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**Australian Government**  
**Department of Defence**

**INQUIRY OFFICER'S REPORT INTO THE DEATH OF  
LIEUTENANT M.K.H. FUSSELL IN AFGHANISTAN  
ON 27<sup>th</sup> NOVEMBER 2008**

A handwritten signature in black ink, appearing to read 'T.J. McCullagh', written over a horizontal line.

**T.J. McCULLAGH**  
Colonel  
Inquiry Officer

23<sup>rd</sup> December 2008

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INTRODUCTION

Background

1. On 22 November 2008, the Special Operations Task Group (SOTG) commenced Operation [redacted] within central Uruzgan province, Afghanistan.

2. On the night of 26-27 November 2008, Force Element [redacted] (FE [redacted]) of the SOTG were conducting an activity [redacted] of OP [redacted]. The task was to clear some compounds [redacted].

SOTG [redacted] staff assessed these [redacted] to be the likely location of important insurgent leaders. In the process of a [redacted] to the target, Lieutenant Michael Kenneth Housdan Fussell was killed by an IED.

3. On 28 November 2008, the Acting Chief of Defence Force, Lieutenant General D.J. Hurley appointed Colonel Terence John McCullagh, an Inquiry Officer, pursuant to the *Defence (Inquiry) Regulations 1985 (Commonwealth)* (the Regulations), to inquire into issues associated with the death of Lieutenant Fussell. Inquiry Assistants for the purpose of assisting the Inquiry Officer were:

- a. Wing Commander Patrick James Keane (Air Force Headquarters);
- b. Captain Aaron Christopher Tucker (Military Police [redacted]); and
- c. Sergeant Jeffrey Douglas Lyon (Military Police [redacted]).

4. A copy of the Instrument of Appointment and Terms of Reference is at Annex A.

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5. The Quick Assessment conducted for Commanding Officer (CO) SOTG is at Annex B.

### **Aim**

6. In accordance with the Terms of Reference, the aim of this Report is to inquire into the issues resulting in the death of Lieutenant Fussell, and to recommend whether the circumstances associated with the incident warrant the appointment of a Commission of Inquiry (COI). The report will consider whether:

- a. substantial weaknesses or deficiencies (isolated or systemic) appear to exist in Defence systems, policy, equipment, practices, procedures and training in the context of the incident; and
- b. substantial shortcomings in Defence actions and decisions materially relevant to the incident, both prior and subsequent thereto, appear to exist.

### **Approach**

7. The broad approach adopted was as follows:

- a. Colonel McCullagh and Wing Commander Keane deployed from Australia to the  
Colonel McCullagh conducted  
planning and scoped the Inquiry
- b. Captain Tucker and Sergeant Lyon deployed from HQ JTF 633 in Baghdad to  
Tarin Kowt to conduct preparatory work prior to the arrival of the Inquiry Officer;
- c. Colonel McCullagh and Wing Commander Keane deployed to Kandahar and  
Tarin Kowt to interview relevant witnesses, assisted by Captain Tucker and  
Sergeant Lyon;
- d. statements and copies of relevant documents were obtained from relevant  
personnel at:
  - (1) SOTG Force Command Element (FCE) at Camp Baker, Kandahar;
  - (2) SOTG FE at Camp Russell, Tarin Kowt; and
  - (3) Mentoring and Reconstruction Task Force (MRTF) at Camp Holland, Tarin  
Kowt.
- e. responses to requests for information (RFI) and relevant documents were obtained  
from:
  - (1) Headquarters Joint Task Force 633 (HQ JTF 633);
  - (2)
  - (3) Headquarters Joint Operations Command (HQ JOC);

- (4) Army Headquarters;
- (5) Air Force Headquarters;
- (6) Headquarters Special Operations Command; and
- (7) Defence Community Organisation.

#### Site visits

8. The Inquiry Team visited:
  - a.
  - b. SOTG Force Control Element (FCE), Camp Baker, Kandahar, Afghanistan;
  - c. SOTG, FE Camp Russell, Tarin Kowt, Afghanistan; and
  - d. Mentoring and Reconstruction Task Force (MRTF), Camp Holland, Tarin Kowt, Afghanistan.

#### Interviews

9. A list of witnesses to this Inquiry and their statements or records of interview are in Binder Two.

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### BACKGROUND

#### FE

10. At the time of this incident, the fighting element of the SOTG was FE comprising regular and reserve personnel. All personnel deployed fully competent in their primary skills.

11. A description of the organisational make up of FE is set out in the CONOPS for OP at Annex C. Although the majority of personnel within FE are reserve personnel, many are former Australia Regular Army, and many have experienced multiple operational tours.

