INQUIRY OFFICER'S REPORT INTO THE DEATH OF CORPORAL M.R.A. HOPKINS IN AFGHANISTAN ON 16TH MARCH 2009

References:

A. CDF Instrument of Appointment and Terms of Reference dated 24 Mar 09
B. *Concept of Operations*

C. Mentoring and Reconstruction Task Force OPLAN

D. Map
E. Map
F. DI(G) Pers 20-6 *Death of Australian Defence Force Personnel* dated 20 May 08
G. DI(G) Pers 11-2 *Notification of Australian Defence Force and non-Australian Defence Force Casualties* dated 20 May 08
H. HQ JTF633 SI(Pers) 04-06 *MEAO Mortuary Affairs Management* dated 22 Sep 08
I. ADFP 06.1.4, *Administrative Inquiries Manual*, AL1, 2007

Appointment and Terms of Reference

1. I, Colonel William Richard Hanlon, having been duly appointed by Air Chief Marshal Allan Grant Houston, AC, AFC, Chief of the Defence Force, to inquire into the death of Corporal Mathew Ricky Andrew Hopkins in accordance with the Terms of Reference attached to the Instrument of Appointment (Annex A) herein submit my report.

Inquiry Officer Team

2. The Inquiry Officer Team consisted of myself as the Inquiry Officer and the following Inquiry Assistants:

a. Lieutenant Colonel Craig John Barker, and

b. Warrant Officer Class Two Paul Michael Paterson.

Methodology

3. Following in Australia, the Inquiry Team moved to via the arriving on the morning of 1 Apr 09. Following the team moved forward with an unscheduled stop at due to bad weather, arriving on the evening of 7 Apr 09.

4. On arrival, the team commenced reading the evidence pack provided to them At this point it was identified that the personnel directly involved in the incident either remained deployed forward or were on ROCL/ROCTFA. It was clear of in theatre tactical transport it was impractical for the Inquiry Team to conduct interviews with the soldiers in PB locations. Evidence from these

members was gathered via the initial provision of statements, followed up by an interview The Inquiry Team was still in location when the members on ROCL/ROCTFA arrived back and these personnel were interviewed on 17 Apr 09. HQ MRTF personnel involved were also interviewed at over the period 9 – 13 Apr 09. The Inquiry Team concluded gathering evidence at MRTF on 17 Apr 09.

5. In interviewing the personnel from the PB it was impracticable to provide them a copy of the Instrument of Appointment, Terms of Reference and Annex D, Chap 6 of ref I. In these cases I provided them with a verbal brief on these documents and had them acknowledge they had received such a brief. These briefings were recorded and have been retained.

6. I consulted the QA (Annex B) conducted by the MRTF dated 17 Mar 09.

7. The Inquiry Team were unable to visit the site of the incident due to the security situation but this is not considered to be an impediment to the conduct of the Inquiry. A satisfactory appraisal of the incident site was able to be conducted through the examination of maps, provided

Introduction

8. On the morning of 16 Mar 09 an element of MRTF Operational Mentoring and Liaison Team (OMLT) led by LT from PB , located approximately 12 km North of Camp HOLLAND, was operating in its assigned mentoring role in support of elements of Afghanistan National Army The morning's activity was the provision of mentoring support to an ANA lead patrol consisting of Afghan soldiers broken into two manoeuvre groups. LT was providing mentoring to Group 1 of ANA, while SGT provided mentoring to Group 2. CPL M.R.A. Hopkins was attached to LT Group 1 as the Section Commander (Sect Comd) providing support to the mentors. The OC OMLT, MAJ was also present, in LT Group 1, as an observer.

9. At approximately 0931h insurgent (INS) forces initiated contact with the patrol in the vicinity of the village of KAKARAK, approximately South West of PB During the initial part of the engagement CPL Hopkins was struck by INS small arms fire and killed.

