flight Medic and the US C/1-1 18D Advanced Medic.¹⁸⁴ All NZSAS members attending were NZSAS Patrol Medic qualified. The

- 182 Witness 4, page 7, para A15.
- ¹⁸³ Witness 16, page 14, para A54-A56.
- 184 Witness 16, page 12-13, para A53.

¹⁷⁸ Witness 27, page 1-2, para A3-A4.

¹⁷⁹ Exhibit AS, page 3.

¹⁸⁰ Witness 27, pages 4 -7, para A12-14 & A21-23.

¹⁸¹ Exhibit AS, page 4.

RNZAMC Medic was the designated medic for the practice.¹⁸⁵ The US 18D is a US Special Forces Medical Sergeant, and the C/S Hawk 62 Flight Medic is trained to provide medical support in the MH-60M Blackhawk.¹⁸⁶

- 115. Once C/S Hawk 62 was reconfigured for casualty evacuation LCPL Kahotea was secured on the splint board and transferred to the aircraft. The C/S Hawk 62 Flight Medic, the C/1-1 18D Advanced Medic, TM5 and the RNZAMC Medic accompanied LCPL Kahotea in the aircraft to the Auckland Hospital Helicopter Pad.¹⁸⁷
- 116. Once inside the Emergency Department the C/1-1 18D Advanced Medic, the RNZAMC Medic, TM5 hand over LCPL Kahotea to ED staff, but then remain to assist ED staff under their direction and supervision.¹⁸⁸

What actions were taken regarding the treatment of the injuries to the deceased, and were these in accordance with best medical practice? If not why not?

- 117. LCPL Kahotea was administered significant concurrent medical treatment. That treatment began at the incident site, continued during transit to Auckland Hospital and ceased only when he was pronounced dead in the Emergency Department Theatre. Broadly, the medical treatment administered by military medics included the following:
 - (a) Incident site Assessment and initial survey, Nasopharyngeal airway (NPA) attempt, oral airway attempt, Cricothyrotomy (CRIC) attempt and second successful Cricothyrotomy (CRIC), AED defibrillation, Capnography application (US equipment not held by NZDF medics), assisted breathing via bag, CPR and secured to a splint board for transit.¹⁸⁹
 - (b) On-board C/S Hawk 62 in transit CPR continued, airway maintained and AED defibrillation applied approximately three times.¹⁹⁰
 - (c) In the Emergency Department hand over to Auckland Hospital staff and provided assistance with ongoing CPR as directed by Emergency Department technicians. LCPL Kahotea met the threshold for trauma surgery. That threshold was that his circulatory system was able to operate independently for one minute.¹⁹¹
- 118. The Papakura Garrison Medical Officer commented that all medical treatment was in order with best practice, and the medical treatment applied was spectacular. She noted that all medics worked well as a team, were well prepared, and reacted promptly and effectively. They also reacted well to a situation involving one of their own, which can

¹⁸⁵ Exhibit T.

¹⁸⁶ Witness 3, interview 1, page 18, para A36; Witness 10, page 15, para A39.

¹⁸⁷ Witness 22, page 6, para A38; Witness 16, page 14, para A53.

¹⁸⁸ Witness 22, page 6, para A38.

¹⁸⁹ Witness 18, page 10, para A54; Witness 16, page 12-14, para A53.

¹⁹⁰ Witness 18, page 10, para A54; Witness 22, page 5-7, para A32, A37-A38.

¹⁹¹ Witness 3, page 17, para 33.

often be a very difficult circumstance. Handover to hospital staff was thorough and succinct and the medical team integrated well with the hospital medical team.¹⁹² The Chief Medical Officer in the Auckland Hospital described LCPL Kahotea's injuries as unsurvivable and the medics had done well to maintain a faint pulse.¹⁹³

What process was followed post-incident to request medical assistance?

- 119. Upon ascertaining that LCPL Kahotea had fallen the Safety Officer categorised the casualty as Priority 1 and immediately called 111. Concurrently, the Safety Officer requested that C/S Hawk 62 be reconfigured for casualty evacuation. The Safety Officer had to hang up on the 111 operator as the conversation was becoming confused and priority had to be given to liaising with the C/S Hawk 62 aircrew. Once liaison was completed the Safety Officer called 111 back and updated them on the situation. The Safety Officer asked to be placed in contact with Auckland Hospital as by that time plans were being formulated to utilise C/S Hawk 62 to transport LCPL Kahotea directly to hospital. 111 staff were unable to oblige, so the Safety Officer rung the Emergency Department directly and initiated direct liaison. The Safety Officer handed his phone to MWD providing medical support to initiate patient hand over to the ED Doctor.¹⁹⁴
- 120. The Safety Officer established contact with 111 a third time to ensure a ground casualty evacuation option was still a viable option. A runner was sent to the corner of Petersons Road as it can be difficult to locate the MOE House within the AMTA. Once C/S Hawk 62 was airborne the Safety Officer rang the Emergency Department staff a second time where he handed the phone back to MWD to pass the final patient treatment information.¹⁹⁵ All communication with emergency services was conducted via cell phone.