#### Lieutenant Fussell

12. Lieutenant Fussell was an artillery officer in the Australian Regular Army and posted to 4<sup>th</sup> Battalion (Commando), The Royal Australian Regiment (4 RAR (Cdo)) in January 2008. He deployed to Operation SLIPPER as a member of the SOTG, He was the senior Joint Terminal Attack Controller (JTAC), trained to call-in and direct offensive air

and ground assets (such as artillery and mortars) onto targets. A copy of Lieutenant Fussell's PMKeyS Service history is at Annex D.

13. Lieutenant Fussell was not a qualified commando, but had completed some elements of commando training, including special forces individual weapon training. This is not unusual, as a number of the specialists within a commando organisation are not qualified commandos, and are employed for their specialist skills.

**OP**

14. OP was a operation, aiming to capture or kill a number of known insurgent leaders in Uruzgan province. The Operation was aimed at different areas and groups,

OP required planned clearances of known targets as well an ability to conduct targeting

15. The on 26-27 November 2008 targeted insurgent leaders. The action was aimed at likely locations of the insurgent leaders. FE deployed and prepared for operations.

16. The threat of IED in this area was assessed. In response to previous SOTG operations in the region, insurgents had emplaced IEDs in potential positions and on routes to the populated area (the 'green belt') adjacent to the river at the valley floor.

17. The IED threat was well known and FE employed tactics to mitigate the threat, as discussed later in this report.

18. The following documents relevant to OP are annexed to this report:

- a. Task Force 66 Concept of Operations (CONOPS) – Annex C;
- b. Task Force 66 Warning Order – Annex E;

- c. Task Force 66 Directive – Annex F; and
- d. FE  
– Annex G.

**Authorisation**

19. OP was a operation within the International Security Assistance Force (ISAF) command and control framework.

- a.
- b.
- c.

20.

- a.
- b.
- c.

d.

21.

- a.
  - b.
-

c.

22. FE was notified at [redacted] that all approvals and concurrences for the [redacted] evening of 26-27 November 2008 had been obtained.

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## INCIDENT

### Move to IED Strike Location

23. Over the previous [redacted] FE was involved in a humanitarian affairs and key leadership engagement (HA/KLE) activity [redacted] FE worked for most of the night 25-26 November 2008. After extracting from [redacted], personnel were able to get some rest (in the order of 4-5 hours) before moving [redacted] in anticipation of the next task. Shortly after commencing that move, FE received a warning order [redacted] for the [redacted] to be conducted on the night of 26-27 November 2008. While moving towards the proposed [redacted] FE received additional data during a [redacted] stop.

24. FE reported to the [redacted] at Camp Russell that they were secure in the [redacted] at [redacted] hrs. There FE received the approved [redacted] concerning the activity [redacted] At [redacted] hrs mission support packages were sent [redacted] and received by FE [redacted]. Orders were compressed [redacted] to commence the infiltration as soon as possible in order to conduct the operation and be out of the green belt by first light.

25. After departing [redacted] at [redacted] hrs on 27 November 2008, FE commenced a [redacted] infiltration to the target. FE was moving [redacted] with spacing between personnel [redacted], which was appropriate. Lieutenant Fussell was 11<sup>th</sup> in the order of march

26. FE personnel were using night vision equipment. Luminosity from ambient light on that night was extremely low

Some personnel

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were with the lead element of FE

### IED Strike

27. At the time of the incident, members from FE At approximately 0112 DE hrs on 27 November 2008, Lieutenant Fussell contacted the pressure plate of an IED causing it to detonate.

28. The pressure plate for the IED was approximately 65 cms long and 12 cms wide,

Further information about the IED is set out below at paragraph 108. Photographs and maps ridgeline and the crater from the IED are at Annex H.

29.

30. A number of personnel observed Lieutenant Fussell being thrown down the slope to the left. members moved forward and cleared a safe route to allow Primary Health Care Team (PHCT) personnel access to Lieutenant Fussell and to other personnel affected by the blast. established himself as the on-scene commander at the incident site and coordinate the clearance of the area, the extraction of Lieutenant Fussell and the subsequent search for Mission Essential Items (MEIs).

### Post-strike actions in the field

31. After placing Lieutenant Fussell on a stretcher, Personnel collected as much equipment as could be located in the darkness. personnel began to clear a path back , closely followed by personnel carrying Lieutenant Fussell on a stretcher.

32.

33. The stretcher party and support personnel returned safely . A brief was received from FE at 0516 DE hrs on 27 November 2008. The report indicated that Lieutenant Fussell had suffered traumatic amputations not consistent with life. The aero-medical evacuation (AME) helicopter departed Tarin Kowt at 0544 DE hrs and arrived at at 0551 DE hrs. Lieutenant Fussell's remains arrived back at Tarin Kowt, draped in an Australian National Flag, at 0603 DE hrs.



