WORSLEY INQUIRY/OUT/2007/

INQUIRY OFFICER'S REPORT INTO THE DEATH OF
8265028 PTE LJ WORSLEY IN AFGHANISTAN ON 23 NOV 07

References:
A. CDF Instrument of Appointment dated 27 Nov 07
B. CDF Terms of Reference dated 27 Nov 07
C. Quick Assessment by - Death of Australian During
   Operations dated 24 Nov 07
D. Map Central and Western Uruzghan Province Planning Map - Afghanistan, 1:100,000
E. AHQ (DGPP-A) R650307 2005/1021958 Risk Acceptance of Rabintex X200 Attack
   Helmet dated 9 Mar 06
F. DMO (LSD) Minute SMSP/OUT/2007/121 Provisional Design Acceptance of
   Enhanced Combat Helmet dated 21 Mar 07
G. CDF ROEAUTH - ROE Serial 5 dated 12 Oct 07
H. Di(G) ADMIN 45-2 Reporting and Investigation of Alleged Offences within the
   Australian Defence Organisation dated 30 Oct 01
I. Di(G) PERS 11-2 Notification of Service and Non-Australian Defence Force casualties
   dated 18 Dec 01
J. ADFP 1.1.1 Mortuary Affairs dated Jan 07
K. Di(G) PERS 20-6 Deaths within and outside Australia of Australian Defence personnel
   dated 18 Sep 06
L. CDF Directive 12-2006 Interim Arrangements for CDF Commissions of Inquiry into ADF
   Suicides and Deaths in Service dated 30 May 06
M. Defence (Inquiry) Regulations, 1985, Part 8, CDF Commissions of Inquiry dated
   26 Jun 07
N. ADFP 202 Administrative Inquiries Manual

Appointment and Terms of Reference

1. 1. 8223830 COL PJ Short, DSC, having been duly appointed by Air Chief Marshal Allan
    Grant Houston, AO, AFC, Chief of the Defence Force, to inquire into the circumstances and
    facts surrounding the death of 8265028 Private Luke James Worsley in accordance with the
    Terms of Reference attached to the Instrument of Appointment (Annex A) herein submit my
    report.

Inquiry Officer Team

2. 2. The Inquiry Team consisted of me as the Inquiry Officer and 8223745 COL Gary Bruce
    Hevey, RFD, as the Assistant Inquiry Officer.
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Introduction

3. On the night of 22/23 Nov 07, were conducting a search and clearance operation in the vicinity of approximately 30 kilometres of Tarin Kowt, Afghanistan. During the course of the clearance significant enemy resistance was encountered resulting in the combat death of PTE LJ Worsley (the incident).

Methodology and Approach

4. The inquiry Team had already been assembled and deployed in theatre in order to inquire into two previous FATALCAS incidents. As a result, the Team were able to gather statements and other evidence in a timely manner. The Team was supported in location by ADF Investigative Service staff. Due to the high security risk, the Team was not able to visit the actual site of the incident. This was not considered to be a significant shortfall given the availability of imagery. The Team was able to conduct the Inquiry without any impact upon deployed forces. A Quick Assessment was conducted by the 56 and is attached at annex B.

Synopsis of Incident

5. The planned and conducted a direct action mission to search and clear two compounds of interest (consisting of several smaller compounds) in order to disrupt enemy forces. This mission, code named , was the fourth phase in series of actions under The target compounds were located approximately which lies 30 kilometres of Tarin Kowt, Afghanistan. Intelligence indicated the compounds were regularly used by Taliban forces for meetings. At hours local, whilst conducting multiple room entries, the force element (FE) initiated an engagement with one enemy armed with a RPK light machine gun, assessed to be a sentry in an alley way. The enemy was killed in action (KIA) and the initial plans to seek invited entry into the compounds were abandoned. At this time, call signs and made manual entry into an adjoining compound. PTE Worsley was the first member of and to enter this compound. Almost immediately upon entering the compound, PTE Worsley identified a person with a PGM heavy machine gun. This enemy was approximately 18 metres distance from PTE Worsley. During the ensuing fire fight, PTE Worsley was fired on and killed by the enemy machine gunner. PTE Worsley was killed by a single gun shot wound to the head. An intense close quarter battle continued within the compound, involving high volumes of small arms fire and the use of fragmentation weapons by and . FE to neutralise the threat. The enemy engaged and FE from multiple directions. All enemy within the compound were killed. A total of friendly, enemy and two local national non-combatants were KIA as a result of persons of interest were detained. A number of unverifiable reports have indicated other persons may have been wounded. A separate inquiry is investigating the matter of the non-combatant KIAs.