Was the medical evacuation process in accordance with relevant orders, policies and procedures? Was the medical evacuation conducted in accordance with correct procedure?

121. The medical plan contained in the Exercise Instruction was approved by the Garrison Medical Officer and is constructed in accordance with DFO(A) Volume 7, Book 3, Chapter 6 Special Operations Training, Section 2 Planning Safe Training, paragraph 6.2.1008.¹⁹⁶ AMTA Standing Orders 01/15, Part 1, Chapter 1, Section 2 Medical Support and CASEVAC Procedures covers medical considerations to be adhered to. Paragraph 1205 allows consideration to use of NZDF helicopters for Casualty Evacuation (CASEVAC) if configured to take patients and activity managers should seek advice on this. Following that logic an appropriately configured US helicopter could also be used.

¹⁹² Witness 12, page 8, para A40.

¹⁹³ Witness 3, page 17, para A33.

¹⁹⁴ Witness 10, page 11-13, para A23-A28.

¹⁹⁵ Witness 10, page 11-13, para A23-A28.

¹⁹⁶ Exhibit AB; Exhibit E, Annex H.

- 122. The Medical plan states that a Priority 1 casualty requires immediate evacuation by the quickest means to the nearest civilian hospital as advised by 111. The PACE plan annotated in the Exercise Instruction Medical Annex is as follows:
 - (a) Primary Notification of an incident is to be made via cell phone to national emergency service. Immediate air or road evacuation to be effected utilising Rescue helicopter or Ambulance at civilian services discretion.
 - (b) Alternate Organic move to safety vehicle, utilise safety vehicle to move to the nearest medical facility with civilian emergency services. (Note this is the primary method for P3 casualties)
 - (c) Contingency In the event that civilian evac assets aren't available for P1 or P2 Casualty it is possible for RWCASEVAC to occur using organic airframes if a time saving of >90 mins can be expected. Contingency evac should only be undertaken on recommendation of medic.
 - (d) Emergency Utilising the most appropriate of the above methods.
- 123. The MH-60M was to be used for Rotary Wing CASEVAC if the primary means of civilian Aeromedical Evacuation (AME) or ground evacuation is unavailable or a timesaving of more than 90 minutes could be expected. The logic behind having civilian (Westpac Helicopter) evacuation as the primary means is due to requiring the airframe to be capable of patient transfer and an appropriately trained medical professional on-board.¹⁹⁷ This is not always the case with organic helicopter assets being used for NZ based training. In this case there was an appropriately trained medical professional (the US C/S Hawk 62 Flight Medic and the US C/1-1 18D Medic) able to provide in-flight treatment, and C/S Hawk 62 was the designated evacuation airframe (once re-configured). Additionally, the US aircrew and medical staff had conducted liaison with Base Medical Flight Whenuapai, conducted a reconnaissance of Auckland Hospital, its associated landing pad, and the alternate landing site in the Auckland Domain nearby during the planning phase.¹⁹⁸
- 124. The Safety Officer made the decision to employ C/S Hawk 62 for CASEVAC due to: the Blackhawk being in location, the appreciation that the Westpac helicopter would have to land at the AMTA Range 300m mound which would require transporting the patient from the MOE House to that location, the AMTA Range by night is a difficult place to direct the unfamiliar aircraft to given its lack of lighting and concerns around additional delay this might incur.¹⁹⁹ It is the opinion of the Court that the Safety Officer applied the Casualty Evacuation Plan correctly based on the assessment of the casualty.

¹⁹⁷ Witness 11, page 22, para A72.

¹⁹⁸ Witness 3, interview 1, page 15, para A33.

¹⁹⁹ Witness 10, page 12, para A24.

Released under the Official Information Act 1982

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Comment on any other matters the Court considers relevant to the purpose of the Inquiry.

125. s. 6(a)

126. Whilst not specifically outlined in the Terms of Reference or the interviews, the Court noted a particular enthusiasm to pursue robust and realistic training in an effort to make individuals and teams better. This is not necessarily a NZSAS-only trait, and commonly exists throughout the NZDF. However, consideration should be given to systematic themes around this topic and the appetite to pursue training opportunities, potentially to the detriment of individuals or the organisation.

CONCLUSIONS

127. Exercise Vector Balance Net 2019 (Ex VBN) was a S. 6(a)

activity involving 1st NZSAS Regiment (1 NZSAS Regt); No 3 Squadron (3 Sqn) and Parachute Training Support Unit (PTSU) RNZAF; US C Company, 1st Battalion, 1st Special Forces Group (C/1-1); and US 160th Special Operations Aviation Regiment (160 SOAR). Phase One Integration Training was planned over the period 04 -12 May 2019 which included helicopter insertion training at Ardmore Military Training Area, Auckland, New Zealand.