34. Later on the morning of 27 November 2008, a path was cleared back to the incident site. On the way back to the incident site an IED was located. At around this time, personnel located a spotter overlooking the incident site. the individual decamped. Personnel were sent to the IED. Enroute to the IED they located another IED. The main charges were blown in place.

35.

36. FE eventually returned to Camp Russell, Tarin Kowt, on 27 November 2008.

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### EFFECT OF THE INCIDENT

#### Nature of injuries to Lieutenant Fussell

37. The Certification of Death (Form AD 604) was signed by (the Medical Officer) at 0618 DE hrs, 27 November 2008. A copy is at Annex I. Outpatient Clinical Record notes for Lieutenant Fussell are also at Annex I.

38. Lieutenant Fussell's remains were handed-over to the NSW Coroner on 3 December 2008.

39. Health Joint Operations Command attended the post mortem of Lieutenant Fussell on 4 December 2008. He was accompanied by the Medical Officer from He advised that the examining forensic pathologist will release a full report through the Coroner in due course.

40. observations were that Lieutenant Fussell sustained massive multiple trauma He assessed that the nature and extent of injuries were such that death would have been immediate. He further assessed that the nature, force and direction of the blast meant that the body armour worn by Lieutenant Fussell was not able to afford life saving protection. He finalised his report by saying that there was no evidence of any significant first aid or medical treatment. He assessed that it would have been immediately evident from the massive trauma that Lieutenant Fussell had died instantly and was not able to be resuscitated. report is in Binder Two.

### Nature of injuries to other personnel

41. It was initially reported that two members of FE were wounded in action as a result of the IED strike:

a. was immediately in front of Lieutenant Fussell and was thrown by the blast to the right hand side. Initially he felt pain in his legs but fortunately did not suffer any serious leg injury. got to his feet soon afterwards and after receiving minor treatment from medics, continued with his duties and returned with FE to Camp Russell that evening. suffered concussion, hearing damage and musculo-skeletal injuries. He was evacuated back to Australia on 23 December 2008 as a result of those injuries.

b. It was initially reported by FE that suffered superficial wounds as a result of the IED blast. This report was subsequently corrected, as suffered these minor injuries earlier during the infiltration.

42. On 29 November 2008, SOTG reported to JTF 633 a further notification of casualty (NOTICAS) for FE as a result of the incident. was directly in front of in the line of march and also suffered concussion, hearing damage and musculo-skeletal injuries. Despite his injuries, after the blast he acted as the Incident Scene Commander to coordinate the clearance of the area, extract Lieutenant Fussell and recover MEIs. NOTICAS has subsequently been closed and he is returned to full duty with FE

43. Whilst not reported by way of the NOTICAS process, it is also probable that other members of FE suffered degrees of hearing damage as a result of the explosion.

### Mission Essential Items

44. There was considerable damage to Lieutenant Fussell's military equipment

45. All MEI, were recovered from the site. A check of MEI confirmed that all items were recovered.

### Findings

46. After considering the information collated, the Inquiry Officer found that:

- a. Lieutenant Fussell inadvertently activated a pressure plate IED;
- b. Lieutenant Fussell was killed instantly by the resulting explosion on 27 November 2008; and
- c. two personnel suffered injuries as a result of the explosion that were reported through the NOTICAS process; was subsequently returned to

Australia as a result of his injuries while his duties. has returned to

47. The findings in relation to the cause of death of Lieutenant Fussell are reached by the Inquiry Officer based upon the information available and determined on the balance of probabilities. They remain subject to any later official findings by the New South Wales Coroner.

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## CONTRIBUTING FACTORS

### Terrain

48. The terrain covered to the incident site was a rugged mix of hills, ridgelines and steep gullies, almost completely free of plant life and covered in a scree of rocks, gravel and dust. FE was required to navigate through this area, This terrain is common in the area

49. The site of the IED strike was a ridgeline running approximately northwest/southeast with a rounded top. The northeastern side of the ridgeline was very steep (approximately 45 degree slope) while the southwestern side was less steep (approximately 25 degree slope).

50.

### Weather and Light

51. Weather conditions on that evening were clear, with temperatures just below freezing. The moon was a new moon and luminosity was very low, approximately 0.3 per cent. Due to the limited ambient light however, the majority of witnesses stated that they could clearly see

### Preparation of FE for the task

52. FE was certified ready for operations by Commander Special Operations Australia prior to departure from Australia. The inquiry did not review the work-up

training and final mission rehearsal exercise conducted in Australia prior to deployment. Nevertheless, some witnesses expressed views about the efficacy of the pre-deployment training.