Background

10. To understand the incident, the concept of operations of the OMLT needs to be understood. The insertion of mentoring elements in support of the ANA began with the deployment of MRTF in Oct 08. Ref B describes the OMLT as follows:

> "OMLT are a critical element of ISAF's strategy to develop an effective Afghan National Security Force and improve the security and long term development of Afghanistan (AFG).

11. CO MRTF intent for the conduct of OMLT operations is contained in ref C and his method statement is as follows:

12. To conduct operations the OMLT is structured to work alongside and mentor the assigned ANA from The OMLT members live and operate from the PB occupied by the ANA The tasking and tempo of the OMLT, while influenced by the mentors, is set by the intent and mission of the supported ANA commander. The main influencing process is through the provision of a patrol programme, however changes to intent and plans are often caused by the day to day actions and decisions of the supported ANA commander.

13. The OMLT structure (Annex C) includes a

14. The presence of an should be noted.

At the time of his death CPL Hopkins was fulfilling the role as the Sect Comd of the OMLT Sect.

15. During the conduct of operations the OMLT submits a to HQ MRTF and this details the intended conduct of activities for the upcoming 24h. This may change during the course of the day, and indeed during the course due to the requirements of the supported ANA element and updates are submitted as required. Overall, planning for operations in support of the ANA lacks certainty

due to the disparate nature of the level of ANA and the supported commander.

Date, Time and Place of the Incident

16. The incident took place on 16 Mar 09 between 0930h and 1105h local Afghanistan time (1600h to 1735h AEDT) in the vicinity of the village of KAKARAK URUZGAN PROVINCE, AFGHANISTAN. This location is approximately South-West of PB and North of the MRTF base at Camp HOLLAND, TARIN KOWT.

Forces Involved

17. **Australian.** Australian forces involved were:

a. An element of Team , OMLT, MRTF consisting of:

b. Attached to the patrol were also elements of HQ OMLT, MRTF consisting of:

c. The OMLT were supported by

18. **Afghan.** Elements of ANA based from PB commanded by LT

19. **Coalition.** The Coalition Forces involved in the incident were:

a. Two provided offensive support during the contact.

b. One AME helicopter provided AME support.

c. The Dutch Role 2 Medical Facility at Camp HOLLAND, TARIN KOWT, where CPL Hopkins' body was initially received and where his repatriation commenced.

d. The Theatre Mortuary Affairs Evacuation Point for mortuary support

Synopsis of the Incident

20. The patrol departed PB at and moved West towards the The patrol consisted of two manoeuvre elements each of ANA soldiers together with the OMLT personnel. moved with Group 1 and with Group 2 The patrol was commanded by LT (known hereafter as the 'ANA Comd') with LT providing mentor support. The patrol was a patrol to the West of the in the vicinity of KAKARAK and was to continue to provide a presence in that area.

21. The patrol crossed the and continued to proceed West to the vicinity of KAKARAK village. The patrol went just across the river prior to continuing the planned patrol route At this time there was a discussion between LT and the ANA Comd on the TTP he was employing and the subsequent conduct of the patrol.

22. At approximately , CPL Hopkins and LCPL identified and engaged a to South-West of the patrol's location. The decision was made by the ANA Comd, in consultation with LT to who was located in the vicinity of an Afghan compound (Quala). The ANA Comd placed SGT Group 2 into a position and Group 1 moved Whilst moving, the INS initiated contact with Group 1 from the vicinity of a berm at a distance of approximately 50-100m at 0932h.

23. At the point of contact, MAJ and LT who had been travelling at the rear of Group 1, were caught in the open while CPL Hopkins and LCPL were able to move quickly to the nearby compound, move inside and secure it before beginning to provide fire to the South. At about this time the INS initiated additional contact from compounds to West, at a distance of approximately 250m. Elements of SGT Group 2 commenced engaging to the West and this allowed MAJ to move from open ground and into the compound occupied by CPL Hopkins and LCPL A short time later LT was also able to move from open ground and into the same compound. By this time the INS had engaged from positions to the South East.

