ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: [redacted]

BOARD DATE: 30 May 2025

DOCKET NUMBER: AR20240012550

APPLICANT REQUESTS: on behalf of her spouse, a deceased Servicemember:

- reversal of the line of duty (LOD) determination finding that his death was not in the (NLOD)
- a personal appearance before the Board

APPLICANT'S SUPPORTING DOCUMENT(S) CONSIDERED BY THE BOARD:

- DD Form 149 (Application for Correction of Military Record), 12 November 2024
- Table of Exhibits (Ex) 1 through 29

  - Ex 1: Joint Statement of Applicant and BA___
  - Ex 2: Marriage License, 2020
  - Ex 3: Death Certificate of Servicemember, 2024
  - Ex 4: letter, Army Human Resources Command (AHRC), Casualty and Mortuary Affairs (CMA), 6 August 2024
  - Ex 5: letter, AHRC, CMA, 3 July 2024
  - Ex 6: Mississippi Army National Guard Orders 27-012-0020, 12 January 2024
  - Ex 7: Statement, Major (MAJ) JR___, 10 September 2024
  - Ex 8: Statement, Captain (CPT) CS___, 13 September 2024
  - Ex 9: Statement, Chief Warrant Officer 5 (CW5) SC___, 11 September 2024
  - Ex 10: Statement, CW5 JO___, 5 September 2024
  - Ex 11: Statement, CW4 JD___, 26 September 2024
  - Ex 12: Statement, CW3 LG___, 5 November 2024
  - Ex 13: Statement, CW3 JT___, 29 August 2024
  - Ex 14: Statement, CW3 Retired (Ret) CC___, 29 August 2024
  - Ex 15: Statement, CW3 Ret JK, 9 September 2024
  - Ex 16: Army Regulation 15-6 (Procedures for Investigating Officer and Boards of Officers) Report of Investigation (ROI) findings and Recommendations regarding the Class A mishap of AH-64E Tail Number [redacted]-xxxxx

- Ex 17: Army Publishing Directorate (APD), Record Details of Technical Manual (TM) 1-1520-251-10 (Operator's Manuel for Helicopter, Attack, Longbow Apache AH-64D), 29 March 2002
- Ex 18: excerpt of TM 1-1520-251-10, 29 March 2002
- Ex 19: APD Record Details of TM 1-1520-251-10-2, 3 July 2023
- Ex 20: excerpt of TM 1-1520-251-10-2, 3 July 2023
- Ex 21: (Aircraft Corporation) Press Release, 1999
- Ex 22: (Aircraft Corporation) Promotional Material
- Ex 23: Statement of President Joe Biden, February 2024
- Ex 24: Memorial Service Ceremony Program, 2024
- EX 25: Statement of Mississippi Governor, 2024
- Ex 26: Mississippi House Resolution Honoring Servicemember, 2024
- Ex 27: Officer Record Brief (ORB)
- Ex 28: Applicant statement, 2024

FACTS:

1. This case comes before the Board in connection with another similar case with the same issues by which the Servicemember and a second helicopter pilot were both killed while flying together in the same helicopter.

2. In a jointly written narrative provided by both the applicant and the widow of the second Apache helicopter pilot, she states:

a. Her husband took off on Mississippi Army National Guard training flight aboard an AH-64D Apache helicopter from Army Aviation Support facility in Tupelo, MS. It was a retirement flight for a fellow pilot to cap off more than 20 years of service to the U.S. military. Her husband was honored that his fellow pilot wanted to fly with him on his final flight.

b. It was supposed to be a day of celebration. Family and friends were at the facility awaiting their return. Words cannot express the feelings that accompanied the news that their Apache had crashed, and both the Servicemember and the pilot were killed. Her family and friends were shocked and in disbelief.

c. The President of the United States commented that the two Guardsmen embodied the very best of our Nation.

d. She received the initial notification that the deaths of both pilots were being classified as not in the line of duty and immediately submitted an appeal to the U.S. Army Human Resources Command, thinking decency and common sense would prevail. In August 2024 she received a letter from the Army Mortuary Affairs notifying her that their joint appeal had been denied and it did not include new evidence. Their

only recourse was to apply to the Army Review Boards Agency (ARBA) with new evidence.

e. They obtained copies of Army Regulation 15-6 investigation and looked into the facts to conduct their own investigation. They have learned about their husbands from the leaders and peers who knew them. They were considered "the very best of the best" Apache pilots in the Army, careful, safety-minded professionals with outstanding reputations and a long list of military decorations.

f. Summary of New Evidence. Based on the Army Regulation 15-6 investigation, several critical errors led to an erroneous finding of "Not in the Line of Duty." They obtained statements from eight current Apache pilots, several of which were present at the facility the day of the crash. None of them were interviewed as part of the Army Regulation 15-6 investigation.

(1) The Army Regulation 15-6 investigation cited an inactive TM 1-1520-251-10 and based its findings on a limit of 30 degrees pitch and a limit of 60 degrees roll. This TM was superseded by TM-1-1529-251-10-2, which lists a pitch limit of 60 degrees and a roll limit of 120 degrees. This error grossly distorted the findings of the Army Regulation 15-6 investigation because the inactive TM places much stricter maneuvering limits on the AH-64D Apache helicopter. Evaluating the actions of the pilots against the wrong standard should by itself invalidate the findings of the Army Regulation 15-6 investigation.

(2) The Army Regulation 15-6 investigation did not document the unique maneuverability of the Apache in assessing the actions of the pilots. Every Apache pilot they spoke with attested the that the Apache is capable of aerobatic maneuvers that other helicopters cannot do, to include full rolls. Online videos demonstrating the Apache's aerobic capabilities can be readily found. These capabilities did not appear to be known to the officer who conducted the Army Regulation 15-6 investigation.