- 128. On 08 May 2019 at 1947 hours LCPL Kahotea fell while undertaking a 'bump' helicopter insertion onto the roof of the Method of Entry (MOE) house. The injuries sustained due to the fall resulted in his death which was declared at Auckland Hospital at 2100 hours that night.
- 129. A Single-Point Wheel 'bump' is a subcategory of a Helicopter Rooftop Single-Point Landing. In this method the helicopter hovers beside and 'bumps' the front wheel against the edge of a rooftop allowing for lateral insertion of troops onto a structure.
- 130. The Coroner will ultimately determine the cause of death. However, the Pathologist identified the direct cause of LCPL Kahotea's death to be blunt force head and neck injury. In his opinion this is consistent with falling from significant height and hitting the ground head first and coming to rest.
- 131. The exact cause of LCPL Kahotea's fall could not be determined by the Court. LCPL Kahotea was last seen in the middle of the helicopter on his knee preparing to exit the helicopter. Shortly after he was observed falling vertically between the MOE house and the helicopter. The evidence supports that LCPL Kahotea initiated a planned exit from the aircraft but was unable to land successfully on the MOE house roof and instead fell.
- 132. The Court has been able to discount the following as contributing factors to his fall: excess aircraft movement during his exit, personal equipment failure, or interference by the Military Working Dog.
- 133. It is the Court's opinion that the fall was most likely due to a misstep whereby LCPL Kahotea either did not locate the edge of the airframe, did not locate the roof, or when landing on the roof tripped on a stanchion.
- 134. The Court is unable to rule out a snag or trip within the aircraft contributing to the misstep.

Experience.

135. LCPL Kahotea was an experienced NZSAS operator and junior commander. He was fully qualified by course to undertake air mobile operations, and trained and experienced to work at height within a military context. As the 'bump' is not a recognised NZDF rotary wing insertion technique LCPL Kahotea was not previously trained, experienced or qualified to conduct 'bump' insertions.

Planning.

- 136. The planning conducted for Ex VBN was detailed and in accordance with normal expectations. The inclusion of 'bump' training was unexpected and impromptu, and therefore not included in the deliberate planning process.
- 137. When the 'bump' was introduced by 160 SOAR there was an opportunity for all NZ and US participants to pause and reassess the training requirement but this did not occur.

138. s. 6(a)

139. Further, directly prior to night training iterations the opinion of all participants was sought regarding the degree of comfort to proceed with night iterations of both Fast Roping and 'bump' serials. On receipt of this feedback, NZ and US commanders then collectively agreed it was safe and appropriate to proceed, despite the fact that two NZ teams had not conducted a 'bump' deployment by day.

Foreign Forces Training and Interoperability

- 140. 1 NZSAS Regt was the hosting unit for Ex VBN. However, when integrating foreign forces who contribute capabilities that span multiple component areas of responsibility the Regt is not resourced with the subject matter expertise; most notably with respect to rotary wing operations.
- 141. Due to a resourcing conflict, 3 Sqn was unable to provide the support requested by the Special Operations Component Commander, nor was that request fulfilled by another appropriately qualified unit. Because of this a comprehensive joint approach to achieve effective planning, interoperability and integration of participating elements was not fully realised for Ex VBN.

Risk Management

- 142. Multiple units developed individual Risk Management Plans for Ex VBN. The Court believes that an exercise such as this; with multinational air and ground elements, conducting dynamic training by day and night, would greatly benefit from multiple advisors at appropriate rank and experience in the exercise location. This was not the case for Ex VBN.
- 143. 1 NZSAS Regt produced the Unit Activity Hazard Register for Ex VBN. At the time of the incident Version 2 was in effect, however remained unsigned due to inclusion of additional unrelated risks. 3 Sqn and PTSU provided specific activity focussed Risk Management Plans for subsequent phases. C/1-1 provided a Deliberate Risk Assessment Worksheet which pertained solely to Fast Roping. 160 SOAR did not provide a Risk Management Plan, instead relying on the C/1-1 risk assessment.

- 144. General Orders for NZDF Military Aviation Operations (Aviation Orders) contain specific reference to foreign aircraft risk management. As the exercise host 1 NZSAS Regt was not adequately resourced to fully appreciate the extent of these orders. While 3 Sqn was involved in some parts of the Ex VBN planning, there was no NZ rotary wing subject matter expert present during Phase One to assist with aviation risk assessment and compliance with Aviation Orders.
- 145. It is evident that an overarching Risk Management Plan would have been more appropriate given the range of activities to be conducted. Regardless of all Risk Management Plans in place, none included the 'bump' deployment. s. 6(a)

Qualifications and Currency

- 146. US Forces held the appropriate qualifications and currency requirements to plan and conduct their respective roles and responsibilities for this particular activity, s. 6(a)
- 147. 1 NZSAS Regt Ground Force personnel were appropriately qualified and current to conduct Fast Rope deployments. However, they are not trained, experienced, or qualified in 'bump' deployments.
- 148. The appointed Safety Officers were qualified by course and rank to be Air Mobile Safety Officers. The RNZAMC Medic was fully qualified to conduct his duties.