6. A detailed sequence of events using imagery of the incident site is at Annex C.
Date, Time and Place of Incident

7. The incident occurred at Nov 07 Nov 07 local Nov 07 (reference D) approximately 30km of Tarin Kowt, Afghanistan.

Units Involved

8. as part of was conducting the operation. They were accompanied by six Afghanistan National Army (ANA) personnel. was operating in support of the operation.

Authority to Conduct the Operation

9. The operation during which the incident occurred was code named was one of a series of operations within the construct which had been approved at the National and International Security Assistance Force levels (annex D refers).

Involvement of other Military Forces

10. Throughout the conduct of the mission, including the prosecution of the contact, National Army personnel accompanied BCCG during the conduct of the task. They were co-located with Company Headquarters throughout the execution of the task.

Involvement by Civil and Service Authorities

11. A theatre based Australian Defence Force Investigation Service team provided assistance to the Inquiry Team. There has been no service investigation into the incident.

12. The death of PTE Worsley has not been investigated by any other military or civil agency.

Death and Injuries

13. Deaths. 8265028 PTE Luke James Worsley, posted to the 4th Battalion, The Royal Australian Regiment (Commando) (4 RAR), was killed in action as a result of this combat related incident. His next-of-kin was informed by the Commanding Officer 4 RAR accompanied by a service padre, on 23 Nov 07.

14. At all times following his death, PTE Worsley was treated with dignity and respect by his comrades. His repatriation to Australia and the military funeral was indicative of a man who died in the service of his country.

15. An autopsy was conducted on PTE Worsley by the NSW Forensic Pathologist at the Department of Forensic Medicine, Glebe on 3 Dec 07. The Pathologist found the direct cause leading to death was a gunshot wound to the head (annex E refers). At annex E, the
Pathologist postulates that there may be two entry wounds to PTE Worsley's head by stating "...penetrating injuries in the left temple and occipital region of the back of the head." This statement was inconsistent with the analysis by the Inquiry Officer (IO) when considering statements taken and viewing the helmet worn by PTE Worsley at the time of the incident. The matter was cleared up during a telephone conversation (see appendix one to annex E) which provided greater clarity to the Pathologist concerning the circumstances of the incident. It is the finding of the IO that only a single penetrating injury, located in the left temple exists. The injury located at the occipital region was caused by the exiting projectile.

16. Injuries. There were no other injuries to Australian service personnel as a result of this incident.

Damage to Property

17. PTE Worsley's service related combat helmet was damaged during the incident. The helmet has been returned to Australia for further forensic testing. The results of this testing are not expected to be available prior to the submission of this report. Notwithstanding, it is the opinion of the Inquiry Officer that the helmet was not a contributing factor to the death of PTE Worsley. This matter is further discussed in para 33.

18. The remainder of PTE Worsley's issued equipment and clothing was destroyed as a result of blood contamination prior to the arrival of the Inquiry Team. Whilst not an issue in this case, care should be exercised for future matters where retention of evidence may be important.

19. There was some collateral damage that occurred as a result of this incident. This matter is being addressed through a separate inquiry.

Witnesses

20. Statements. Statements were obtained from the following witnesses:

a.
b.
c.
d.
e.
f.
g.
h.
i.
j.
k.
These statements are contained at annexes F to R. Due to security risks; statements from local nationals could not be attained.

I advise that I found each of the witnesses honest and forthcoming. They appeared to be experienced well trained soldiers who handled the difficult task with which they were confronted with professionalism. I found no evidence of collusion between them or any attempt to reconstruct their version of events to try and fit with other versions provided by their comrades. While there were some small variations in relation to unimportant matters those variations are such as one would expect having regard to the vagaries of individual memory, different perspectives from which observations were being made and the general “fog of war” issues involved in a sustained and intense close quarter battle.

Environmental Conditions

23. **Terrain.** The terrain is predominately rural with large open fields of view surrounded by large, dominating mountains. Access to the area is by a single lane, compacted earth road. The area is sparsely populated. The local nationals reside in a system of small compounds within larger compounds. The compounds are constructed from mud brick surrounded by walls six to eight feet tall. There is little symmetry to the design of the compounds as many are added on to pre-existing structures over time. Life is centred upon the Tiri Rud River which provides water for irrigation of crops, the main source of income. The irrigated areas are commonly referred to by coalition forces as the green belt (GB).

24. **Incident Site.** The compound where the incident occurred is a small mud brick compound within a larger compound system. This compound is rectangle in shape measuring approximately 21 metres by 13 metres surrounded by eight foot mud brick walls. A series of rooms and/or covered areas line the inside of the compound along the walls. The centre of the compound is largely open except for an outhouse positioned near the centre south. A single entry point to the compound exists located along the southern wall.

25. **Weather.** The weather conditions at the time of incident were reported as cool but fine with no inclement conditions prevailing. The weather is assessed as having no impact on the outcome of the incident.

26. **Visibility.** Although night time, some members described visibility as good due to a high amount of ambient light. These conditions can be advantageous to either opposing force. This light diminished within the confines of the compounds particularly in shaded areas and into the green belt. There was no street lighting in this area. Notwithstanding, all personnel forces were also provided.

27. **Cultural Environment.** The local area had been the subject of intelligence interest for a protracted period leading up to the incident. Due to its relative isolation, the area was a known regular meeting place for Taliban commanders and fighters. The area itself lies to the lines of communication meet key terrain where three Taliban at annex S refers).
reporting indicates that local nationals largely support the Afghanistan Government and simply feed and accommodate the Taliban because of coercion.

28. **Noise.** During there was no noise. Whilst static in the FUP, a number of dogs began barking in response to small groups of fighting age males moving away from the compound system. This noise masked the move of personnel to the compounds. Once troops in contact occurred, a significant amount of noise erupted as a result of combat.

29. **Human Activity.** Whilst static in the FUP, personnel observed two groups of three fighting age males move east to west away from the compounds of interest. This was considered suspicious behaviour. An element of the during the early stages of the compound clearance was confronted by a fighting age male armed with an RPK. This male had been observed scaling down a rooftop. His actions were akin to that of a tactically positioned sentry.

**Operational Conditions**

30. **Adequacy of Intelligence.** has access to coalition intelligence sources and the incident area had been the subject of intelligence interest for a protracted period of time. The general area had a history of Taliban activity including previous contacts with coalition forces, known staging bases for Taliban attacks and locations for improvised explosive device making materials (annex S refers). was aware of a number of Taliban medium value interest commanders who frequented this area. The area was a well known Taliban meeting location. There was no understatement of the threat at the time of the incident.

31. **Adequacy of Orders.** Detailed orders were issued by the Officer Commanding prior to departing their Forward Operating Base, Camp Russell on 20 Nov 07. updated and amended the orders throughout the period of the operation. The Officer Commanding issued orders each time they were received by . Many members were unequivocal in their belief that orders were adequate and pertinent to the task. There were no indications that orders issued were anything but clear and effective.

32. **Adequacy of Techniques, Tactics and Procedures (TTPs).** Many members commented that they considered the execution of the task as effective and in accordance with established TTPs. Some members commented that PTE Worsley’s individual actions were also in accordance with TTPs. It is the assessment of the IO that PTE Worsley had conducted correct TTPs

33. **Actions On.** The original plan was abandoned once troops in contact occurred. This necessitated a manual entry by (consisting of the compound where PTE Worsley was killed in action (KIA). The ensuing noise would have alerted the occupants to an imminent forced entry and provided them a brief period of time to prepare. It is highly likely that the enemy who engaged and killed PTE Worsley used this time to collect his weapon and possibly, to adopt a fire position to his advantage. Notwithstanding, it was appropriate for to conduct a manual entry once troops in contact had occurred. Had they delayed their entry into this compound it
could have provided more time for all enemy fighters to prepare themselves resulting in increased friendly force casualties.

34. Adequacy of Command and Control. The operational ground commander placed himself in

   direct actions without being decisively engaged by enemy fighters. He retained

   as Officer Commanding

   likewise placed himself sufficiently rearward to understand the circumstances of the contact and direct friendly forces as appropriate. He manoeuvred his Headquarters throughout the contact as the circumstances dictated. Both Team Leaders within

   were located with their members throughout the task including the contact. From member’s statements there is overwhelming suggestion that control was being exerted by the team leaders and their actions were well coordinated. It is the assessment of the IO that given the closeness and intensity of the fighting within such a complex environment, that additional casualties, both friendly and non-combatant, would most likely have resulted had effective control and coordination not been present.

35. Adequacy of Equipment. At the time of the incident, PTE Worsley was equipped with

   SP issued chest webbing including front and rear ballistic armour plates and was wearing the Rabintex X200 Attack Helmet (see annex T). The X200 helmet is preferred over the Enhanced Combat Helmet (ECH) by due to the nature of their tasks. The XP200 helmet is lighter albeit with some reduction in the level of protection compared to the heavier ECH. The reduced level of protection is in the areas of coverage, fragmentation velocities and resistance to ballistic deformation (reference E refers). Whilst the X200 helmet does not accord the same level of protection that the ECH offers,

   types (attachment one within reference F refers). PTE Worsley was struck by a 7.62mm high velocity projectile fired from a PKM machine gun from a distance of 18 metres.