(3) The Army Regulation 15-6 investigation failed to document or consider the high level of training, experience, and skill of both the pilots in reaching its determination. The Servicemember served an Apache Maintenance Test Pilot and Apache Instructor Pilot, and his co-pilot was a Master Aviator. Both pilots had more than 3000 flight hours and both were highly decorated veterans with a track record of flying Apache helicopters in the most stressful situations.

(4) The Army Regulation 15-6 investigation did not make any effort to document the state of mind of the pilots leading up to the mishap. Statements from several of their fellow Soldiers describe them as being in good spirits and eager to complete the last flight safely.

(5) The Army Regulation 15-6 investigation inaccurately described an electronic fault code present on the Apache data recorder as being a "Red X" grounding condition for the aircraft. Several of the Apache pilots they spoke to proactively reviewed the applicable guidance and determined that the fault code was not a grounding condition precluding flight. The Army Regulation 15-6 investigation painted a false picture of the pilots as being reckless prior to takeoff.

(6) The Army Regulation 15-6 investigation referred incorrectly to the aircraft as being an AH-64E instead of an AH64D. The "Echo" model is a different aircraft. This error shows the investigating officer did not understand the complexities of the assignment and likely did a rushed cut and paste job. An officer they spoke to informed members of the Army Regulation 15-6 investigation team bragged about getting the investigation done in record time.

k. Analysis. Both pilots were on orders. Army Regulation 600-8-4 (Line of Duty Policy, Procedures, and Investigations) requires that their deaths be presumed in the line of duty. The Army bears the burden of rebutting that presumption that their deaths were in the line of duty by proving through a preponderance of the evidence that they were not in the line of duty. The co-applicants maintain that the Army never came close to meeting this burden.

(1) The pilots did not engage in any form of misconduct leading to their deaths. There is no suggestion that they were in violation of any law, regulation, or Army policy. The Army Regulation 15-6 investigation cites only a TM as the basis for its finding of misconduct. The inactive TM is materially different from the current TM in ways prejudicial to the pilots. Using inactive guidance as a basis for finding renders the finding null and void. Army Regulation 25-30 (Army Publishing Program) provides that TMs are not policy documents.

(2) The Army Regulation 15-6 investigation does not cite any law, policy, or regulation that the pilots violated. The investigation alleges they were attempting a "barrel roll" prior to the crash. There is not enough evidence to make this determination. There is no video of the incident; both eyewitnesses are deceased.

(3) The Army Regulation 15-6 investigation does not tell what rule was broken by the alleged action. A review of Army Regulation 95-1 (Flight Regulations) does not ban aerobic maneuvers outright; permits them withing certain limitations.

(4) The Army Regulation 15-6 investigation characterizes the pilots as having been grossly negligent, but Army Regulation 600-8-4 defines gross negligence extremely narrowly and the pilot's actions have not been proven to meet that definition.

(5) Army Regulation 600-8-4 states that dare-devil type activities may be considered gross negligence." It does not state they shall be considered gross negligence.

(6) The Army Regulation 15-6 investigation did not cite the "daredevil" provision in its findings; however, the letter from the Army Mortuary Affairs references it as being the basis for the pilot's not in the line of duty determination. Nowhere does the regulation, or any other Army publican define what constitutes a "daredevil" activity.

(7) Army Regulation 600-8-4, D-7, requires that before a finding of gross negligence can be based on dare-devil activity, all circumstances will be considered. The Army Regulation 15-6 investigation failed to examine the unwatchability of the pilots. Their exemplary careers and experience flying the Apache helicopter should have been considered before a rush to judgement was made.

3. The applicant provides:

a. A joint statement co-authored with the spouse of the second Apache helicopter pilot also deceased as a result of the same mishap, which is outlined above.

b. Her marriage license, dated 2020.

c. A death certificate of the Servicemember, dated February 2024, reflecting the cause of death was a helicopter crash.

d. A letter from CMA, AHRC, dated 6 August 2024, noting the CMA reviewed her appeal a second time and did not approve it because in the application, there was no new evidence provided with the application.

e. A letter from CMA, AHRC, 3 July 2024, expressing condolences for the loss of her spouse. It further noted:

(1) After careful review of the LOD investigation, a final determination was made that the Servicemember was "Not in Line of Duty" at the time of his death. Evidence contained in the investigation indicated the Servicemember allowed his pilot to attempt an unauthorized daredevil maneuver in a military aircraft resulting in a fatal crash.

(2) Adverse findings in LOD cases may result in the loss of certain benefits such as, but not limited to, Survivor Benefits or Dependency and Indemnity Compensation from the Department of Veterans Affairs (VA). We recommend you seek legal assistance if you desire to contest the determination.

f. Training orders issued to the Servicemember attaching him to the 149th Aviation Battalion for 1-day on 24 February 2024, for training support.

g. A written statement from Major (MAJ) JR___, dated 10 September 2024, noting he was assigned to the unit with the Servicemember and was the operations officer in charge and present the day that the AH-64D Apache crashed.

(1) He knew both pilots to be exceptional with extensive experience flying the Apache. He flew with them and knew them to have a high regard for safety and their profession. In his career he has flown with a vast array of pilots from the National Guard as well as active duty. Of everyone he flew with, the Servicemember stands out as the single best helicopter pilot. Both pilots were true professionals who had a high regard for safety and their profession. Neither man could be described as being a "daredevil."