24. CPL Hopkins and LCPL moved to the rear of the compound on the Eastern side where LCPL provided fire from the corner of the compound towards the South East. During this engagement CPL Hopkins went to ground behind a dirt mound a short distance from the corner of the compound in order to engage the INS. His fire position was described by MAJ as a very good fire position. Very shortly after adopting the fire position CPL Hopkins was struck in the head by INS fire. MAJ , who had moved to this position, recovered CPL Hopkins out of fire. MAJ and LCPL attempted to provide immediate first aid to CPL Hopkins while at the same time having to engage the INS.

25. With assistance from ANA soldiers, CPL Hopkins was moved into the compound where LT was located. During this period LT requested PTE to move

forward from SGT position to provide medical assistance to CPL Hopkins. PTE moved forward across approximately 50-60m of open ground, under fire, and began to render first aid to CPL Hopkins. LT , in conjunction with SGT who was relaying information from LT coordinated requests for casevac and offensive support AH64 MAJ and LCPL moved to provide security and fire onto the INS positions to the South and South-East. Throughout this period SGT Group 2 continued to engage the INS positions to the West.

26. Over the subsequent period (assessed by MAJ to be 20-30min) the patrol was fixed inside the compound under a considerable weight of fire by small arms, RPG and possible mortar. SGT Group 2 continued to engage to the West, while MAJ and LCPL engaged to the South and South-East. PTE also moved forward with a stretcher to prepare for the evacuation of CPL Hopkins; concurrently LT and SGT organised a withdrawal route. It was during this time that CPL Hopkins stopped breathing but PTE was able to provide expired air resuscitation and revive him.

27. At approximately 1020h, the AH64 came on station and, while they were unable to engage the INS their presence resulted in a temporary reduction in INS fire which allowed LT Group 1 to conduct a fighting withdrawal (ANA carrying CPL Hopkins and AUS members providing covering fire) and marry up with SGT Group 2. By this time CPL Hopkins was displaying no vital signs and PTE had been unable to revive him. From SGT position, the patrol intended to withdraw North and then to an identified casevac location

28. When it became clear that they were not going to make the nominated casevac location without great difficulty, the AME pilot requested the patrol to identify their position and on his own initiative landed near the withdrawing patrol, well within range of INS fire, to execute the evacuation of CPL Hopkins.

29. The OMLT personnel then re-organised the ANA elements into patrol formation and proceeded East Once across the patrol was again engaged by small arms fire, however a show of force by the AH64 led to the cessation of the firing and the patrol returned to PB They were in location at PB at 1201h.

30. Throughout the main part of the contact there appears to have been limited involvement by the ANA patrol personnel.

31. Attached is the compound where the contact took place (Annex D); the MRTF (Annex E), LT Contact Report (Annex F); the MRFT Log extracts (Annex G); and the MRTF Consolidated BDA following the contact (Annex H).

Authority to Conduct the Operation

32. The incident occurred during the conduct of normal framework operations. These activities were appropriately approved as per Australian National requirements by CO MRTF

through the issue of OPORD -dated 28 Feb 09 (Annex I) and noted by DCJTF-A on 26 Feb 09 (Annex J).

33. The normal framework operations of Op were also advised to the ISAF chain of command through a brief sent on 3 Mar 09

Involvement by Civil and Service Authorities

34. The local ADFIS representative opened an ADFIS investigation into the incident IAW DI(G) 45-2 *Admin Reporting and Investigation of Alleged Offences within the Australian Defence Organisation.* There has been no other known Australian, local or Coalition investigations or inquiries into this incident. The ADFIS provided one assistant to the inquiry.

35. The NSW Coroner conducted an autopsy on CPL Hopkins' remains on 24 Mar 09. The coroner's report is yet to be received.

Involvement by Civilians

36. While there is evidence of civilians leaving the area of the incident site prior to the main contact, there is no evidence of involvement by civilians in this incident nor have there been any reports of civilian casualties as a result of the contact.

37. Due to the nature of this incident it is highly probable that there was damage to civilian compounds but this has not been assessed.