Training Conduct

- 149. On arrival at AMTA the 160 SOAR Crew Chiefs gave an aircraft familiarisation brief which covered the aircraft safety aspects required for the conduct of Fast Roping and the 'bump'.
- 150. A Conduct Brief followed the aircraft familiarisation brief and outlined the range of activities to be conducted that day, including the allocation of troops to airframes and sequencing of the progressive training serials for Fast Roping only.
- 151. The Safety Brief was delivered by the Safety Officer after the conduct brief and prior to live helicopter training commencing. This brief was delivered in accordance with DFO(A) Volume 7, Book 3, Chapter 6 Special Operations Training. However, as the 'bump' was not a planned activity it was not included in the content of the brief.
- 152. A progressive training approach was applied to Fast Roping serials. S. 6(a)

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- 153. The Court acknowledges that even if the progressive approach noted in paragraph 95 was applied on the day it may not have had any bearing on the outcome of the incident.
- 154. In the Court's opinion the decision to not apply a progressive training approach was due to a general assessment by all participants s. 6(a)

There was a common theme throughout all witness interviews of those who attended the training that the dangerous activity was Fast Roping, and that 'bump' deployments were 'just like stepping off the aircraft' for a normal landing. This leads Court to believe that a general level of over-confidence existed, negating the thought to conduct a full appreciation of the insertion technique, the trained state of the participants and the effects of a potential change in deployment location. This level of comfort lead to the decision to conduct night 'bump' serials without preceding day time progressive training.

155. s. 6(a)

The location changed

from the northern edge to the western edge of the rooftop. The northern edge was utilised by day with a one storey approximately 5m height risk. The western edge insertion point by night increased to a two storey 10m height risk. The Pathologist assessed the 10m height risk as being significant enough to cause the traumatic and fatal head injuries. The Pathologist and the court surmise that had he fallen the height of a single storey his chances of surviving the fall would have been far greater.

156.s. 6(a)

Counter Terrorism Training

157. s. 9(2)(h) the Exercise Instruction states Ex VBN was not a declared operational activity for the purpose of Section 7 of the Health and Safety at Work Act 2015. The Court believes this is an error as the training conducted was CT in nature. The planning documents for Ex VBN identify the exercise intent to be Expeditionary Counter-terrorism in nature. s. 6(a)



Defence Force Orders and Manuals

158. The exercise was appropriately governed by the following orders and manuals: DFO(A) Volume 7 Training, USSOCOM Manual 350-6, Aviation Orders, Ardmore Military Training Area Range Standing Orders 01/15. ^{s. 6(a)}

Medical Response

- 159. No less than seven medically trained personnel attended to LCPL Kahotea. This included four NZSAS Patrol Medics, one RNZAMC Medic, the 160 SOAR Flight Medic and the US C/1-1 Advanced Medic.
- 160. LCPL Kahotea was administered significant concurrent medical treatment from initial incident through to handover to the Auckland Hospital Emergency Department. Treatments included Cricothyrotomy, AED defibrillation, Capnography, assisted breathing via bag and CPR.
- 161. The Papakura Garrison Medical Officer commented that all medical treatment was in order with best practice, and the medical treatment applied was spectacular. She noted that all medics worked well as a team, were well prepared, and reacted promptly and effectively. Handover to hospital staff was thorough and succinct and the medical team integrated well with the hospital medical team.
- 162. The Chief Medical Officer in the Auckland Hospital described LCPL Kahotea's injuries as un-survivable and the medics had done well to maintain a faint pulse.
- 163. Casualty evacuation (CASEVAC) was conducted via MH-60M Blackhawk reconfigured for this role including inclusion of the 160 SOAR flight medic. The Safety Officer made the decision to employ the Blackhawk based on: the severity of LCPL Kahotea's condition, and the delay with using civilian CASEVAC options. It is the opinion of the Court that the Safety Officer applied the Casualty Evacuation Plan correctly based on the assessment of the casualty.

164. This CASEVAC decision was made possible by prior planning by 160 SOAR including on-site reconnaissance of Auckland Hospital and liaison.

Next of Kin Notification

165. The Next of Kin (NOK) notification was informed by two documents; NZDF SAP records and NZ Army Family Support Plan. These documents identified different NOK points of contact convoluting the notification process. Further, 1 NZSAS Regt could not fully control the informing process due to other members of LCPL Kahotea's team, who had personal relationships with family members, took it upon themselves to inform those family members as soon as possible.

Reporting

- 166. Critical Incident Reporting, NOTICAS and associated Storyboards were constructed and distributed promptly by 1 NZSAS Regt HQ to key NZDF Commanders following the incident. The Safety Officer was required to liaise with multiple emergency services whilst concurrently controlling the incident site.
- 167. The Military Police liaised directly with NZ Police as NZ Police weren't informed by the 111 operators. Once NZ Police had taken control of the scene they were able to conduct independent investigation on behalf of the Coroner.