(2) He expresses the Army Regulation 15-6 investigation conclusion that the pilots were attempting to take the Apache into a full roll prior to the crash as difficult to believe. The investigating officer (IO) cited the wrong maneuverability limits of the Apache. The current TM for the AH-64D permits a limit up to a 120 degree roll while the Army Regulation 15-6 cited a limit up to a 60 degree roll. The Apache is capable of completing a full roll or "barrel roll" and there are videos online of full rolls and advanced maneuvers in the Apache. The pilots were of such accomplishment that it would be reasonable for them to believe that they could successfully execute a full roll in the Apache due to indoctrination. That is not to say that it would be advisable to do, and it would definitely be outside the published limitations of the airframe. Under normal conditions with proper training, he believed pilots of their experience and skill should have been able to perform it successfully.

(3) There was an electrical fault present designated as an "HPSM KD221 contactor fail" fault. This was a fault he was not personally familiar with. It is an obscure fault that is not on the preflight checklist of faults to look for or the pilot response checklist. Apache helicopters of the MSARNG inventory are older airframes with close to 10,000 hours and it is common to have random electronic faults that do not impact the safe operation of the aircraft. The typical pilot consults with avionics and then proceeds after confirmation. That particular fault may have been buried on a fault page with numerous other historical faults. Neither pilot spoke of this fault nor seemed concerned about the conditions of the aircraft following the preflight process. His overall opinion of the crash is that they would not have done anything deliberately reckless or grossly negligent while piloting a helicopter or done anything without regard for each other's safety.

h. A written statement from Captain (CPT) MCS___, noting he was the company commanding officer of 1-149th Aviation Regiment, MSARNG. He was qualified to fly the AH-64D and was at the unit the day the pilots died in the crash. He knew the

Servicemember very well from serving with him in A Company. He was exactly what any leader would want out of a Soldier and a helicopter pilot. He was absolutely by the book and took great pride in the unit. As the standardization officer, he held himself and everyone else to the highest standards expected of a pilot. He never hesitated to make on the spot corrections. The Servicemember made his job easy.

(1) He reviewed the Army Regulation 15-6 investigation and noted several serious problems with the way it was conducted. The NLOD determination was confusing to him:

- both pilots were on orders, in uniform, and flying an authorized training mission
- both pilots accumulated over 3000 hours flying time in the Apache

(2) The Army Regulation 15-6 investigation based its conclusions on a misunderstanding of the aircraft. Someone with a better understanding of the Apache platform should have been assigned to the investigation team. The IO cited incorrect pitch and roll attitudes for the Apache. The Apache is more maneuverable than other helicopters in the Army inventory. Current guidance allows for 60 degrees of pitch and 120 degrees of roll. A maneuver that may seem dangerous and reckless in a Blackhawk, for example, is just part of the mission profile for the Apache.

(3) The Army Regulation 15-6 investigation determined that an "HPSM 2KD221 contactor fail" fault present on the aircraft was a "Red X" grounding condition. From his own review of the TM (1-1520-251-10-2) he could not find where that fault was a grounding condition. He reviewed other TMs and well as spoke to numerous other pilots and subject matter experts of the Apache and not one believed that the fault was a "Red X" condition. It is a notification that there is a miscellaneous electrical fault of a redundant system. There are always numerous codes present on the fault page. He was not able to figure out why the IO determined that this one in particular was a "Red X" condition. The IO did not reference any manual or any other guidance that would classify this fault as a "grounding condition." This unfairly painted the pilots in the wrong light.

(4) He witnessed both the pilots go through the preflight routine for the aircraft and spoke to the Servicemember after the process was completed and the pilots did the checklist exactly by the book and detected no issues with the aircraft. He watched the Servicemember "turn on the switch" and get serious about the preflight procedures, which he had observed him do on countless occasions.

(5) He does not know if it is true that the pilots attempted to do a "barrel roll" in the Apache. There are North Atlantic Treaty Organization demonstration teams that perform full rolls as part of their routines. He thinks the IO failed to articulate that the

Apache is a uniquely maneuverable aircraft and is fully capable of executing a full roll in the hands of an experienced pilot. He thinks if it is the case that the pilots decided to execute a full roll it is wrong to classify pushing the envelope as gross negligence. When one accounts for the type of aircraft as well as the skill and experience of the pilots it is not a case of gross negligence but more like an advanced maneuver that was attempted with a horrible outcome that remains unexplained.

(6) The investigation was rushed and completed in 2 weeks and not given the thorough attention that a tragedy of this magnitude deserved to receive.

i. A written statement from CW5 SMC___, dated 11 September 2024, in which he notes he was assigned to another unit of the MSARNG but knew both pilots. He was deployed with the Servicemember to Iraq and knew him since 2006.

(1) He knew the Servicemember for 8 years and flew the Apache helicopter with him. He was an Apache instructor pilot, mature beyond his years, and a natural leader and mentor to the young pilots. He was a "go to guy" for the Apache helicopter in the MSARNG. He was always meticulous in the way he conducted himself as a pilot and as a Soldier.

(2) He reiterates the Army Regulation 15-6 investigation findings regarding the pitch and roll characteristics and capability of the aircraft while acknowledging he did not know if the pilots attempted a "barrel-roll." Whether or not a barrel roll is authorized, pilots of their caliber would absolutely be assumed to be able to execute the maneuver under normal circumstances. He does not agree with the actions by the pilots as being characterized as a "daredevil" maneuver.

j. A written statement from CW5 JDO___, dated 5 September 2024, noting his unit was the 185th Combat Aviation Brigade, MSARNG, his helicopter experience of 25 years, and his extensive experience with the AH-64D Apache helicopter as well as other airframes. He served as a helicopter instructor pilot and a maintenance test pilot.