Deaths and Injuries

38. **Death.** CPL M.R.A. Hopkins was killed in this combat related incident. At the time he was shot, CPL Hopkins had just taken up a fire position on the Eastern corner of the compound in order to engage the INS who were firing small arms and RPG from the South East. The shot that struck CPL Hopkins inflicted a major head wound that was assessed by the MRTF RMO, as fatal. CPL Hopkins' wound consisted of

Given the circumstances of the contact, I am satisfied that the fatal shot was fired by an INS firing from the South East of CPL Hopkins' position.

39. An autopsy was conducted by the NSW Coroner on 24 Mar 09 and this was attended by Health, Joint Operations Command. While the Coroner's Report was not available to the Inquiry Team, provided observations from the autopsy (Annex K). assessment was that the wound sustained by CPL Hopkins was 'non-survivable and even immediate access to surgical care would not have altered the outcome'.

40. The patrol reported being in contact at 0931h and reported an Australian casualty at 0939h. The personnel interviewed were unable to provide further clarification on these timings. What is known is that CPL Hopkins was struck sometime shortly after 0931h and not later than 0939h.

41. CPL Hopkins was certified dead by MAJ at the Dutch Role 2 Medical Facility at 1105h. CPL Hopkins actual time of death can be estimated from witness statements, the details as recorded on the PM377 - *Field or Transport Medical Report* (Annex L) and from MAJ evidence. Following his wounding CPL Hopkins was treated in the field, initially by MAJ and LCPL and subsequently by PTE , a qualified CFA. Whilst being treated by PTE , CPL Hopkins stopped breathing and PTE was able to revive vital signs. From the PM 377, CPL Hopkins stopped showing signs of life at 1017h. This fits with MAJ statement that when he pronounced CPL Hopkins dead he assessed he had been dead for approximately 40 mins due to the temperature of the body. I would therefore place CPL Hopkins time of death at approximately 1017h.

42. At all times following his death, CPL Hopkins' body was treated with dignity and respect by his comrades. Following his return to Camp HOLLAND MRTF placed a vigil at the Dutch Role 2 Medical Facility until the ramp ceremony and subsequent departure of CPL Hopkins' remains Prior to the ramp ceremony, a church service was conducted by MRTF and attended by Coalition allies.

43. **Injuries.** There were no additional injuries to Australian, Coalition or ANA personnel.

Loss and Damage to Service Property

44. Currently all CPL Hopkins service property has been accounted for. His helmet and body armour was returned to Australia and is currently in the custody of ADFIS. It is likely that this will be written off due to and this will occur through normal unit procedures, as required.

Witnesses

45. Statements and/or interviews were obtained from/conducted with the following witnesses or others involved with the incident:

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Environmental Conditions

46. **Terrain.** The patrol route was concentrated within the area known as the Green Belt West of At the time of the incident, the Green Belt consisted mainly of cultivated fields with numerous irrigation ditches intersecting them. Most fields had either emergent wheat or poppy crops. On average, wheat crops are around 15 - 20cm in height, while poppy crops are 5 - 10 cm. In the cultivated fields, the ground was firm under foot, The trees within the orchards are mainly almond, and were only just beginning to gain foliage at that time of year. Visibility was out to 100 - 300 m at times.

47. **Incident Site.** The incident occurred in the Northern area of the village of KAKARAK, West of . KAKARAK contains numerous compounds situated within cultivated fields. The ground around the contact slopes downward gently from West (elevation 1420m) to East (Elevation 1400m). The ground between the Australian/ANA forces and the INS was generally open – the trees within the fields to the West did not impede view . Contact occurred at distances of 50-250m. During the contact, the patrol were located in and around an Afghan compound Attached is the contact site showing broad terrain (Annex FF) and maps covering the OMLT Team AO (Annex GG - Hard Copy only).

48. **Weather.** The weather at the time of the incident was fine and clear.

49. **Visibility.** The visibility at the time of the incident was considered to be very good.