   PTE Worsley’s helmet, worn at the time of the incident was inspected by the IO. A single penetration of the helmet above the left eye is visible and in the opinion of the IO the pattern is indicative of the initial strike a bullet shaped projectile would make. Imagery of PTE Worsley’s helmet worn on the night of the incident is at annex U. The helmet has since been released for forensic testing (annex V refers). The results of this testing are not expected prior to the submission of this report. Notwithstanding, and based upon references E and F, I find that the type of helmet worn by PTE Worsley was not a contributing factor in his death.

36. Adequacy of Rules of Engagement. Rules of Engagement (ROE) are covered in

   reference G. had been operating with these ROE since arrival in theatre and were familiar with their content and application. From witness statements, it would appear that PTE Worsley identified his assailant upon entering the compound before he was fatally engaged. From member’s statements, PTE Worsley applied the correct ROE by

   PTE Worsley also provided a verbal target indication which alerted his comrades to the immediate threat. PTE Worsley then engaged the identified enemy with three to four rounds prior to being fired upon by the enemy machine gunner. PTE Worsley’s

   is consistent with numerous statements detailing other soldiers positively identifying targets as hostile or a threat prior to engaging.
implications for: and can have deleterious outcomes on both the mission and force protection if not adhered to. For this reason, and the fact

37. Adequacy of Training. Numerous members believed their training and preparation for this operation was sufficient. Many members commented that they had conducted this type of mission on many previous occasions. It is noteworthy that most members have a substantial amount of operational experience having previously deployed on multiple operations.

Alcohol and Drugs

38. There is no evidence identifying alcohol or drugs as factors in this incident.

Other Factors

39. There were no other factors that contributed to the death of PTE Worsley.

Duty Status and Authorisation

40. The force elements involved in the incident were conducting a . The intelligence that led to this action was sound and subsequently confirmed by the results of the action. This task had been duly authorised by the appropriate authoritys.

Performance of Duty

41. The task was conducted in accordance with issued orders and established tactics, techniques and operating procedures. There was no evidence of personnel failing in their performance of duty.

Weaknesses in the System and Method of Control

42. Post-incident procedures including reporting, notification of casualties and mortuary procedures were carried out in accordance with the relevant references.

43. PTE Worsley's equipment and clothing, less helmet, worn on the night of the incident were destroyed due to blood contamination prior to inspection by the Inquiry Officer. Whilst not an issue in this case, care should be exercised for future matters where retention of evidence may be important. The IO was unable to identify a current policy detailing the management of personal equipment and clothing in the circumstances of this incident. Reference K appeared to be the most appropriate policy to provide guidance on this matter.

44. There were no other identified weaknesses in the system or method of control.

Conclusions

45. PTE Worsley was killed in action on 23 Nov 07 from a single gun shot wound that penetrated his left temple. PTE Worsley's death occurred in straightforward circumstances of combat.
46. The equipment that PTE Worsley wore, particularly personal protective equipment was appropriate to the task and the level of threat and was not a contributing factor to his death.

47. Training, intelligence and orders were all sufficient prior to the conduct of the task. Further, ROE applied, TTPs conducted and control exercised during the contact was effective.

48. There were no other contributing factors to this incident.

Recommendations

49. It is recommended that:

a. the appointment of a Commission of Inquiry into this incident is not warranted, and

b. reference K be amended to include the retention of all personal equipment and clothing for notifiable incidents until such time as the appropriate investigating authority has released the items for disposal or otherwise.


Annexes:

A. Instrument of Appointment and Terms of Reference
B. Quick Assessment dated 24 Nov 07
C. Sequence of Events
D.

E. Autopsy Report – PTE Worsley, dated 5 Dec 07
F. Statement by
G. Statement by
H. Statement by
I. Statement by
J. Statement by
K. Statement by
L. Statement by
M. Statement by
N. Statement by
O. Statement by
P. Statement by
Q. Statement by
R. Statement by
S. Statement by

correct as at 011300Z Dec 07
T. Photo Supplement, Indicative PPE – PTE Worsley of 5 Dec 07
U. Photo Supplement, PTE Worsley’s helmet of 23 Nov 07
V. IO Minute to PM-ADF Release of Evidence dated 3 Dec 07