Summary

168. LCPL Kahotea's death is a tragic loss to his family, the NZSAS and the wider NZDF. His service history is one his family and his unit can be proud of. Ex Vector Balance Net had presented a continuation of that proud record where he was leading a team of Special Forces soldiers in an exercise of national importance. Instead it unfortunately resulted in the death of one of NZDF's talented NCO's.

Administration of the Court

- 169. The Court convened in Papakura Military Camp on 13 May 2019 in accordance with the Order for the Assembly of a Court Of Inquiry (MD 634). Throughout its investigations the Court has been well supported, being provided access to witnesses, exhibits and clerical assistance.
- 170. The Court issued rights to five people under Section 200N of the AFDA 1971, as per page 4 of this report. Witness 3 elected to make a formal statement in response to material provided to him, however this statement did not affect the findings of the Court. The remainder of those afforded Section 200N Rights have elected not to make further comment.
- 171. At no time during the conduct was the Court unable to convene under Section 200G of the AFDA 1971.
- 172. Family engagement has been conducted with those family members identified as Next Of Kin by LCPL Kahotea. s. 9(2)(a)

- 173. This Report identifies key personnel involved in the incident. Due to the nature of some individual's employment their identity will require redaction for reasons of operational security.
- 174. The Exhibits and Witness Statements contain the identity of individuals and other sensitive operational information and should not be released without authority of the Convening Authority and appropriate redaction for reasons of operational security.

Family engagement



- 177. LCPL Kahotea's family elected to provide a written response to the Assembling Authority. That response has been reviewed by the court, included in the record of proceedings and provided to the Assembling Authority. Having reviewed the written response the court is satisfied there is no requirement for further investigation or amendment of the proposed recommendations.
- 178. s. 9(2)(a)

RECOMMENDATIONS

179. The Court recommends Chief of Army:

- (a) **Note** that the Court does not see any requirement to cease Air Mobile training as a result of this incident.
- (b) Note that the Court does not see any requirement to cease ^{s. 6(a)} as a result of this incident.
- (c) Direct a review be conducted of current orders and directives concerning the integration of NZDF personnel with foreign forces who use techniques and equipment the NZDF is unfamiliar with, and reporting back on their suitability.
- (d) Request COMJ allocate the subject matter experts to any unit when they are hosting foreign forces who contribute capabilities that span multiple component areas of responsibility. This is in order to ensure risk can be identified and managed by component subject matter experts; and an overarching Risk Management Plan can be formulated.
- (e) Request CAF to consider the incorporation of a wider Airland suite of Air Mobile infiltration capabilities.
- (f) Request Director of Defence Legal Services to conduct a review of the legal advice for Exercise Vector Balance Net.
- (g) s. 6(a)
- (h) Direct Commander JSG to report back on the feasibility of introduction into service of first responder Capnography equipment.
- (i) Direct a review of orders and directives concerning provision and maintenance of personnel family support plans. Specifically, the articulation of appropriate process for informing Next of Kin and family on the occurrence of death or serious injury.
- (j) Write letters of appreciation to the releasing authority of the US Air Safety Investigation. Names will be provided by the COI President.
- (k) Write letters of appreciation to those US and NZ personnel who assisted in the care and evacuation of LCPL Kahotea. Names will be provided by the COI President.
- (I) Consider if the content of this report affects or is likely to affect the character or reputation of any other person in accordance with section 200N of the Armed Forces Discipline Act.

- 180. The Court recommends SOCC:
 - (a) Direct 1 NZSAS Regt to develop a training package for likely Airland insertion techniques, including the 'bump' deployment, in order to develop a skillset which will likely be used when working with foreign forces.
 - (b) Direct 1 NZSAS Regt to reassess the requirement of the protruding metal stanchion on the roof of the MOE House, with a view to mitigating the trip hazard.
 - (c) Direct 1 NZSAS Regt to conduct a full safety assessment of the MOE House to ascertain whether further safety measures could be installed to mitigate an unintended fall from height; notably from the second storey rooftop.
 - (d) Direct 1 NZSAS Regt to conduct refresher training on DFO (A) Volume 7, Book 3, Chapter 6 Special Operations Training, Section 2 Planning Safe Training.
 - (e) **Direct** 1 NZSAS Regt to include dedicated Airmobile Safety Brief and Safety Officer Check List into DFO (A) Volume 7, Book 3, Chapter 6 Special Operations Training.
 - (f) Direct 1 NZSAS Regt to establish a servicing schedule s. 6(a)
 - (g) Ensure the lessons learned from this incident are disseminated to all units likely to integrate with foreign forces who contribute capabilities that span multiple component areas of responsibility. This is in order to ensure lessons are identified and applied for future training activities.

on		2020
President	s. 9(2)(k)	s. 9(2)(a)
	s. 9(2)(a)	
Members	s. 9(2)(k)	s. 9(2)(a)
	s. 9(2)(a)	
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20190513 Army 364

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ASSEMBLING AUTHORITY COMMENTS: COURT OF INQUIRY INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF S1019698 LCPL N.R. KAHOTEA, 1 NZSAS REGT DURING EXERCISE VECTOR BALANCE NET ON 8 MAY 2019

Reference:

A. Record of proceedings, 20190513 Army 364

1. Ref A is a Court of Inquiry (Col) into the circumstances surrounding the death of S1019698 LCPL N.R. KAHOTEA (Nik), 1 NZSAS Regt during Exercise Vector Balance Net on 8 May 2019. I have considered the findings and recommendations of Ref A. Given the Col inquired into a significant matter, I sought an External Legal Review of Ref A in accordance with the President's and Assembling Authority's Guide to Courts of Inquiry ('the Col Guide').

2. The CoI has inquired into a complex and difficult matter. The investigation was robust and the findings and recommendations well considered. With one important exception, the findings of the CoI are accepted. My comments will therefore focus on this one exception, as well as procedural aspects and ancillary matters.

A contributing factor to Nik's fall

The Court's finding

3. The Col was not able to definitively conclude what caused Nik's fall, however the Col found that it was able to discount "excess aircraft movement" during Nik's exit from the helicopter as a contributing factor to his fall.¹

4. The following excerpt is the basis for the Col's finding:²

The RNZAF Air Safety representative on the US Air Safety Investigation, recalls seeing the aircraft location and tail boom orientation data, and concluded that aircraft movement was within normal tolerances. This leads the Court to believe that the airframe was stable and did not significantly deviate from its settled position on the building. Both TM1 and MWD deployed themselves easily from the seated position on the edge of the Blackhawk floor, and neither saw LCPL Kahotea fall.

5. The Col goes on to say, in respect of TM3 (who was meant to exit the helicopter after Nik):³

It was once he was in the door that he saw the gap between the airframe and the rooftop had opened up to approximately 1 m. [...] The Court believes this gap is a result of the pilot being made aware of LCPL Kahotea's fall and the pilot was already pulling away from the building to land.

^{6.} The Col also notes:⁴

¹ Ref A, para 132.

² Ref A, para 31.

³ Ref A, para 35.

⁴ Ref A, para 125.

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s. 6(a)			

7. For the reasons set out below, my assessment of what was likely a contributing factor to Nik's fall differs to what the Col found. Given this is a crucial aspect of the Col's findings, it is important I set out the reasoning for my differing view in detail.

The CCTV footage shows downward movement of the helicopter tail

8. It is apparent from the CCTV footage that there is discernible downward movement in the tail of the helicopter at the moment instantly prior to, or at, the time that Nik would have expected to have egressed onto the rooftop.⁵ TM2 was the person who exited the helicopter before it was Nik's turn. The video footage indicates downward movement of the tail of the helicopter immediately after the silhouette of TM2 appears on the rooftop and when it would be expected that Nik would exit the aircraft. It is *then* a number of seconds before the helicopter moves away from the building.

Witness statements indicate horizontal movement away from the building

9. The statements provided by witnesses about the gap between the helicopter and the building strongly indicate that horizontal movement away from the building occurred leading up to, or at the moment of, Nik's exit from the helicopter (and that this movement occurred before the helicopter moved away from the building to land). This assessment is based on the following evidence:

- a. The first three troops to exit and the military working dog were able to deploy themselves easily off the helicopter from the seated position on the edge of the helicopter floor.⁶
- b. TM1 was the first to exit. S. 9(2)(ba)(i)
- c. MWD, who exited S. 9(2)(ba)(i) with TM1, also recalls that his feet were able to touch the roof of the building from his seated position on the aircraft ^{S. 9(2)(ba)(i)}
- d. TM2 was the third to exit. TM2 described a gap between the helicopter and the roof of the building of "about one foot".¹¹
- e. Nik was the next to exit. The ground force commander (21C) was watching from a distance of 75 metres away and described being able to make out silhouettes exiting

⁵ Exhibit P, 4min 30 sec timestamp.

⁶ Report, paragraphs 31 and 34.

⁷ TM1's Police statement of 10 May 19; TM1's Col statement of 10 Oct 19 at A17:s. 9(2)(ba)(i)

⁸ TM1's Col statement of 10 Oct 19 at A21.

⁹ MWD Col statement 24 May 19, A21.

¹⁰ MWD Col statement of 24 May 19 at A21, MWD's police statement of 9 May 19.

¹¹ TM2's Police statement of 9 May 19; see also TM2's Col statement of 29 Nov 19 at A37.

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the aircraft: s. 9(2)(ba)(i)

12

f. TM3 was meant to be the fifth person to exit and was meant to exit after Nik (but did not observe Nik's egress or subsequent fall). As TM3 approached the edge to exit, TM3 noticed the gap between the aircraft and the building was about one metre.¹³ TM3's statements immediately after the incident state that, upon reaching the edge of the helicopter, he noticed a gap of around one metre and decided not to exit on that basis. TM3 states that around five seconds later he was stopped from exiting by a crew member, and *then* the helicopter moved away.

TM3's evidence

10. The Col acknowledges TM3's account of the one metre gap, but says.¹⁴

The Court believes this gap is a result of the pilot being made aware of LCPL Kahotea's fall and the pilot was already pulling away from the building to land.

11. In my assessment this inference is not supported by the evidence of TM3. TM3's evidence immediately after the incident was that, upon reaching the edge of the aircraft, he noticed a gap of approximately one metre and on that basis he decided not to exit the aircraft. Around five seconds later CC2 stopped him, and *then* the helicopter moved away. In particular, the relevant excerpts of TM3's evidence is as follows:

¹² 21C's Police statement of 9 May 19.

¹³ TM3's Police statement of 9 May 19; TM3's second Police statement of 10 May 19, After Action Review Notes of 10 May 19 (Exhibit AK).

¹⁴ Ref A, para 35.

¹⁵ TM3's Police statement of 9 May 19.

¹⁶ TM3's second Police statement of 10 May 2019.

¹⁷ Exhibit AK, E-3-4 at [26].

TM3's evidence corroborated by other witnesses

12. TM3's recollection of the sequence of events is corroborated by several witnesses, including TM2, one of the ground forces who did not ultimately exit the helicopter (TM5), S. 6(a) (P1), CC2, and CC1:¹⁸

s. 9(2)(ba)(I)

13. Furthermore, on the night of the incident TM2 made a personal note in which he recorded under the heading "Sequence of events":

s. 9(2)(ba)(i)

Reconciling the RNZAF Liaison Officer's evidence with the evidence of TM3 and others

14. The RNZAF Liaison Officer to the US Investigation Team (RNZAF LO) was given the opportunity to listen to the cockpit voice recorder. His description of what he heard confirms that CC2 had stopped the troops from exiting *before* the helicopter pulled away:¹⁹

¹⁸ In respect of TM5, TM5's Col statement of 27 May 19; in respect of P1, P1's Col statement of 21 May 19 at A3; in respect of CC2, CC2's Col statement of 21 May at A28, A29, A35, A54; in respect of CC1, CC1's Col statement of 20 May 19 at A19. ¹⁹ RNZAF LO's Col statement of 11 Oct 19 at A1.

15. The Col's principal basis for concluding that the aircraft did not deviate from its settled position (until it pulled away from the building in response to Nik's fall) appears to be the technical data obtained in the course of the US Air Safety Investigation.

16. In my view, however, the technical evidence provided by the RNZAF LO was ambiguous. On the one hand, the RNZAF LO noted that: 20

s. 9(2)(ba)(i)

17. It is unclear without further information how a shift of five degrees translates in terms of the gap; it may be that a five degree shift is consistent with TM3's observation of a one metre gap.s. 6(a), s. 9(2)(ba)(i)

²⁰ RNZAF LO's Col statement of 11 Oct 19 at A1.

²¹ RNAZF LO's Col statement of 11 Oct 19 at A1: s. 9(2)(ba)(i) . It follows that it is not accurate for the Court to say, as it did at [31] of its report, that "The RNZAF Air Safety representative on the US Air Safety Investigation recalls seeing the aircraft location and tail boom orientation data."

²² RNZAF LO's Col statement of 11 Oct 19 at A5; A7 and A10.

²³ RNZAF LO's Col statement of 11 Oct 19 at A.

²⁴ P2's Col statement of 20 May 19 at A5.

²⁵ P2's Col statement of 20 May 19 at A9.

 $^{^{\}rm 26}$ CC1's Col statement of 20 May 19 at A21.

²⁷ CC1's Col statement of 20 May 19 at A28.

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s. 9(2)(ba)(i)

s. 9(2)(ba)(i)

22. In the absence of technical data relating to the movement of the helicopter's tail, the Col is left to choose between the evidence of TM3, who has been steadfast about the size (and timing) of the gap, and the evidence of the crew who were not able to see the gap.²⁹ The Col appears to accept, at [35] of its report, TM3's evidence that the gap was around one metre, but discounts its significance or probative value on the basis of its conclusion that the gap resulted from the helicopter lifting off in response to Nik's fall.

23. For the reasons outlined above, it is my view that the evidence shows that the helicopter only pulled away after CC2 had stopped TM3 from exiting, which in turn occurred a few seconds after TM3 had noted a gap of one metre. In other words, the one metre gap was more likely than not the result of the helicopter tail drifting.

s. 9(2)(ba)(i)

26. As outlined above, it is evident from the evidence of TM3, CC2 and P1, together with the cockpit voice recording outlined by RNZAF LO, that TM3 observed the one metre gap a matter of seconds before he was stopped by CC2 and therefore before the helicopter departed. In other words, it was not *concurrent*.

27. P1's response at the AAR seems to have coloured TM3's response to the Col's question about the cause of the gap. Notwithstanding that, TM3 then told the Col:

²⁸ Witness 25's Col statement of 11 Oct 19 at A17.	
²⁹ RNZAF LO's Col statement of 11 Oct 19 at A7: s. 9(2)(ba)(i)	; P2's Col statement of 20 May 19 at
^{A5} s. 9(2)(ba)(i)	; CC2's Police
statement of 10 May 19 S. 9(2)(ba)(i)	
; CĆ1's Col statement of 20 May 19 at A25: S. 9(2)(ba)(i)
30 TM2/2 Call statement of 0 Aug 10 at A40	

³⁰ TM3's Col statement of 8 Aug 19 at A49.