50. **Cultural Environment.** At the time of the incident KAKARAK was considered to be an area with but it was unknown as to whether the local population was

51. **Human Activity.** The incident took place within a rural concentration of human habitation. Prior to incident a number of the patrol members indicated small numbers of people moving within KAKARAK and just prior to the contact shows a number

of women and children rapidly moving away from the contact area. During the incident there was no observable human activity aside from INS forces.

52. **Contribution of Environmental Conditions to the Incident.** The contact occurred within complex terrain of cultivated fields, human habitation and a number of fields with trees. This terrain was similar to operating conditions MRTF has been operating in since deployment. By Mar 09 MRTF soldiers were very experienced in the terrain within which they operated. As such the environmental conditions did not contribute adversely to the outcome of the incident in any direct way.

Operational Conditions and Factors

53. **Pre-Patrol Intelligence.**

a.

b. **Previous Patrolling Activity.** A number of previous patrols had been conducted in and around the KAKARAK area.

c. Passage of Intelligence. The dissemination of intelligence throughout the MRTF-

I assess that the dissemination of intelligence throughout MRTF supports the conduct of operations

d. **Understanding of the Intelligence.** I am confident that there was a common understanding of the relevant intelligence between the intelligence/operations staff and the OMLT elements operating on the ground.

54. **Pre-patrol Planning.**

a. **General.** Overall, with the ANA provides ongoing challenges to the OMLT personnel. The ANA do not appear to have a

for a variety of reasons. The OMLT personnel consider this to be part of the operational environment and work around these issues accordingly. The OMLT HQ attempts to mitigate this through the provision of patrol forecast that holds the ANA to a form of planning and also forms part of the ongoing development of the ANA capability.

b. **Intent for Normal Framework Operations.**

c. **Planning for 16 Mar 09.** LT and SGT conducted planning the afternoon and evening prior to the patrol.

Within the constraints of operating with the ANA the planning process appeared to be suitable for the task. The patrol size on the day of ANA and Australians is considered to be a sizable force package for a patrol of this nature.

55. **Orders.** LT delivered orders late on the evening of 15 Mar 09. Those present described the orders as clear. All members interviewed indicated an understanding of the intent for the patrol on 16 Mar 09.

56. **Command and Control.** From witness statements it appears LT and SGT maintained good command and control throughout the incident. They coordinated well and SGT provided support to LT in the passage of information and maintenance of radio communications with OMLT HQ. The efforts of both LT and SGT were significant in maintaining cohesion throughout a prolonged, chaotic and confusing contact and in the subsequent orderly withdrawal of the combined patrol.

57. **Contribution of Operational Conditions and Factors to the Incident.** Other than the changeable nature of ANA operations, there are no factors in the operational conditions or factors that impacted adversely in the conduct of the patrol.

Training and Procedures

58. **Training.**

a. **General.** All personnel were trained and qualified for the roles they undertook. Overall, the general training for their roles, the training provided through OMLT task specific training, and the mission rehearsal exercise appeared to have prepared the members of the OMLT and HQ MRTF well for the situation encountered.

b. **Specific**. CPL Hopkins' role required the skills and training of Sect Comd. After reviewing the relevant PMKeyS entries and taking witness statements, I am satisfied that CPL Hopkins was fully qualified in this role and was an experienced and capable JNCO, having previously served a tour of duty in Afghanistan as a Private soldier. I am similarly satisfied that PTE was qualified to perform his role as a CFA.

59. **Tactics, Techniques and Procedures.** The TTP employed during the incident were appropriate to the task and were well performed throughout the incident.

60. **Passage of Information**. The passage of information during the incident was from the troops in contact (TIC) to the OMLT HQ and then to HQ MRTF . From an examination of operations and radio logs the information was passed in a timely manner. CO MRTF provided updates to CJTF 633 during the incident.

61. **Contribution of Training and Procedures to the Incident.** All training and procedures supported the conduct of the incident. The level of training and the application of procedures allowed the patrol to maintain good order under significant pressure and subsequently extract itself from the area of contact.