(1) He knew both pilots for many years. The pilots embodied the highest standards of professionalism expected of military helicopter pilots.

(2) He was present at the airfield on the date of the helicopter crash. He spoke to both pilots prior to the flight and recalls the Servicemember briefing the flight plan. He did not recall either mentioning the fault code. It is an extremely obscure fault that he did not think would be on the checklist of faults to look for in the preflight process and did not think it is easy to see on the fault page and would take multiple key presses to find even if one knew to look for it.

(3) He has no personal knowledge as to the circumstances of the crash.

(4) He reiterates earlier statements of the aircrafts capabilities and notes the correct limits of the Apache pitch and roll limits. He did not think it was correct for the IO to evaluate the pilots against the wrong TM standard of pitch and roll limits.

(5) Both pilots took their jobs seriously. They were not cavalier about the mission and fully intended to complete it safely.

k. A written statement from CW4 JED___, dated 26 September 2024, noting he was assigned to the 151st Aviation Regiment, MSARNG, and had 9 1/2 years as a crew-chief in the Air national Guard and was an Army Helicopter pilot since 1997 with 26 years of flying experience, including the AH-64.

(1) He did not fly with the Servicemember but knew him and knew that he was an excellent instructor pilot. Both pilots were flew in the civilian sector as well. They were both tremendously experienced helicopter pilots and true professionals.

(2) He did not have personal knowledge of the circumstances that led to the crash. He believes the Army Regulation 15-6 investigation made glaring errors showing a lack of understanding of how the AH-64D operates. The overall investigation was hastily thrown together.

(3) He reiterates earlier statements of the aircrafts capabilities and notes the correct limits of the Apache pitch and roll limits outlined in the active TM. He notes this discrepancy significantly changes the perception of the recklessness of the pilots. He notes further the aircraft was an AH-64D, not an AH-64E, two different models of Apache helicopters with significant differences in the way they operate.

(4) He reiterates earlier statements concerning the contactor fail fault code as to its "Red X" grounding condition—that it is not a "Red X" grounding condition.

(5) He notes further, the Apache is a maneuverable helicopter. It was designed to perform aerobatic maneuvers as part of combat operations. Full barrel rolls were well within the capability of the aircraft. He did not know if the pilots were attempting to execute a barrel roll, but he did think they would have been reasonable to think that they could execute such a maneuver successfully. If they did attempt an advanced maneuver in the aircraft, it was not because they were reckless by nature or "cowboys" in the cockpit. It just got away from them somehow.

l. An email from CW3 LG___, dated 5 November 2024, noting he was an Apache pilot since 2013 and was a pilot in the command. He completed that Tactical Operations Course and the Maintenance Test Pilot Course. He served with both pilots. When he heard that the investigation concluded the pilots were attempting a full barrel roll prior to the crash, his reaction was disbelief. He always knew them to put a high premium on

safety. His second thought was that if it was true that they were attempting to roll the helicopter, they had the skill and expertise that they should have been able to do it successfully. He thinks it is regrettable that the Army Regulation 15-6 investigation was not conducted by an Apache pilot who would have known the nuances of the aircraft better.

m. A written statement from CW3 JRT___, dated 29 August 2024, noting he was assigned to 149th Attack Reconnaissance Battalion (ARB), MSARNG. He served as an Apache helicopter Instructor and Safety Officer. He flew the Apache helicopter for 5 years.

(1) He was present the day the pilots died in the crash of the Apache they were flying. He reiterates earlier statements of the aircrafts capabilities and notes the correct limits of the Apache pitch and roll limits outlined in the active TM. He reiterates earlier statements concerning the contactor fail fault code as to its "Red X" grounding condition.

(2) He had no personal knowledge of what caused the Apache to crash. He had the opportunity to speak to the Servicemember following his preflight checks the morning of the crash. He never mentioned any concerns with the aircraft.

n. A letter from CW3 CC___, dated 29 August 2024, noting he was a retired from the Tennessee Army National Guard.

(1) The AH-64D Apache helicopter is 100% capable of flying many different aerobatic maneuvers and performing a barrel roll. He personally flew many of these maneuvers in the Apache during combat, flight training, and in other flights.

(2) From what he was told about the Army Regulation 15-6 investigation, it appeared there was a contactor fail fault present when the aircraft took off. As an Apache pilot, some faults are mandatory check faults and others are not and more difficult to see in the data. This particular fault was not one of the mandatory checklist faults and was buried deep inside the fault pages. He wonders if this fault was part of any other electrical issues going on inside of the aircraft after takeoff. It does not show up in the display panel so if it was not detected during preflight, the pilots would have had no knowledge of it. He believes it was not negligence on the part of the pilots in missing this fault indication. There is no chance the Servicemember would have taken off knowing his aircraft had a grounding fault.

o. A letter from CW3 JK___, dated 9 September 2024, in which he notes he was a retired CWO3 with the MSARNG who had more than 20 years' experience in the military and flew the AH-64D Apache for 10 years. He notes, in part:

(1) He had the honor of flying extensively with both pilots and logged 100s of hours flying with both pilots over the course of his time in their unit. Both pilots had a proven track record of operating successfully in high workload, zero fail type environments.

(2) He experienced and emergency landing with the Servicemember, who was on the controls. They experienced a failure of the main transmission and went through the emergency checklist which he committed to memory. The Servicemember brought the Apache down safely and they were both able to walk away unscathed. The Servicemember handled everything during the crisis by textbook. He flew the initial test flight after the Apache was repaired.

(3) He does not think anyone will ever know what happened to cause the Apache to crash but both pilots would never have done anything willfully negligent.

p. A redacted copy of memorandum, Headquarters (HQ), 185th Expeditionary Combat Aviation Brigade, MSARNG, dated 23 April 2024, subject: Findings and Recommendations for Army Regulation 15-6 Collateral Investigation Regarding the Class A Mishap of AH-64E Apache Helicopter, Tail Number [redacted]-XXXX. The applicant highlighted relevant portions of the investigation. This memorandum is available for Board review. The Army Regulation 15-6 investigation, its exhibits numbered 1 through 23, its evidence, including Maintenance Data Recorder (MDR) ("black box"), its flight data, pilot voice recordings with transcriptions, and crash site photographs, are not available for Board review. This memorandum reads, in part:

(1) References.

- Army Regulation 15-6 (Procedures for Administrative Investigations and Board of Officers), 1 April 2016
- Army Regulation 25-50 (Preparing and Managing Correspondence), 10 October 2020
- Army Regulation 735-5 (Financial Liability Investigation and Property Loss), 9 November 2016
- Army Regulation 95-1 (Flight Regulations), 22 March 2018
- Aircrew Training Manual TM 1-1520-251-10 (Operator's Manual for Helicopter Attack, AH64D Longbow Apache)
- Army Techniques Publication (ATP) 3-04.1 – Terrain Flight Modes

(2) The IO summarized the findings. On 23 February 2024 an AH-64D (ACFT 630) belonging to Alpha Company, 1-149th ARB, crash-landed in the vicinity of (Church) near (City), MS. The estimated cost damage was $25,879,820.16. The IO found the mishap was not the result of maintenance issues with the aircraft. All evidence supported that the aircraft crashed due to a grossly negligent act on the part of

both aviators flying this aircraft. The IO recommended all financial liability be levied against both pilots.

(3) Summary of Facts. On 23 February 2024, the pilots began their preflight for a routine training flight. Both pilots were briefed on the Risk-Common Operating Picture (RCOP) by the Standardization Officer. All mission information indicated a routine flight with favorable weather and no threats. The MDR indicted that there were a series of high-power switching module (HPSM) faults active during preflight and remained open throughout the flight. These faults required a "Longbow Reset" be performed before ACFT 630 took off. These faults were never reported to the crew chief. These faults were critical enough that had they been identified, they would have caused the aircraft to be grounded until they were repaired.

(a) According to (Name redacted), an AH-64D/E maintenance test pilot/maintenance examiner assigned to 46th ASB: "The number 2 HPSM contains a series of contactors that open or close based on system demand from the helicopter. The [direct current] (DC) is supplied to the number 2 [Regulated Transformer Rectifier Unit] (RTRU), in the event the number 2 RTRU fails, there is a DC contactor that closes in order to continue to supply DC power to the number 2 side of the helicopter (KD221 Contactor). If that contactor is failed and subsequently the number 2 RTRU fails, then it will not close, and you will lose everything on the D-Bus for the number 2 side of the helicopter which includes the flight control computer (FMC) and back up flight control system (BUCS)."

(b) (Name redacted)'s assessment of the MDR data was validated by another AH-64D/E maintenance test pilot/maintenance examiner, who was assigned to 166th Aviation, Fort Cavazos. Both aviators are trustworthy subject matter experts with over 20 years of service on all maintenance issues regarding AH-64D/E Apache helicopters. (Name redacted) stated that the aircraft should never have been permitted to take off with his open fault. See exhibits.

(c) Aside from the HPSM fault, ACFT 630 was operating normally. It was 20 hours out of going into a 500-hour phase and the weight was reported to be within optimal performance standards. No components needed to be replaced prior to going into phase.

(d) The pilots took off in ACFT 630 and proceeded to fly the approved mission route. According to the RCOP, the mission was a single ship flight to conduct a standard terrain flight for (name redacted) who was returning to flight status because of a medical condition. This flight was also intended to be the pilot on the stick last flight in the AH-64 Apache due to him retiring that day. It was a low risk factor mission.

(e) The MDR data along with supporting audio transcripts between (both pilots) from inside ACFT 630 show that both pilots discussed and both decided to execute an unauthorized barrel roll maneuver. However, the maneuver was unsuccessful and within 6 seconds, resulted in ACFT 630 crashing in the vicinity of (town), MS. The crash site was approximately 15 minutes from landing back at the Army Airfield Support Facility.

(4) Findings.

(a) The IO team found that the Company Commander, A Company followed applicable rules and regulations but the leadership and maintenance personnel of AASF number 2 did not conduct themselves in the same manner. (Name redacted) never received the Flight Reference Card implementation or was not indicated in the records. The Risk Common Operational Picture (RCOP) was correctly briefed by (name redacted), it was not correctly filled out and signed by the Servicemember as per AASF Number 2 Standard Operating Procedure. This mission was not on the approved initial flight schedule for 23 February 2024, nor was the pilot on the stick (Name redacted) scheduled to fly a mission that day. The acting AASF Number 2 Commander and Final Mission Approval Authority, approved and signed the RCOP which constitutes approval for take-off. These findings are not the cause of ACFT 630 crash, but they provide an example of additional record keeping issues and discrepancies that were discovered.

(b) The IO team found multiple discrepancies within AASF Number 2 maintenance logbooks, aircraft green book, and aircraft notebook for ACFT 630. For example, the IO team discovered AASF Number 2 had not updated their crash plan since April 2022 and the crash call tree was not updated with current personnel or numbers. The radios had not worked properly in years. There was a reduced Very High Frequency (VHF) range and inoperable Ultra High Frequency (UHF) radio, lack of Joint Battle Command Platform installed, and no standardized Primary Alternate, Contingency, and Emergency (PACE) plan. Once ACFT 630 was over 5 miles away form AASF Number 2, Flight Operations could no longer communicate with the aviators over VHF, so they used the only other option available which was a cell phone.

(c) The HPSM 2 KD221 Contactor Fail fault was a critical issue that would have grounded ACFT 630 until corrected. When asked what action should have been taken to correct it, ACFT 630 crew chief stated in an email "The HPSM Contactor Fail fault would be a cause to perform longbow reset. It should not fly with that fault. The fault does not show up on the EUFD [Enhanced Up Front Display] so if they didn't check the fault page, or if it showed up after they had already checked it, then they may not have known. They did not relay any kind [of] fault information to me during their run up."

(d) During the preflight the pilots failed to ensure there were not critical faults, such as the critical HPSM 2 KD221 Contactor Fault fail. There were also a HPSM 2

SRU A8 Fail, a HPSM 2 SRU A1 Fail, and a Pilot IHU Fail that the aviators never reported or corrected by conducting a longbow reset.

(e) The pilots deviated from the approved mission RCOP which was to conduct a standard terrain flight for Readiness Level progression for the Servicemember and the (Name redacted) final retirement flight in an AH-64D. According to the audio transcripts during this flight, the aviators discussed how (Name redacted) (the pilot on the stick) had flown by the book his entire career and wanted to do a barrel roll before retiring since he had never done one. Army TM 1-1520-251-10, paragraph 5.9 maneuvering limits clearly states that intentional maneuvers beyond attitudes +/- 30 degrees in pitch and +/- 60 degrees in roll are prohibited. The Servicemember also wanted to do one but his only knowledge of how to perform this maneuver was from watching a video. Neither aviator asked for approval from Flight Operations, Standardization Officer, or FMAA to conduct this maneuver.

(f) The IO team reviewed ACFT 630 maintenance records, and short life report and found no mechanical issue that would have caused ACFT 630 to crash.

(g) Based on the audio transcript from ACFT 630 during this flight, and supported by ACFT 630 MDR data, both pilots are accountable for the mishap that caused ACFT 630 to crash.

(h) The IO was unable to find any Army publication where conducting a barrel roll maneuver was doctrinal. Army TM 1-1520-251-10, paragraph 5.9 maneuvering limits does state that intentional maneuvers beyond attitudes +/- 30 degrees in pitch and +/- 60 degrees in roll are prohibited. A review of the MDR data shows that ACFT 630 roll angle changed from a roll angle semicircle of 0.00116, increased to 0.987369, repeated again with a roll angle semicircle of -0.9567 and increasing until ending at 0.932556. According to the audio transcript, (Name redacted) was the PI (pilot on the stick flying the aircraft) and wanted to perform the barrel roll and the Servicemember was the PC (Pilot in command of the aircraft), but instead of denying the PI's (Name redacted) request, he supported it, helped plan it while in flight, and never contacted AASF Number 2 Flight Operations for approval. Their decision to execute a barre roll that they had never done before, combined with their inexperience on how to do the maneuver, ultimately resulted in loss of control and the ACFT 630 crashing.

(i) The IO team along with (Name redacted) reviewed the MDR data. (Name redacted) explained to the team that the variation in numbers of the pitch, roll, yaw, altitude, loss of oil pressure, rate of vertical descent, and engine and main rotor system overspeed indicated that at one point ACFT 630 was inverted. These facts support the finding that the aviators attempted to barrel roll the aircraft.

(j) A review of the wreckage photos reflected the extent of the damage to ACFT 630. Evidence shows that (both pilots) purposely put ACFT 630 in the position without knowing if the aircraft would be able to complete the barrel roll or damage the aircraft making it unrecoverable. Given the aircraft's altitude listed in the MDR recorder (approximately 5000 feet mean sea level (MSL) and 1400 above ground level (AGL)), rate of descent while inverted (approximately 4300 feet per second (FPS)), low oil pressure in engines and transmission, and engine gearbox, engine overspeed and main rotor overspeed (119%), the aviators had no time to react and recover the aircraft before striking the ground. (Exhibit 11, 13a)

(k) The evidence collected during this investigation uncovered that (both pilots) willfully discussed and planned to execute an unauthorized barrel roll They failed to properly check any faults prior to take-off, actively disregarded proper safety procedures, knowingly deviated from the approved RCOP, and failed to request permission to conduct the maneuver. (Name redacted) and Servicemember acted with gross negligence while flying ACFT 630 by attempting a barrel roll.

(4) Recommendations.

(a) That the 149th ARB continue the current safety stand down to address proper techniques in the event of a crash.

(2) A training session be conducted by 1-149th ARB and AASF Number 2 specifically tailored around performing unauthorized and risky maneuvers.

(3) AASF Number 2 develop a training brief for continuity purposes that includes a Class A mishap.

(4) AASF Number 2 repair their radios and institute a proper PACE plan.

(5) AASF Number 2 continue to improve their maintenance record as multiple discrepancies were found with their records while reviewing the maintenance records for ACFT 630.

(6) That (Name redacted) be relived from any financial liability associated with ACFT 630.