³¹ Exhibit AK, E-3-4 at [26] and [27].

³² TM3's CoI statement of 8 Aug 19 at A51.

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a = 0/2 (ha)/i			_
s. 9(2)(ba)(l)			

28. These answers are consistent with TM3's original account.

29. In my view the "technical information" derived from the US investigation, as expressed at [35] of Ref A, has been overstated. S. 6(a), S. 9(2)(ba)(i)

My finding as the Assembling Authority

30. On the key issue of what was a possible contributor to Nik's fall, my assessment differs from the finding of the Col. It is my assessment that the evidence indicates that it is more likely than not that the gap between the aircraft and the roof of the building had quickly widened to one metre by the time Nik exited or while he was exiting the helicopter. There is substantial contemporaneous evidence that the one metre gap observed by TM3 preceded the helicopter's departure, rather than resulting from the helicopter moving off in response to Nik's fall. It is also my assessment that there was vertical downward movement in the helicopter's tail which occurred immediately before or during Nik's egress, as indicated by the CCTV footage.

31. Based upon the above assessment of the evidence, it is my view that helicopter movement may have hindered Nik's ability to establish secure footing on the rooftop.

32. This finding does not suggest Nik was aware of the helicopter's movement and that he made a decision to exit the aircraft regardless. On the contrary, I suspect Nik was not aware that the helicopter had moved at the time before his exit or that it was moving at the moment of his exit. Nik was operating in low light, with night vision goggles, reduced peripheral vision and he would have known that his teammates preceded him without difficulty. This underscores the importance of ensuring that robust safety measures are in place and carried out with precision, such as the crew member observing at all times the gap between the helicopter and the building.

33. Nik was a highly professional and experienced soldier and therefore it is my assessment that Nik would have felt that he was able to refrain from exiting the aircraft had he had a full appreciation of his surroundings.

Procedural aspects

s. 6(a)

³³ TM3's Col statement of 8 Aug 19 at A64.

³⁴ TM3's Col statement of 8 Aug A68.

s. 6(a)

Ancillary matters

Application of CDF Declaration 02-2018

36. I note the Col's assessment that CDF Declaration 02-2018 for Counter Terrorism Response applied to the bump landing activity. I will reserve comment on this finding because this very question is currently before the Courts and is yet to be resolved. I will say, however, that where NZDF training activities may fall within the scope of a CDF Declaration, commanders responsible for the activity must leave no room for uncertainty about whether they consider a CDF declaration applies. It is my expectation that a commander's assessment of whether a training activity is exempt from the Act is made with utmost care and is documented in a precise manner. This will require commanders to properly and fully consult with suitably experienced legal advisers and, where required, the Directorate of Safety.

37. I am concerned that, in this case, there was inconsistency among the exercise documentation as to whether the training activity was within the scope of the CDF Declaration prevailing at the time for counter terrorism response. The exercise instruction stipulated the exercise was at DLOC, which is at odds with other exercise documentation for the activity. Further, the s. 9(2)(h) to the exercise instruction made no mention of CDF's declaration for counter terrorism response and its application to the exercise activity. In this case, the level of precision in the documentation and the level of care afforded to the assessment of whether the applicable declaration applied to VB19 fell well below my expectations.

Timing of Col completion

38. It has been over two years since Nik's accident. Where family have a vested interest in the findings and recommendations of a CoI and where there is a high likelihood of legal proceedings occurring, it is important that, while the CoI not be rushed, it be conducted expeditiously. The individual complexities will determine the length of time it will take to inquire into a matter. However, as a general guide, it is my expectation that, where there is a prospect of legal proceedings by an external regulator, a CoI will have a draft report prepared within six to eight months of an incident. In future, assembling authorities should bear this in mind when selecting CoI members. I have relayed this point to Defence Legal Services with a view to assessing whether guidance about timeliness in the CoI Guide should be added.

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External Legal Review

39. The Col Guide provides that an ELR should be undertaken for Col that inquire into significant matters. This is the first time an ELR has been undertaken since the Col Guide was published. I take this opportunity to comment that the ELR has been demonstrated to be a vital part of the inquiry process and the guidance on ELR in the Col Guide has been validated.

Conclusion

40. As alluded to previously, this has been a robust inquiry into a difficult and complex set of circumstances. I acknowledge the professionalism and efforts by the members of the CoI in providing a comprehensive report. I also acknowledge the forbearance and patience of Nik's family while the NZ Army has worked to understand what occurred that led to Nik's tragic passing.

MAJ GEN ASSEMBLING AUTHORITY

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For Information: COURT OF INQUIRY OFFICE (Attention: s. 9(2)(a)