Post Incident Events and Factors

62. **Medical Treatment.** The first aid provided by MAJ and LCPL immediately after CPL Hopkins was shot was appropriate given they were in direct contact with the INS at the time. PTE subsequently made all possible effort to sustain vital signs in CPL Hopkins. The actions of PTE in crossing open ground under fire to render assistance to his comrade and his subsequent efforts are highly commendable.

63. **CASEVAC.** According to radio logs the initial report of a casualty was received at 0943h and the casevac request received at 1004h. The AME was launched at 1038h and LT had radio contact with the AME at approximately the same time. The AME had wheels down at the incident site at 1046h. Given the nature of the contact and the inability for the AME to land at the incident site due to heavy contact these timings are appropriate and within the set guidelines. The AME pilot picked up CPL Hopkins in a field within of the INS positions to the West and should be commended for the support provided to Australian TIC.

64. **Casualty Notification.** All elements involved indicated that the casualty notification process worked in a timely and appropriate manner.

65. **Repatriation.** There were no major issues with the repatriation of CPL Hopkins. The various ramp ceremonies and his subsequent burial were reported to have occurred in an appropriate manner showing due respect for a fallen soldier.

Other Factors.

66. **Equipment.** CPL Hopkins was wearing all mandated protective equipment at the time of the incident, including his Body Armour and Kevlar Helmet. The CO MRTF , OC OMLT, LT and other soldiers made specific comment during the course of the inquiry on the weight of impacting on the operations they are undertaking. Evidence was given that while providing high

levels of protection, is not optimal for the type of light infantry operations that the OMLT were conducting. Evidence was further given that a form of body armour that provides a better would be more suitable for the OMLT operations. The CO and OC OMLT clearly stated that this issue was not a contributing factor in CPL Hopkins' death and the available evidence supports this position. The did contribute to the difficulty in recovering CPL Hopkins from an exposed position and evacuating him to the casevac location. Witness statements indicate that the patrol had great difficulty in evacuating CPL Hopkin's body to the medivac helicopter and this was attributed in part to the

67. MRTF has formally raised this issue with the chain of command through Operational User Requirement MRTF 004/08. AHQ conducted a Battle Worthiness Board on 30 Apr 09 and addressed the issue of body armour provided to the OMLT. As part of this process an equipment solution to the issues raised was identified with the intent to issue OMLT a more appropriate equipment solution. This is considered a satisfactory outcome.

68. **Drugs and Alcohol.** There is no evidence that drugs or alcohol were involved or contributed to CPL Hopkins' death.

69. **Other.** There were no other factors contributing to the incident.

Performance of Duty

70. From assessing the evidence and gathering witness statements there was no evidence of any personnel failing in the performance of their duties. The task was performed in accordance with orders and established TTPs.

Conclusion

71. CPL Hopkins was killed in action on 16 Mar 09 from a single gunshot wound to the head. The wound was fatal and no medical intervention would have saved his life. His death occurred in the straightforward circumstances of combat and as a direct result of INS action. CPL Hopkins was undertaking a duly authorised task in accordance with the MRTF and OMLT mission.

72. The members of the patrol performed creditably in dangerous and chaotic circumstances and under heavy INS fire. The ability of the patrol to perform to the level they did and maintain cohesion is a testament to their training.

73. Training, intelligence, planning and orders were all sufficient prior to the incident and there were no shortfalls in this area that contributed to CPL Hopkins' death.

74. Members of the patrol made strong comment on the suitability of the issued combat body armour for the conduct of operations in support of the ANA. It was felt that an equipment solution that maintains a more appropriate balance between on the battlefield should continue to be sought in the future. These comments were endorsed by CO MRTF and the AHQ Battle Worthiness Board and a solution identified.

75. A Commission of Inquiry is unlikely to discover any further relevant material, information or evidence in the context of this incident.

Findings

76. I find that the circumstances associated with the death of CPL Hopkins do not warrant the appointment of a COI.

Recommendations

77. I recommend that the appointment of a COI into this matter is not warranted.

W.R. HANLON
Colonel
Inquiry Officer

May 09

Annexes: