Exhibit 11

DEPARTMENT OF THE ARMY
U.S ARMY HUMAN RESOURCES COMMAND
1600 SPEARHEAD DIVISION AVENUE
FORT KNOX, KY 40122

September 28, 2023

Freedom of Information Office

Mr. Jack Whitney

Tucson, AZ 85732
ontheline297@gmail.com

Dear Mr. Whitney:

This is in response to your Freedom of Information Act (FOIA) request dated June 21, 2021, for "the accident investigations for the parachute accident that killed SFC Ethan Carpenter. The accident occurred on 3/15/2019 at the Parachute Training and Testing Facility at Pinal Airpark, AZ." We assigned control number FA-23-3640 to your request for our administrative and tracking purposes – please refer to this number when inquiring with us about your request.

A copy of the requested LOD is enclosed. We processed your request in accordance with Department of Defense Instruction (DODI) 1300.18, Military Personnel Casualty Matters, Policies and Procedures, Army Regulation 638-8, Army Casualty Program, Army Regulation 638-34, Army Fatal Incident Family Brief Program, and under the provisions of the Freedom of Information (FOIA) and Privacy Acts. Personal information of others has been excised from the documents pursuant Exemptions 3 and 6 of the FOIA. Exemption 3 covers information specifically exempted from disclosure by statute. Accordingly, 10 U.S.C. § 130b prohibits the disclosure of personally identifying information regarding personnel assigned to an overseas, sensitive, or routinely deployable unit. Exemptions 6 permits the government to withhold all information about individuals in "personnel and medical files and similar files" when the disclosure of such information "would constitute a clearly unwarranted invasion of personal privacy." This information, if disclosed, would constitute a clearly unwarranted invasion of personal privacy. Accordingly, the personal information of others is exempt from disclosure under Exemption 6 of the FOIA without the data subjects' express written consent, subpoena and/or court order. We will always protect your family's personal information from any unauthorized disclosure in the same manner.

On behalf of the U.S. Army Medical Command, personal health information of others has also been excised from the report under Exemption 6 of the FOIA, as it would also constitute a clearly unwarranted invasion of personal privacy.

Please do not consider this a denial of your request, but our effort to provide you with responsive records in a timely and efficient manner. If you require a formal response, you may submit a letter in writing to this Command, ATTN: AHRC-FOI. Upon receipt, your request will be processed though our Initial Denial Authority, Major General Thom, Commander, U.S. Army Human Resources Command.

For further assistance and to discuss any aspect of your request, you have the right to contact the Army FOIA Public Liaison Officer, by email at usarmy.belvoir.hqda-oaa-ahs.mbx.rmda-foia-public-liaison@army.mil, or by phone at (571) 515-0306. Additionally, you have the right to contact the Office of Government Information Services (OGIS) at the National Archives and Records Administration (NARA) to inquire about the FOIA mediation services they offer. The contact information for OGIS is as follows: NARA-OGIS, 8601 Adelphi Road-OGIS, College Park, MD 20740-6001, email at ogis@nara.gov: telephone at (202) 741-5770; toll free at (877) -684-6448; or facsimile at (202) 741-5769.

If you are not satisfied with our response and you have already requested a formal response, you have the right to appeal to the Office of the General Counsel through the Department of the Army, U.S. Army Human Resources Command, ATTN: AHRC-FOI, 1600 Spearhead Division Avenue, Department 107, Fort Knox, Kentucky 40122-5504. Your appeal must be postmarked or electronically transmitted within 90 days of the date of this response.

If you have any questions, feel free to contact me at (502) 613-4055, or via e-mail at rebecca.a.morris8.civ@army.mil.

Sincerely,

Becky Morris

Becky Morris
Government Information Specialist

Enclosure

United States Army Special Operations Command
Freedom of Information Act/Privacy Act Request Form

(This is a request under the Freedom of Information Act (5 U.S.C. 552))

Current Date	2011-01-26 14:50:20				
Title		Last Name	WHITNEY	First Name	JACK	Initial	
Company/Affiliation				Email	ONTHELINE297@GMAIL.COM		
Address 1	PO BOX 13533			Phone Number	5206046612		
Address 2				Work Number			
City	TUCSON	State	Arizona	Zip Code	85732	Cell Number	
Country	United States						

I request that the following documents be provided to me. (Identify the documents as specifically as possible here and check one of the boxes below).

Description of Records: I am seeking the accident investigations for the parachute accident that killed SFC Ethan CARPENTER. The accident occurred on 03/15/2019. The accident occurred at the Parachute Training and Testing facility at Pinal Airpark, AZ.

- (•) I agree to accept a releasable copy of the requested document(s). I understand that some information of documents may be withheld as authorized and cited in the Department of Defense Regulation 5400.7, Freedom of Information Act Program, paragraph c3.2.1 Exemptions one through nine.
- ( ) I will not accept a releasable copy of the requested document(s). I wish to have my request referred to the appropriate reviewing authority for a final review and release determination. I understand that my request will be processed in the order that it was received and that it could exceed a year before I receive a final decision.

Fee Categorization - Select the category that best describes you or your organization:

- ( ) A representative of the news media affiliated with the newspaper, magazine, television station etc., and this request is made as part of news gathering and not for a scholarly or scientific purpose and not for commercial use.
- ( ) Affiliated with an educational or non-commercial scientific institution, and this request is made for a scholarly or scientific purpose and not for commercial use.
- ( ) Affiliated with a private business and am seeking information for use in the company's business.
- ( ) Family of a deceased Service Member (free processing/fees waived).
- (•) Individual seeking information for personal use and not for a commercial use.

I am willing to pay fees. If you estimate that the fees will exceed this limit, please inform me first. The total willing to pay: $25

- [ ] (If applicable) I request a waiver of fees for this request because disclosure of the requested information to me is in the public interest because it is likely to contribute significantly to the public understanding of the operations or activities of the Army and is not primarily in my commercial interest. (Include details about how the requested information will be disseminated by you to the general public in the section Description of Records.)

Signature Field: 

Submit by Email | Print Form | Reset Form

STATEMENT OF MEDICAL EXAMINATION AND DUTY STATUS

For use of this form, see AR 600-8-4; the proponent agency is DCS, G-1

THRU (Include ZIP Code)	TO (Include ZIP Code)	FROM (Include ZIP Code)
Commander (b) (3) /(b)(6) 75th Ranger Regiment Fort Benning, GA 31905	Commander, (b) (3) /(b)(6) 75th Ranger Regiment Fort Benning, GA 31905	(b) (3) /(b)(6) 75th Ranger Regiment (b) (3) /(b)(6) Fort Benning, GA 31905

1. NAME OF INDIVIDUAL EXAMINED (Last, First, and Middle Initial)	2. SSN	3. GRADE
Carpenter, Ethan , C.	(b) (6)	E-7

4. ORGANIZATION AND STATION	5. ACCIDENT INFORMATION	
	a. DATE	b. PLACE (City and State)
(b) (3) /(b)(6) 75th Ranger Regiment Fort Benning, GA 31905	20190315	Marana, AZ

SECTION I - TO BE COMPLETED BY ATTENDING PHYSICIAN OR HOSPITAL PATIENT ADMINISTRATOR

6. INDIVIDUAL WAS ☐ OUT PATIENT ☐ ADMITTED ☒ DEAD ON ARRIVAL

7. NAME OF HOSPITAL OR TREATMENT FACILITY ☒ CIVILIAN ☐ MILITARY
Banner University Medical Center

8. HOUR AND DATE ADMITTED
0723 15 March 2019

9. HOUR AND DATE EXAMINED
0723 15 March 2019

10. NATURE AND EXTENT OF ☒ INJURY ☐ DISEASE ☒ RESULTING IN DEATH (Explain)
While on AD the SM was conducting military free fall operations and sustained a midair collision resulting in a fatality.

11. MEDICAL OPINION: a. INDIVIDUAL ☐ WAS ☒ WAS NOT UNDER THE INFLUENCE OF ☒ ALCOHOL ☒ DRUGS (Specify)

b. INDIVIDUAL ☒ WAS ☐ WAS NOT MENTALLY SOUND (Attach Psychiatric evaluation if appropriate)

c. INJURY ☐ IS ☒ IS NOT LIKELY TO RESULT IN A CLAIM AGAINST THE GOVERNMENT FOR FUTURE MEDICAL CARE

d. INJURY ☒ WAS ☐ WAS NOT INCURRED IN LINE OF DUTY BASIS FOR OPINION
While on AD the SM was conducting military free fall operations and sustained a midair collision resulting in (b) (6) (b)(6) and death.

12. THE FOLLOWING DISABILITY MAY RESULT ☐ TEMPORARY ☐ PERMANENT PARTIAL ☒ PERMANENT TOTAL

13. BLOOD ALCOHOL TEST MADE (b)(6)

14. NO. OF MG ALCOHOL/100 ML BLOOD (b)(6)

15. DETAILS OF ACCIDENT OR HISTORY OF DISEASE (how, where, when)
On March 15, 2019 the SM was conducting military free fall operations in Marana, AZ, and sustained a midair collision that (b)(6) and death.

16. DATE	17. TYPED OR PRINTED NAME OF ATTENDING PHYSICIAN OR PATIENT ADMINISTRATOR	18. SIG
20190409	(b) (6)(b) (6)(b) (6)	(b) (6)

SECTION II - TO BE COMPLETED BY UNIT COMMANDER OR UNIT ADVISER

19. DUTY STATION
☒ PRESENT FOR DUTY ☐ ABSENT WITHOUT AUTHORITY
☐ ABSENT WITH AUTHORITY ☐ ON PASS ☐ ON LEAVE

20. HOUR AND DATE OF ABSENCE

a. FROM	b. TO

21. ABSENCE WITHOUT AUTHORITY MATERIALLY INTERFERRED WITH THE PERFORMANCE OF MILITARY DUTY (Explain in Item 30 type of duty missed, hours of duty, and how it did or did not interfere with performance)
☐ YES ☐ NO

22. INDIVIDUAL WAS ON
☒ ACTIVE DUTY ☐ ACTIVE DUTY FOR TRAINING
☐ INACTIVE DUTY TRAINING

23. HOUR AND DATE OF TRAINING

a. BEGAN	b. ENDED

24. RESERVIST DIED OF INJURIES RECEIVED PROCEEDING ☐ DIRECTLY TO TRAINING ☐ DIRECTLY FROM TRAINING

25. MODE OF TRANSPORTATION	26. HOUR BEGINNING TRAVEL	27. DISTANCE INVOLVED	28. NORMAL TIME FOR TRAVEL

29. DUTY STATUS AT TIME OF DEATH IF DIFFERENT FROM TIME OF INJURY OR CONTRACTION OF DISEASE
☐ PRESENT FOR DUTY ☐ ABSENT WITH AUTHORITY ☐ ABSENT WITHOUT AUTHORITY

30. DETAILS OF ACCIDENT - REMARKS (If additional space is needed, continue on reverse) (Attach inclosures as necessary)
On March 15, 2019 the SM was conducting military free fall operations in Marana, AZ, and sustained a midair collision that resulted in (b) (6) (b)(6) and death.

31. FORMAL LINE OF DUTY INVESTIGATION REQUIRED ☒ YES ☐ NO

32. INJURY IS CONSIDERED TO HAVE BEEN INCURRED IN LINE OF DUTY (Not applicable on deaths) ☐ YES ☐ NO

33. DATE	34. TYPED NAME AND GRADE OF UNIT COMMANDER OR UNIT ADVISOR	35. SIGNATURE
20190409	(b) (3) /(b)(6)	(b) (3) /(b)(6)

DA FORM 2173, OCT 1972 REPLACES DA FORM 2173, 1 JUN 66, WHICH IS OBSO

APD LC v2.01ES

REPORT OF INVESTIGATION
LINE OF DUTY AND MISCONDUCT STATUS

1. REPORT DATE (YYMMDD): 190424

2. INVESTIGATION OF (X one): [ ] INJURY [ ] DISEASE [ ] ILLNESS [X] DEATH

3. STATUS (X as applicable): [X] a. REGULAR OR EAD; [ ] b. CALLED OR ORDERED TO AD FOR [ ] (1) MORE THAN 30 DAYS [ ] (2) 30 DAYS OR LESS; [ ] c. INACTIVE DUTY TRAINING (Type); [ ] d. SHORT TOUR OF ACTIVE DUTY FOR TRAINING

4. TO (Major Army or Air Force Commander): Headquarters, United States Army Special Operations Command, Fort Bragg, North Carolina 28310

5. NAME OF INDIVIDUAL (Last, First, Middle Initial): Carpenter, Ethan, C

6. SSN: (b) (6)

7. GRADE: E7

8. ORGANIZATION AND STATION: (b) (3) /(b)(6) 75th Ranger Regiment Fort Benning, GA 31905

9. OTHER MILITARY PERSONNEL INVOLVED IN THE SAME INCIDENT

NAME (Last, First, Middle Initial) a.	SSN b.	GRADE c.	d. LOD INVESTIGATION MADE (X) YES	NO
(b) (3) /(b)(6)(b) (3) /(b)(6)(b) (3) /(b)(6)			(b)(6)	

e. DURATION (Applies ONLY to 3.c and d.)

	DATE (YYMMDD)	HOUR
(1) START		
(2) FINISH		

10. BASIS FOR FINDINGS (As determined by investigation)

a. CIRCUMSTANCES	(1) HOUR	(2) DATE (YYMMDD)	(3) PLACE
	0723	191315	Marana, Arizona

(4) HOW SUSTAINED: While on active duty, the SM was conducting military free fall operations and sustained a midair collision.

b. MEDICAL DIAGNOSIS: The collision (b)(6) nd death.

c. PRESENT FOR DUTY? (X) [X] YES [ ] NO — If absent: (X) [ ] WITH AUTHORITY [ ] WITHOUT AUTHORITY (Do not complete 10 e. and f. in death cases.)

e. WAS INTENTIONAL MISCONDUCT OR NEGLECT THE PROXIMATE CAUSE? (X) [ ] YES [X] NO

f. WAS INDIVIDUAL MENTALLY SOUND? (X) [X] YES [ ] NO

g. REMARKS: See AR 15-6 - line of duty findings and recommendations

11. FINDINGS (X one. Do not complete in death cases.) [X] IN LINE OF DUTY [ ] NOT IN LINE OF DUTY - NOT DUE TO OWN MISCONDUCT [ ] NOT IN LINE OF DUTY - DUE TO OWN MISCONDUCT

12. INVESTIGATING OFFICER

a. TYPED NAME (Last, First, Middle Initial)	b. GRADE	c. BRANCH OF SERVICE	d. SSN
(b) (3) /(b)(6)	(b)(3)(b)	Army	(b) (3) /(b)(6)

e. ORGANIZATION AND STATION: (b)(3)(b) 75th Ranger Regiment, Fort Benning, GA 31905

f. SIGNATURE: (b) (3) /(b)(6)

13. ACTION BY APPOINTING AUTHORITY

a. HEADQUARTERS	b. DATE (YYMMDD)
75th Ranger Regiment	190504

c. (X one. Indicate reasons and substituted findings on back.) [X] APPROVED [ ] DISAPPROVED

d. TYPED NAME (Last, First, Middle Initial): (b) (3) /(b)(6)

e. GRADE	f. BRANCH OF SERVICE	g. SSN
(b)(3)(b)	USA	

(b) (3) /(b)(6)

14. ACTION BY REVIEWING AUTHORITY

a. HEADQUARTERS	b. DATE (YYMMDD)
U.S. Army Special Operations Command	

c. (X one. Indicate reasons and substituted findings on back.) [X] APPROVED [ ] DISAPPROVED

d. TYPED NAME (Last, First, Middle Initial): Beaudette, Francis M.

e. GRADE	f. BRANCH OF SERVICE	g. SSN
O-9	Army	

h. SIGNATURE: SAME AS FINAL APPROVING AUTHORITY

(b) (3) /(b)(6)

BY THE AUTHORITY OF
THE SECRETARY OF THE ARMY

AUG 02 2019

(b) (3) /(b)(6)

FRANCIS M. BEAUDETTE
LTG, USA
COMMANDING

DD FORM 261, OCT 95 — PREVIOUS EDITION WILL BE USED — Adobe Professional 8.0

DEPARTMENT OF THE ARMY
HEADQUARTERS, 1ST SPECIAL FORCES COMMAND (AIRBORNE)
BLDG E-2040 DESERT STORM DR.
FORT BRAGG NORTH CAROLINA 28310-8500

AOSO-OSW 04 November 2019

MEMORANDUM FOR Commander, U.S. Army Special Operations Command, 2929 Desert Storm Drive, Fort Bragg, North Carolina 28310-9114

SUBJECT: Findings and Recommendations for Continuation of Army Regulation (AR) 15-6 Investigation into the Death of SFC Ethan Carpenter During Military Free Fall (MFF) Training

1. BACKGROUND.

a. Appointment: On 02 August 2019, I was appointed as an investigating officer (IO) pursuant to AR 15-6 to conduct a continuation of the original administrative and line of duty investigation into the death of SFC Ethan Carpenter. Guidance from the Commanding General, USASOC, indicated that my review should include a thorough analysis of whether the circumstances alleged are accurate and merit correction. My initial suspense was 02 September 2019; two 30-day extensions were requested and granted to allow sufficient time for medical experts to review the evidence and provide expert opinion. The following specific questions were directed by the USASOC Commanding General as points of particular emphasis required of my investigation:

b. Provide a more specific timeline and greater fidelity on the following questions:

(1) Who was the first Special Forces Medical Sergeant (MOS 18D) or qualified medic to arrive at the scene of the accident? How soon after the accident did they arrive? What did they observe on arrival? Did they provide medical treatment?

(2) When did Emergency Medical Services (EMS) arrive at the scene of the accident? When did SFC Carpenter arrive at the hospital? Did treating physicians document medical observations and reach conclusions? If so, detail those observations and conclusions, and further elaborate on the impact and effectiveness of medical intervention.

(3) Given the medical observations and conclusions, did the medical evacuation procedures have an impact in this case? Should they be altered or modified?

SUBJECT: Findings and Recommendations for Continuation of Army Regulation (AR) 15-6 Investigation into the Death of SFC Ethan Carpenter During Military Free Fall (MFF) Training

(4) Any other matters deemed relevant and within the scope of either my appointment orders or those of the original investigating officer, dated 25 March 2019.

c. Method of Investigation: I began my investigation by receiving a legal in-brief from CPT Charles "Brad" Johnson on 06 August 2019, where I was briefed on the status of the investigation, notable findings, and the USASOC Commanding General's concerns that necessitated additional investigation. I was allowed to review the initial investigation, and was provided with a hard copy of the investigation and all associated materials for continued review and reference on 07 August 2019. From 08 August 2019 to 15 August 2019, I read the initial investigation, taking notes and establishing my investigative plan. On 26 August 2019 I conferred with CPT Johnson at USASOC SJA to brief him on my initial impressions, my investigative plan, and to receive guidance. I contacted the Ranger Reconnaissance Company (RRC) Commander, CPT Carpenter, on 27 August 2019 to obtain the RRC Military Free Fall (MFF) Standard Operating Procedure (SOP) and the Off-Post Training (OPT) Concept Brief mentioned but not provided in the initial investigation. I received these products on 04 September 2019 From 26 August 2019 to 06 September 2019 I attempted to contact the Pinal County Medical Examiner, Dr. John Hu, to seek additional details and his medical opinion on a line of inquiry. I made contact with the Pinal County ME's Office on 06 September 2019 and received a sworn statement from Dr. Hu on 12 September 2019. I sought additional medical opinion from the USASOC Surgeon's Office on 25 September 2019, and was referred to the (b)(6) expertise. I made contact with medical experts at the JTS, including the Armed Forces Medical Examiner's liaison officer to the JTS, on 01 October 2019, and explained the relevant details of the circumstances surrounding the training fatality to them. On 04 October 2019, I provided them with the relevant statements, the Pinal County ME's report, and additional details pertaining to the investigation for their review. On 30 October and 02 November 2019 I received their witness statements and reviewed their opinions. From 31 October to 03 November 2019 I drafted my findings and submitted my completed investigation for legal review on 04 November 2019.

d. Summary: The medical opinions of the Pinal County Medical Examiner (ME), experts at the Joint Trauma System (JTS), and the Armed Forces Medical Examiner all (b)(6) (b)(6) Given that RRC personnel searched for SFC Carpenter for nearly two hours before locating him, it is possible that he expired as his teammates searched for him. (b)(6) (b)(6) SFC Day and which, if any, (b)(6) with the ground, it is impossible to

SUBJECT: Findings and Recommendations for Continuation of Army Regulation (AR) 15-6 Investigation into the Death of SFC Ethan Carpenter During Military Free Fall (MFF) Training

determine with any degree of certainty how long SFC Carpenter lived after receiving his injuries. Based upon the preponderance of medical evidence and the medical opinions of experts including Medical Examiners and Trauma Surgeons, it is possible, however unlikely, (b)(6) (b)(6) (b)(6) The extent of SFC Carpenter's injuries more than likely would As SFC Carpenter would have needed a blood transfusion (b)(6) , neither of which could have occurred at the scene of the accident, evacuation to a hospital would have been necessary. As it is unlikely that any medical intervention would have saved SFC Carpenter's life, I do not find that medical evacuation procedures were a contributing factor to his death.

2. FACTS:

a. Regarding Question(s) 1: "Who was the first Special Forces Medical Sergeant (MOS 18D) or qualified medic to arrive at the scene of the accident? How soon after the accident did they arrive? What did they observe on arrival? Did they provide medical treatment?"

(1) SFC Philbin, a Special Operations Combat Medic (SOCM) – qualified Ranger Medic, was the first qualified medic to reach SFC Carpenter (Exhibit L). SFC Philbin did not reach SFC Carpenter until 0653 hrs, approximately one hour and fifty-one minutes after the first jumpers from SFC Carpenter's stick (Stick 1) began landing on Kodiak DZ (Exhibit B). Personnel from Stick 2, still on the aircraft, flew search patterns looking for SFC Carpenter from the ramp of the aircraft and were the first to spot SFC Carpenter's canopy near the end of the runway. The aircraft was given clearance to land and the jumpers of Stick 2 ran to the site of SFC Carpenter's body, making SFC Philbin the first trained medic to reach SFC Carpenter (Exhibits B and L). As SFC Philbin and the others had been rigged to jump as the second stick of jumpers on the aircraft, they did not have any medical equipment with them when they located SFC Carpenter. SFC Philbin was the first to assess SFC Carpenter's condition and determine necessary treatment, but it was not until one of the ground search teams, led by SFC Bowman and SFC French arrived moments later with a medical kit, at approximately 0700 hours, that medical equipment arrived on scene (Exhibit H).

b. Regarding Question(s) 2: "When did Emergency Medical Services (EMS) arrive at the scene of the accident? When did SFC Carpenter arrive at the hospital? Did treating physicians document medical observations and reach conclusions? If so, detail those observations and conclusions, and further elaborate on the impact and effectiveness of medical intervention."

SUBJECT: Findings and Recommendations for Continuation of Army Regulation (AR) 15-6 Investigation into the Death of SFC Ethan Carpenter During Military Free Fall (MFF) Training

(1) EMS was notified at approximately 0648 hours, about one hour and forty-six minutes after it was realized that SFC Carpenter was not accounted for (Exhibit B). (b)(6) [redacted] Exhibit T).

(2) Regarding the effectiveness of medical intervention, both COL Shackelford of the Joint Trauma System (JTS) and Lt Col Mazuchowski of the JTS and the Armed Forces Medical Examiner's Office (b)(6) [redacted] (Exhibits D and E). Unfortunately, at the time (b)(6) [redacted] SFC Carpenter (b)(6) [redacted] (b)(6) [redacted] (Exhibit E).

c. Regarding Question(s) 3: "Given the medical observations and conclusions, did the medical evacuation procedures have an impact in this case? Should they be altered or modified?"

(1) Given the documented nature and severity of SFC Carpenter's injuries it seems unlikely that any medical intervention, unless performed almost immediately, would have saved SFC Carpenter's life. Even if located immediately, SFC Carpenter would have required a (b)(6) [redacted] that would not have occurred at the point of injury and would have required evacuation to a hospital. The overwhelming medical opinion is that SFC Carpenter (b)(6) [redacted] (Exhibits C, D and E). Civilian life flight personnel from Tucson did not arrive on scene until 28 minutes after they were notified (Exhibit B), meaning that a round trip flight to a higher level of care would have taken approximately 60 minutes, pushing the limits of even the most generous estimates of survivability for SFC Carpenter. (b)(6) [redacted]

SUBJECT: Findings and Recommendations for Continuation of Army Regulation (AR) 15-6 Investigation into the Death of SFC Ethan Carpenter During Military Free Fall (MFF) Training

(b)(6)

d. Regarding Question(s) 4: "Any other matters deemed relevant and within the scope of either my appointment orders or those of the original investigating officer, dated 25 March 2019."

(1) Finding:

a. In the initial investigation, the cause for the mid-air collision that occurred between SFC Carpenter and SFC Day while they were under canopy is described as "a dynamic turn caused by an uneven opening in SFC Day's canopy." (Exhibit A, Page 15, Paragraph 3d). The initial investigation goes on to detail that "while not mentioned as a partial or total malfunction, this rare event occurs when one side of the canopy (the left in this instance) open while the other side (right side in this instance) is still filling up with air and causes the jumper to turn while not under his canopy."

b. This explanation is factually incorrect and misleading. SFC Day's own sworn statement identifies that what he actually experienced was a premature brake line release (Exhibit P). This event is a known and identified partial malfunction and is mentioned as a part of every Emergency Procedures review during military free-fall pre-jump activities, with corrective action briefed should this malfunction occur. A premature brake line release also could cause a jumper to immediately enter into a violent turn in one direction, as it has the same effect as pulling a canopy's steering toggle (in fact the brake line) on one side, which is precisely how one steers a ram-air canopy like those found on the Military Javelin parachute. SFC Day performed corrective action exactly as briefed upon identifying the malfunction and is at no fault. By the time he corrected his malfunction and regained control of his canopy it was already too late, and he collided with SFC Carpenter (Exhibit P).

c. It is worth noting that while some level of inquiry into who packed SFC Carpenter's parachute is apparent in the initial investigation, there is no follow-up as to who packed SFC Day's parachute – the one that experienced the partial malfunction and the ultimate cause of the collision. As such, there is no deeper investigation into the packing procedures and rigger checks associated with the packing of SFC Day's parachute. I was unable to collect additional information regarding SFC Day's parachute packing after the fact. I also assessed that interviewing the packers at this juncture would not be helpful, as a significant amount of time has elapsed since the day in

question and the packers do not have an incentive to self-report known deficiencies. The objective evidence indicates the riggers and civilian contracted parachute packers present were all qualified to pack and inspect the Military Javelin parachute system. The training of the parachute riggers and civilian contract packers is well-documented and the sworn statements all state that all parachutes were packed in accordance with procedures and regulations, with rigger checks conducted as required.

(2) Recommendation:

a. While the training, qualifications, certification, and level of experience of the riggers and civilian packers involved in parachute packing for this training is well-documented in MFRs and sworn statements, based upon my experience it seems highly unlikely that a brake line would spontaneously come unstowed – as SFC Day experienced - had a parachute been packed and checked to standard.

b. USASOC G3 and 75th Ranger Regiment riggers associated with military free-fall training and operations should review internal procedures and processes to determine whether additional controls, procedures, or checks should be implemented when overseeing the parachute packing work of civilian contracted parachute packers.

(3) Finding:

a. No fewer than four personnel noticed a jumper (now known to be SFC Carpenter) flying his canopy in the wrong direction, contrary to what was planned, briefed, and expected, on his way to conduct an off-drop zone landing (TSgt Atkinson, SSG Brown, LT Haas, and SSG Allen - Exhibits O, U, and V). None of the personnel who noticed these events reacted to the information they observed. As military free-fall training is inherently high-risk, made more so by the conditions the Rangers were training in that morning – combat equipped with oxygen mask, under NVGs, during period of darkness – the fact that a jumper was flying in the wrong direction and acting in a manner other than what was planned, briefed, and expected should have been considered a potential emergency to all who witnessed it, and one that warranted a response.

b. Typically, off-drop zone landings or "low jumper" procedures are mentioned during the pre-jump briefing before any military free-fall jump, ensuring that all jumpers understand actions to take should another jumper experience issues making it to the drop zone. Procedures typically state that if a jumper in the stick is seen to be heading off course toward an off-drop zone landing (off DZ landing), or if a jumper experiences some kind of equipment malfunction that precludes him from making it to

the drop zone (low jumper), another jumper will always follow that jumper and attempt to land with him. This is done because under canopy it can be difficult to know the circumstances causing the jumper to land off the intended drop zone, and the intent is to ensure that there is not an isolated or lost jumper incident, like the one experienced on 15 March 2019.

c. The Ranger Reconnaissance Company (RRC) Military Free-Fall (MFF) Standard Operating Procedure (SOP) has no detailed procedures for off-drop zone landings or "low jumper" procedures (Exhibit R). There are no search procedures outlined in the RRC MFF SOP though it is noted in the initial investigation that search procedures were discussed and rehearsed prior to the commencement of training in Arizona (Exhibit A).

d. Although the jumpers of Stick 1 were conducting a Full Mission Profile (FMP) jump meant to simulate conditions found in a real-world scenario, the jumpers did not utilize communications systems on the jump as would have been required in combat or in a stand-off/High-Altitude High Opening (HAHO) jump profile.

(4) Recommendation:

a. It is the overwhelming medical opinion of the experts who reviewed this case (b)(6) . However, had SFC Carpenter's injuries (b)(6) RRC (b)(6) (b)(6) (b)(6) . RRC leadership should codify in writing and adhere to an SOP for off-drop zone jumpers and low jumpers, particularly for jumps conducted during hours of limited visibility when determining the state of a jumper under canopy is made more difficult by darkness. Consider immediately activating a medical vehicle to follow a jumper conducting an off-drop zone landing from the moment his actions are noted until he lands, so as to be on site immediately in the event he is experiencing a medical emergency. Two jumpers in Stick 1 (TSgt Atkinson and SSG Brown) both noted SFC Carpenter flying away from the drop zone and yet did not respond or attempt to follow SFC Carpenter (Exhibits O and V). RRC leadership should ensure off-drop zone landings and low jumper procedures are mentioned as a part of each pre-jump briefing and adhered to for all jumps. As any off-drop zone landing is a deviation from what is planned, briefed, and expected, and given the difficulty of determining the state of a jumper during period of darkness, any off-drop zone landing during period of darkness should be considered a potential emergency and responded to as such.

SUBJECT: Findings and Recommendations for Continuation of Army Regulation (AR) 15-6 Investigation into the Death of SFC Ethan Carpenter During Military Free Fall (MFF) Training

b. For all full mission profile (FMP) jumps and not just stand-off/HAHO jumps, RRC leadership should ensure all parachutists jump with and utilize communications systems. Had all jumpers jumped with radios and utilized communications under canopy (as they would in combat), the jumpers in the stack and potentially those monitoring on the drop zone might have realized that SFC Carpenter was unresponsive when he did not check in over the radio upon deploying his canopy. Similarly, those monitoring the jump might have known sooner that a collision occurred had SFC Day had a radio and been able to relay the details of his mid-air collision with SFC Carpenter. This might have allowed RRC medics to be better postured not just to deal with SFC Day's injuries, but to follow SFC Carpenter during his descent to his point of impact, allowing them to render aid more quickly.

(5) Recommendation:

a. USASOC G3 should establish a written policy directing all subordinate CSUs and CSCs to contact the Armed Forces Medical Examiner's (AFME) Office in the event of training-related or non-combat fatalities. Whereas civilian medical examiners typically only seek to establish a cause of death and determine whether it was the result of a homicide or some other cause, the AFME's personnel additionally seek to more thoroughly document injuries in greater detail in order to better informing line of duty and AR 15-6 investigations. In this particular instance, had the AFME been contacted to assist with the autopsy of SFC Carpenter, (b)(6) (b)(6) answers to the questions directed by the USASOC Commanding General.

3. POC for this memorandum is the undersigned at 910-643-8987 or charles.schumacher@socom.mil.

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