(7) The late Servicemember and (Name redacted) be financially liable for the destruction of AH-64D Apache Tail Number [redacted]-xxxxx.

q. An APD website printout reflecting TM-1-1520-251-10 was inactivated as of July 2023.

r. An excerpt of inactive TM-1-1520-251-10, paragraph 5.9, dated 29 March 2002, reflecting that maneuvering limits beyond attitudes +/- 30 degrees in pitch and +/- 60 degrees in roll are prohibited.

s. An APD website printout reflecting TM-1-1520-251-10-2 was active as of 3 July 2023.

t. An excerpt of active TM-1-1520-251-10-2, paragraph 5.9, dated 3 July 2023, reflecting that intentional maneuvering limits beyond attitudes +/- 60 degrees in pitch and +/- 120 degrees in roll are prohibited.

u. An (Aircraft Company) press release on the AH-64D Longbow Apache helicopter performance and agility in aerobatic tests.

v. An (Aircraft Company) promotional material about the AH-64D Longbow Apache helicopter.

w. Statement from President Joe Biden.

x. A MSARNG memorial service program guide for both of the deceased pilots.

y. Mississippi Governor Executive Order honoring the Servicemember.

z. Mississippi House Resolution honoring the Servicemember.

aa. Officer Record Brief.

bb. Statement of the applicant, the widow of Servicemember, in which she notes: She is a widow, mother, and a wife who lost her entire world. Her husband was more than a Soldier and a skilled Apache pilot. He was a man of unwavering loyalty, dedication, and a spirit that carried his family and country through every hardship. The Not in the Line of Duty determination was a decision that feels like an insult, not only to his legacy, but also to his sacrifices and his love for his family and country. She requests reconsideration of the decision, to give she and her children the closure and honor that he deserves. She met her husband as a colleague before he became her husband. They flew in helicopters together, she as a flight nurse and he as a pilot. He was focused, attentive, and dedicated to their safety. His skill, care and commitment in the cockpit allowed her and so many others to work with confidence and trust knowing he would bring them home safely. Since his passing, her children and she have carried the weight of his absence.

4. A review of the Servicemember's service records show the following:

a. On 3 September 2004, he enlisted in the Army National Guard of the United States for 8 years; on the same date he enlisted in the MSARNG for 6 years.

b. On 12 August 2009, he attained the rank of sergeant.

c. On 10 May 2010, he was honorably discharged from the MSARNG to accept an appointment as a warrant officer in the MSARNG.

d. On 11 May 2010, he was commissioned a Warrant officer in the MSARNG.

e. On 5 February 2013, he was appointed a Reserve Warrant Officer two at AASF Number 2, Tupelo, MS.

f. On 9 November 2018, he was appointed a Reserve WO3.

g. On 19 March 2021, he was ordered to active duty in support of Operation Inherent Resolve.

h. He served in:

- Kuwait from 20 May 2021 to 19 June 2021
- Syria from 20 June 2021 to 10 July 2021
- Iraq from 22 July 2022 to 19 January 2022
- Kuwait from 20 January 2022 to 1 February 2022

i. On 22 April 2022, he was honorably released from active duty and transferred to control of the MSARNG.

j. On 22 December 2023, he was promoted to CW4.

k. On 20 February 2024, he was awarded Master Army Aviator Wings.

l. On 23 February 2024, he was ordered to Temporary Duty for training for 1 day.

m. On the same day he died in a helicopter mishap.

n. On 28 February 2024, he was posthumously awarded the Mississippi Magnolia Cross for meritorious service to the MSARNG and its aviation units while serving at the most demanding levels.

BOARD DISCUSSION:

After reviewing the application and all supporting documents, the Board determined relief was not warranted. The applicant's contentions, the military record, and regulatory guidance were carefully considered. One potential outcome discussed was to grant relief based upon the statement of other aviators stating the FSM in question was a "by-the-book" individual. However, based upon the evidence in the record showing the FSM was attempting to execute unauthorized maneuvers (as noted in the voice recorder transcript and statements of other eyewitnesses present), the Board concluded there was insufficient evidence of an error or injustice warranting a change to the FSMs line of duty investigation.

BOARD VOTE:

Mbr 1	Mbr 2	Mbr 3	
:	:XXX	:	GRANT FULL RELIEF
:	:	:	GRANT PARTIAL RELIEF
:	:	:	GRANT FORMAL HEARING
:XXX	:	:XXX	DENY APPLICATION

BOARD DETERMINATION/RECOMMENDATION:

The evidence presented does not demonstrate the existence of a probable error or injustice. Therefore, the Board determined the overall merits of this case are insufficient as a basis for correction of the records of the individual concerned.

[redacted]

I certify that herein is recorded the true and complete record of the proceedings of the Army Board for Correction of Military Records in this case.

REFERENCES:

1. Army Regulation 15-6 (Procedures for Investigating Officers and Boards of Officers) establishes procedures for investigations and boards of officers not specifically authorized by any other directive. The investigating officer or board of officers has the following responsibilities:

a. Make findings – a finding is a clear and concise statement of a fact that can be readily deduced from evidence in the record. It is directly established by evidence in the record or is a conclusion of fact by the investigating officer or board. Negative findings (for example, that the evidence does not establish a fact) are often appropriate. The number and nature of the findings required depend on the purpose of the investigation or board and on the instructions of the appointing authority. The investigating officer or board will normally not exceed the scope of findings indicated by the appointing authority. The findings will be necessary and sufficient to support each recommendation. The standard of proof for a finding is that it must be supported by a greater weight of evidence than supports a contrary conclusion, that is, evidence which, after considering all evidence presented, points to a particular conclusion as being more credible and probable than any other conclusion. The weight of the evidence is not determined by the number of witnesses or volume of exhibits, but by considering all the evidence and evaluating such factors as the witness's demeanor, opportunity for knowledge, information possessed, ability to recall and relate events, and other indications of veracity.

b. Make recommendations – the nature and extent of recommendations required also depend on the purpose of the investigation or board and on the instructions of the appointing authority. Each recommendation, even a negative one (for example, that no further action be taken) must be consistent with the findings. Investigating officers and boards will make their recommendations according to their understanding of the rules, regulations, policies, and customs of the service, guided by their concept of fairness both to the Government and to individuals.

c. Investigations or boards may be formal or informal. In an informal investigation or board, a report will be written unless the appointing authority has authorized an oral report. Written reports of informal investigations will use DA Form 1574 (Report of Proceedings by Investigating Officer/Board of Officers); however, its use is not required unless specifically directed by the appointing authority. Every report, oral or written, on DA Form 1574 or not, will include findings and, unless the instructions of the appointing authority indicate otherwise, recommendations.

d. Paragraph 2-8. Approval Authority. Upon receipt of a completed investigation or board containing the legal review, the approval authority will conduct a final review of the IO's or board's findings and recommendations and the legal review. The approval

authority may approve, disapprove, modify, or add to the findings and recommendations, consistent with the evidence included I the report of proceedings. The approval authority may also concur in or disagree with recommendations that cannot be implemented at his or her level. The approval authority may take action different than that recommended with regard to a respondent or another individual unless the specific regulation or directive under which the investigation or board was appointed provides otherwise.

2. Army Regulation 600-8-4 (Line of Duty Policy, Procedures, and Investigations), currently in effect, prescribes policies and procedures for investigating the circumstances of injury, illness, disease, or death of a Soldier. It provides standards and considerations used in making line of duty (LOD) determinations.

a. Paragraph 2-3d Benefits affected by line of duty investigation. Disability retirement and severance pay. Soldiers who sustain permanent disabilities while on active duty must meet requirements of the applicable statutes to be eligible to receive certain retirement and severance pay benefits. One of these requirements is that the disability must not have resulted from the Soldier's misconduct or gross negligence and must not have been incurred during a period of AWOL.

b. Paragraph 2-4. Standards applicable to line of duty determinations.

(1) A Soldier's injury, illness, disease, or death is presumed to have occurred ILD unless rebutted by the evidence.

- injury, illness, disease, or death proximately caused by the Soldier's misconduct or gross negligence is "not in line of duty-due to own misconduct"
- simple negligence, alone, does not constitute misconduct and is, therefore, still considered to be in line of duty

(2) Standard of proof. Unless another regulation or directive, or an instruction of the appointing authority, establishes a different standard, the findings of investigations governed by this regulation must be supported by a greater weight of evidence than supports a contrary conclusion (such as, by a preponderance of the evidence). The weight of the evidence is not determined by the number of witnesses or volume of exhibits, but by considering all the evidence and evaluating factors, which as a whole, shows that the fact sought to be proved is more probable than not.

- consider all the evidence
- all direct evidence, that is, evidence based on actual knowledge or observation of witnesses

- all indirect evidence, that is, facts or statements from which reasonable inferences, deductions, and conclusions may be drawn to establish an unobserved fact, knowledge, or state of mind
- no distinction will be made between the relative value of direct and indirect evidence
- in some cases, direct evidence may be more convincing than indirect evidence. In other cases, indirect evidence may be more convincing than direct evidence (for example, statement of a witness)
- evaluate factors such as a witness's demeanor, opportunity for knowledge, information possessed, ability to recall and relate events, and relationship to the matter to be decided

c. Section II. Terms. Gross negligence is failure to exercise even the slightest amount of care; it is a conscious and voluntary disregard of the need to use reasonable care. Gross negligence is likely to cause harm or injury to persons, property, or both, and includes the deliberate disregard of another person's safety. Gross negligence is considered misconduct for the purposes of this regulation.

3. Army Regulation 95-1 (Flight Regulations), currently in effect, covers manned/unmanned aircraft operations, crew requirements, and flight rules. It also covers Army aviation general provisions, training, standardization, and management of aviation resources. The term aircraft and aircrew member will be considered synonymous and include both manned and unmanned requirements. Where there are differences, they will be annotated and clarified. Applicability. This regulation applies to the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve unless otherwise stated. Also, it applies to persons involved in the operation, aviation training, standardization, and maintenance of such aircraft and systems including aircraft on loan, lease, and bailment to the Army, the Army National Guard, and the U.S. Army Reserve.

a. Paragraph 3-1. Operations and Safety. Army aircraft will be utilized for authorized purposes only. Army owned, operated, or controlled aircraft will only be used to transport Army personnel, government property, other official government passengers, or other passengers and cargo as authorized by statute and DOD issuances, or Army Directives, regulations, or policies. Specifically, use of Army aircraft must comply with paragraphs 3–2, 3–3, 3–4, or 3–5 of this chapter and must not otherwise be prohibited by paragraph 3–6 of this regulation.

b. Paragraph 5-1. General. Army personnel engaged in the operation of Army aircraft/UAS shall comply with applicable:

(1) Federal aviation regulations, laws, and rules.

(2) The International Civil Aviation Organization regulations.

(3) Host country regulations, laws, and rules.

(4) Military regulations.

(5) Non-aviation federal and state laws applicable to Army aviation operations.

(6) DOD flight information publications.

(7) Aircraft operator's manuals approved supplements and checklists and applicable air worthiness releases.

4. Technical Manual 1-1520-251-10, chapter 5, Operating Limits and Restrictions, identifies operating limits and restrictions that will be observed during ground and flight operations. Paragraph 5.2 provides the operating limitations set forth in this chapter are the direct results of design analysis, test and operations experiences. Normal, transient, and maximum limits are displayed via the MPDs to the crew with corresponding digital readouts, vertical scales, timers and color coding. Compliance with restrictions and limits outlined in this chapter will allow the pilot to safely perform the assigned missions and to derive maximum utility from the aircraft.

//NOTHING FOLLOWS//