53. The CO SOTG, \_\_\_\_\_ gave the Inquiry Team a comprehensive insight into work-up training and preparation of FE \_\_\_\_\_ for the task on that evening. FE \_\_\_\_\_ arrived in country between late October and early November. After initial briefs, including briefs from the personnel at the FCE at Kandahar, FE \_\_\_\_\_ commenced a hand-over/take-over with the outgoing Force Element, FE \_\_\_\_\_. This involved the following:

- a. \_\_\_\_\_ November 2008: a joint FE \_\_\_\_\_ and FE \_\_\_\_\_ participation in OP \_\_\_\_\_
- b. \_\_\_\_\_ November 2008: a full \_\_\_\_\_ training activity at Camp Russell. CO SOTG described the after action report process as excellent.
- c. \_\_\_\_\_ November 2008: planning and battle preparation for OP \_\_\_\_\_

54. In the days leading up to the activity on \_\_\_\_\_ November 2008, FE \_\_\_\_\_ was involved in two \_\_\_\_\_ tasks and one humanitarian affairs and key leadership engagement activity \_\_\_\_\_. CO SOTG described the tasks as well conducted activities by FE \_\_\_\_\_

55. In the CO SOTG's view, FE \_\_\_\_\_ was well prepared for the activities undertaken on \_\_\_\_\_ November 2008, \_\_\_\_\_. The activity that evening was, in the CO's assessment, the most demanding activity undertaken by FE \_\_\_\_\_, but well within their capability.

### Intelligence

56. Intelligence for the operation appeared sound.

### Planning

57. Planning for the operation at the FCE and \_\_\_\_\_ level appeared to be sound. \_\_\_\_\_ was integrated into a manoeuvre plan, and a draft \_\_\_\_\_ developed and sent to FE \_\_\_\_\_ by the \_\_\_\_\_. There is no evidence to suggest that the operational plan produced by the \_\_\_\_\_ was anything other than sound.

58. Nevertheless, there are some relevant aspects of planning conducted at FE \_\_\_\_\_ level which may have been relevant:

- a. FE \_\_\_\_\_ received a warning order to conduct the \_\_\_\_\_ at approximately 1745 DE hrs and receipt was acknowledged \_\_\_\_\_

- b. FE received some operational information including a [redacted] for this task [redacted] at 1930 DE hrs. In accordance with this tasking they moved to a position [redacted] south
- c. FE arrived in the [redacted] for this activity at 2208 DE hrs on [redacted] November 2008 and some additional planning took place. Planning continued until company orders were held at approximately 2330 DE hrs. A [redacted] was received at 2338 DE hrs according to the log.
- d. The FE reported a departure [redacted] at 0016 DE hrs on 27 November 2008. The [redacted] estimated departure time to commence the infiltration was [redacted], some [redacted] before the FE actually departed that evening.
- e. [redacted] reported to CO SOTG that he had sufficient time and resources to conduct the [redacted]

### Fatigue

59. A number of witnesses on the patrol stated that they were fatigued on the evening, but not to extreme levels. Some witnesses described that they were just following the person to their front. This is consistent with the pattern of activities undertaken by FE [redacted] in the days leading up to the [redacted] on the evening, in particular the all night activity conducted in [redacted] on the morning [redacted] November 2008. It should be noted, however, that many members of FE [redacted] rested and slept in an earlier [redacted] after [redacted] for approximately five hours.

### Orders

60. Orders were hastily given at company level and below that evening, and in some cases, formal orders were not given. Comprehensive orders were not delivered to all FE personnel [redacted]. Witnesses described the process as rushed. Lieutenant Fussell attended company orders and was informed of the route. It is apparent that Company orders were delivered at about [redacted] with a desire to depart [redacted] at [redacted]. FE [redacted] reported leaving [redacted]

### Route selection and execution

61. Route selection from [redacted] to the vicinity of the target was done by [redacted]. Route selection took into account the IED threat, the terrain and the task. The route was approved [redacted]

62. The route was broadly carried out as planned by the lead elements of FE [redacted]

### Time and speed

63. intended to conduct the operation and extract a safe distance This intent was going to be difficult to achieve in the time available given the distance required to be covered on the infiltration to the force separation point and the time required to conduct clearances of the compounds

64. At the Orders Group, OC FE gave direction to make "best speed" on the infiltration. The patrol departed and Lieutenant Fussell activated the IED During this period, FE covered a distance of approximately kilometres in just under an hour. This included movement through rough terrain . The patrol was travelling faster than the usual planning figure for the infiltration, expressed to the Inquiry Team in interviews. Most personnel, including the lead elements, described a deliberate pace of advance though perceptions of personnel were varied on this issue.

65. Given the importance of the target, the tone of the compressed orders group and the fact that this was the most difficult mission attempted by FE to date, there was a sense of urgency, and the Inquiry Team perceived a sense of haste for the infiltration.

### Counter-IED measures

66. There is no evidence to suggest that personnel were unaware of the IED threat. Interviewed witnesses stated that they were aware of the IED threat along ridgeline and many witnesses were aware of the specific IED threat for this mission A number of counter-IED measures were employed:

a.

b.

67.

68.

**Personal protective equipment**

69. At the time of the incident, Lieutenant Fussell was wearing his combat body armour and helmet. However, the armour and helmet could not have protected him from the blast.

**Tactics, techniques and procedures (TTP)**

70.

71.

72. It was not possible to determine how close the [redacted] was [redacted] in the vicinity of the IED strike. After the incident, [redacted] personnel conducted extensive clearance of the area of the explosion,

**Track discipline**

73. From the information provided by witnesses it appears likely that personnel in front of Lieutenant Fussell were walking

74. In interviews with personnel behind Lieutenant Fussell, a number of them said they were moving [redacted] and saw others doing so. The order of march from Lieutenant Fussell back was as follows:

a.

b.

c.

d.

e.

f.

g.

h.

i.

j.

k.

75. The evidence indicates that many personnel in the order of march

For some personnel there appears to have been an assumption that the route in front of them was cleared

76. The Inquiry concludes that a number of personnel suffered cognitive dissonance when faced with the dilemma of either staying precisely on the route or following the person immediately to their front. Most chose to follow the person to their front, most likely because they rationalised the dissonance through directly witnessing the path to their front by the person in front of them

77. From the evidence available it is not possible to determine why Lieutenant Fussell was walking on the



### Medical treatment

78. The first person to get to Lieutenant Fussell after the IED strike was a member of the who cleared a safe path from his location to Lieutenant Fussell. checked Lieutenant Fussell but could not find a carotid arterial pulse. Very soon afterwards, members of the Company Primary Health Care Team (PHCT) reached Lieutenant Fussell. Each member of the PHCT gave evidence to the fact that Lieutenant Fussell was deceased.

79. Thereafter, medical personnel checked and treated other members of FE who were affected by the blast. of FE suffered injuries from the blast, received minor treatment, and remained in the field. suffered superficial wounds, was treated by the PHCT and also remained in the field.

80. No medical treatment was attempted in relation to Lieutenant Fussell as the extent of his injuries made it quite clear that he was deceased. The observations by and the PHCT were confirmed as correct according to the observations of the ADF Medical Officer. observations are described at paragraphs 39 and 40.

### Aero-medical evacuation

81. Lieutenant Fussell and his personal effects were evacuated from by an aero-medical evacuation helicopter early on the morning of 27 November 2008, arriving at Tarin Kowt at 0603 DE hrs. At Tarin Kowt, the SOTG medical officer confirmed Lieutenant Fussell's death at 0644 DE hrs.

### Leadership

82. Some witnesses, particularly the more senior members of FE raised concerns about the leadership of the OC Relevant to the activities undertaken on the evening of November 2008, the concerns raised by personnel in relation to leadership can be characterised as a lack of organisational skills, which led to a hasty and compressed orders group, and a poor appreciation of time and space to complete the task; and a lack of confidence in the OC by the senior members of FE

83. Although there was a sense of haste on the evening of 26-27 November 2008, the speed of movement was not at a pace consistent with personnel demonstrating reckless behaviour in order to meet timings. There was no evidence that personnel were consistently running or speed walking to maintain spacing in the order of march, which might have caused personnel to move to easier ground or be inattentive.

84. Even if there was a lack of confidence by senior personnel in the leadership of there is no evidence to suggest that this had any direct affect on the manner in which individual personnel were exercising track discipline

85. Consistent with the role of this Inquiry as a fact finding exercise, which does not focus on the attribution of blame, no finding is made with respect to leadership, either as a contributing factor in this incident or more generally. In my view, if these assertions were accurate they did not make a substantial contribution to the death of Lieutenant Fussell. Notwithstanding that these matters are not directly relevant to this Inquiry, the assertions in relation to the leadership of [redacted] and more generally within FE should be passed to the chain of command for further examination.

#### **Failure to stop an unsafe practice**

86. The evidence of witnesses indicates that a number of personnel observed other personnel [redacted] not complying with the TTP. Accordingly, it is possible that a number of personnel were in a position to stop an unsafe practice. Consistent with the role of this Inquiry as a fact finding exercise, which does not focus on the attribution of blame, no finding is made with respect to whether certain personnel were aware of and in a position to stop an unsafe practice, but failed to do so. However, this issue is clearly raised by the evidence provided by witnesses and should be examined by an appropriate authority within the chain of command.

#### **Findings**

87. After considering the potential factors, the Inquiry Officer found that:

- a. FE was certified ready for operations by Commander Special Operations Australia prior to departure from Australia. The Inquiry Officer has accepted this assessment.
- b. CO SOTG had sufficient evidence to form a view that FE was experienced enough to undertake the task that evening. The Inquiry Officer has accepted the assessment of CO SOTG.
- c. [redacted] reported to CO SOTG that he had sufficient time and resources to conduct the task.
- d. Although the orders [redacted] were rushed and incomplete, they did not contribute to the death of Lieutenant Fussell.
- e. Route selection from [redacted] was appropriate to the task.
- f. Although there was limited moonlight, there was sufficient light [redacted] allowing FE personnel to see [redacted].
- g. Track discipline in the minutes prior to the strike was inadequate in respect to the threat and the [redacted] FE. This may have been contributed to by a combination of:
  - (1) a sense of urgency and haste given the importance of the mission and the time available;

- (2) fatigue; and
  - (3) a misapplication of the TTPs concerning track discipline
- h. Up to personnel may have been in a position to stop the unsafe practice
- i. The post-incident actions of the personnel and the FE were commendable.
88. **Recommendations.** It is recommended that:
- a. the assertions in relation to the leadership of be passed to the chain of command for further examination; and
  - b. the evidence collected by this Inquiry in respect to personnel failing to stop an unsafe practice be further examined by an appropriate authority within the chain of command, in order to determine appropriate action.

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## POST-INCIDENT PROCESSES

### Notification of Next of Kin/Primary Emergency Contact

89. The notification processes are detailed in Defence Instruction (General) Personnel 11-2, *Notification of Australian Defence Force and non-Australian Defence Force casualties* and JTF 633 Standing Instruction Personnel 04-06, *MEAO Mortuary Affairs Management*.

90. CO SOTG telephoned Commander JTF 633 by telephone soon after the IED strike to inform him that that one member of FE was killed in action by an IED strike. HQ JOC recorded the first alert that an incident had occurred was from HQ JTF 633 watchkeeper at 2109Z hrs on 26 November 2008. Thereafter, the Defence senior leadership was advised.

91. The first formal message notification of the incident occurred at 2218Z hrs (0248 hrs DE) when SOTG advised HQ JTF 633 of the IED strike, citing one killed in action (KIA) and two wounded in action (WIA) members.

92. SOTG raised a FATALCAS message for Lieutenant Fussell after his remains had been returned to Camp Holland, positively identified by RSM SOTG, and the Medical Officer confirmed death. The FATALCAS for Lieutenant Fussell was raised by SOTG at 0218Z hrs. SOTG sent two NOTICAS messages to HQ JTF 633 for the two WIA at

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0141Z hrs and 0221Z hrs respectively. The messages advised that each soldier would contact their spouses as soon as the confirmation of the notification of the KIA was complete.

93. Army Headquarters (AHQ) coordinated the notification process. The Director of Coordination – Army (DCOORD-A) was informed of Lieutenant Fussell's death by the Chief of Army (CA), shortly after this information was passed from HQ JTF 633 to the Chief of Defence Force (CDF). In conjunction with Special Operations Command (SOCOMD), notification planning was undertaken, and took place after the FATALCAS had been received by the DCOORD-A.

94. CO 4 RAR (Cdo) described the notification process. Special Operations Headquarters verbally advised CO 4 RAR (Cdo) around 1000/1015 hours AEDT (Australian Eastern Daylight Time) that Lieutenant Fussell had been killed in action.

95. \_\_\_\_\_ was informed of his brother's death \_\_\_\_\_ on 27 November 2008,

\_\_\_\_\_ This occurred on the evening of 27 November 2008.

96. The CO, RSM and 4 RAR (Cdo) Padre flew to Armidale, where the family live, on the afternoon of Thursday 27 November 2008. The CO remained in Armidale until Saturday 29 November 2008 to provide support to the family and to ensure a good link-up with the Defence Community Organisation (DCO). DCO provided a bereavement support team in support of the family.

97. Condolence letters from CO SOTG and OC 1<sup>st</sup> Commando Company were hand delivered to the family on Sunday 30 November 2008.

98. All relevant personnel interviewed considered that the notification process went smoothly and efficiently. There were two issues raised by the SOTG concerning the notification process:

- a. SOTG suggested that FATALCAS and serious NOTICAS information should be compartmentalised until the Primary Emergency Contact (PEC)/Next of Kin (NOK) are informed. It was suggested that the initial reporting be limited to relevant commanders, those needed to inform NOK, and those staff required to undertake time-sensitive action. Only a limited number of people need to know the identity of the deceased or seriously wounded. Furthermore it was suggest that an updated FATALCAS and serious NOTICAS be released after the NOK are informed in order to commence administrative actions. Although there is no suggestion that there was any leakage of information in this case, SOTG

expressed a general concern about the relatively wide audience to sensitive information prior to the NOK being informed.

- b. SOTG described difficulties with allowing WIA soldiers who have minor injuries to self-notify their Primary Emergency Contact (PEC)/NOK. These difficulties are in tension with the principle that all PEC/NOK are informed at the same time. Combat effective WIA soldiers may still be in the fight at the same time that the PEC/NOK for the KIA soldiers are informed. It was suggested that when there are KIA and WIA soldiers that the right to self-notify is removed, and that the notifying unit/s completes all notifications.

99. In respect to compartmentalisation, AHQ was of the view that the current process works and should not be modified. Although this is valid, the integrity of the current system could be improved by compartmentalising fatality information on a need-to-know basis until the NOK are informed.

### Findings

100. The Inquiry found that:

- a. the notification of casualty process went smoothly and efficiently; and
- b. there is merit to the compartmentalised approach suggested by SOTG, of controlling the distribution of sensitive information concerning a fatality to a need to know basis until the PEC/NOK are informed.

### Recommendation

101. It is recommended that Deputy Secretary People Strategies and Policy (as the policy owner for the Defence Instruction Personnel 11-2) examine:

- a. the distribution of FATALCAS information prior to the NOK being informed; and
- b. the suggestion of removing the right to self-notify PEC/NOK for WIA soldiers.

### Repatriation

102. The repatriation processes are detailed in Defence Instruction (General) Personnel 20-6, *Death of Australian Defence Force Personnel*, and JTF 633 Standing Instruction Personnel 04-06, *MEAO Mortuary Affairs Management*.

103. Lieutenant Fussell's remains were carried from the IED strike location to the environment. IED clearance was conducted over lengthy distances by soldiers. It was a commendable and exhausting effort by the soldiers involved.

His remains were flown back to the Role 2 Hospital at Tarin Kowt, examined by Australian Medical Officers

104. On 30 November 2008, SOTG held a memorial service at Camp Russell for Lieutenant Fussell, followed shortly after by a ramp ceremony at Camp Holland airfield attended by Australian and coalition troops. Lieutenant Fussell's and his personal effects were repatriated from Tarin Kowt at 0830Z hrs (1300 hrs DE) on the same day by a RAAF C-130 aircraft to . He was escorted back to Australia by

105. Lieutenant Fussell was placed in the Theatre Mortuary Evacuation Point at until he was repatriated from (after a Ramp Ceremony) on 2 December 2008. Lieutenant Fussell and his personal effects arrived at RAAF Richmond at approximately 0530Z hrs (1630 hrs AEDT) on 3 December 2008, followed by a Ramp Ceremony.

106. A memorial service was held at 4 RAR (Cdo), Holsworthy on 4 December 2008. The funeral was held in Armidale on Saturday 6 December 2008.

### Findings

107. The Inquiry found that:

- a. the repatriation of Lieutenant Fussell and his personal effects was carried out in a professional and effective manner;
- b. there does not appear to exist any substantial weaknesses or deficiencies in Defence systems, policies, equipment, practices and procedures associated with the repatriation of Lieutenant Fussell; and
- c. there were no substantial shortcomings in Defence's actions and decisions materially relevant to the repatriation of Lieutenant Fussell.

### IED information exploitation

108.

a.

b.

- c.
- 109.
- 110.

#### **Additional training**

- 111. As the Inquiry Team was leaving Tarin Kowt on 19 December 2008, SOTG was involved in intensive track discipline and counter-IED training. This included the use of simulated devices and realistic scenarios conducted by experienced personnel
- 112. The CO SOTG also directed that all orders given to FE personnel prior to an operation were to explicitly express the Standard Operating Procedures for all TTPs.

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#### **OTHER ISSUES**

- 113. The role and involvement of the ADFIS in the investigation of deaths by enemy action (sometimes called combat deaths) is an issue which warrants further examination. The HQ JTF 633 Standing Instruction MEAO Mortuary Affairs Management details that ADFIS currently assist the relevant unit with the repatriation and preservation of physical evidence; ADFIS to date has not taken statements from witnesses closely involved in a death caused by enemy action.
- 114. The purpose of ADFIS in investigating deaths on operations is to replicate the role that would be played by the civilian police for a death in Australia. Any sudden or unexpected death is investigated by police and a report provided to the Coroner to support the Coroner's review of the cause of death. Police are investigating initially to determine if there is criminality associated with a death. If there does not appear to be any criminality associated with a death then the investigation is ceased and the information collected is provided to the Coroner. The investigation may be re-commenced depending upon the findings of the Coroner. Given the absence of civilian police in operational areas, ADFIS conducts the initial investigation and provides the information to the relevant Coroner. Importantly, the Coroner has similar information requirements, regardless whether or not a death on operations is caused by enemy action.
- 115. In the ADF a distinction in practice appears to have arisen between deaths that occur on operations generally and deaths due to enemy action. If the initial reporting of a

death through Incident Reports or the Quick Assessment indicates that a death was caused by enemy action, then ADFIS has not always been engaged to conduct the initial investigation to rule out suspicious circumstances. Instead, an Inquiry Officer has been appointed under the Regulations to investigate the circumstances of reported combat deaths. This has involved a somewhat slower and more deliberate process than the initial ADFIS investigation, particularly as ADFIS personnel are already deployed to the area of operations.

116. Although there is no suggestion of suspicious circumstances in this matter, the distinction between a death on operations and death by enemy action, may not be as clear cut in the future. Sometimes this distinction might not be determined until the Coroner has completed inquiries.

117. The early preservation of oral evidence from those closely involved with a death on operations (including death by enemy action) warrants closer examination. This is true regardless of whether the investigation is carried out by ADFIS or under the Regulations.

118. The role of ADFIS in relation to deaths on operations, including deaths that appear to have been caused by enemy action, should be reviewed as a matter of urgency. The apparent ambiguity about the role of ADFIS in relation to a death that appears to have been caused by enemy action should be resolved.

### **Recommendation**

119. It is recommended that the CDF's COI Cell, in consultation with key stakeholders, examine as a matter of urgency the role of ADFIS in relation to deaths on operations, including those that appear to have been caused by enemy action.

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## **CONCLUSION**

### **Commission of Inquiry**

120. The principal purpose of a COI is to inform internal military decision-making. COIs determine the facts and circumstances surrounding an incident so that an informed decision can be made about how, and if possible why, an incident occurred to help avoid a similar recurrence.

121. This Inquiry is, inter alia, a fact finding exercise to aid in the decision as to whether anything would be achieved by the review of this matter in the environment of a formal COI, and whether special circumstances exist to warrant the appointment of a COI into a combat death.

122. The central issue in this matter is the application of a TTP  
in an IED threat environment.  
The particular TTP is sound and accordingly this is not a case where a review of the TTP is required. Rather, it is a case where a TTP was not correctly applied. In the IED environment within Uruzgan province, the application of counter-IED TTPs does not remove the threat, it merely reduces it. In this case however, the TTP was not correctly applied for a short period, with tragic results.

123. A careful analysis of the information collated by the Inquiry reveals that the issue of track discipline, at the heart of this matter, is not complex. The principal measure to



prevent repetition is training; within FE , for future force elements within SOTG, and for other ADF elements deployed to IED environments.

124. A COI in this case would involve the examination of the application of a TTP currently applied by Australian special forces in the specific circumstances of combat in Uruzgan, Afghanistan. Such an inquiry would necessarily be closed for much of its duration both to protect the identities of special forces personnel and to prevent the disclosure of TTPs to the adversary. It is highly unlikely that a review of the facts and circumstances by a COI would provide any greater clarity as to the reason why some personnel did not correctly apply the TTP on this occasion, nor provide any recommendations in relation to training that cannot readily be identified from the information already available.

125. Some of the witnesses have raised broad issues in relation to the leadership within FE For the reasons discussed earlier, these issues are not germane to the death of Lieutenant Fussell, but should be the subject of review by the chain of command. Whilst the leadership issues raised by witnesses are matters of concern, the Inquiry Officer does not believe that they had a bearing on how or why the incident occurred.

126. **Recommendation.** It is recommended that a COI into the death of Lieutenant Fussell on 27 November 2008 is not warranted

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## FINDINGS AND RECOMMENDATIONS

### Findings

127. The Inquiry Officer found that:
- a. Lieutenant Fussell inadvertently activated a pressure plate IED;
  - b. Lieutenant Fussell was killed instantly by the resulting explosion on 27 November 2008; and
  - c. two personnel suffered injuries as a result of the explosion that were reported through the NOTICAS process; was subsequently returned to Australia as a result of his injuries while has returned to his duties.
128. After considering the potential factors resulting in the death of Lieutenant Fussell, the Inquiry Officer found that:
- a. FE was certified ready for operations by Commander Special Operations Australia prior to departure from Australia. The Inquiry Officer has accepted this assessment.
  - b. CO SOTG had sufficient evidence to form a view that FE was experienced enough to undertake the task that evening. The Inquiry Officer has accepted the assessment of CO SOTG.
  - c. reported to CO SOTG that he had sufficient time and resources to conduct the task.

- d. Although the orders \_\_\_\_\_ were rushed and incomplete, they did not contribute to the death of Lieutenant Fussell.
  - e. Route selection from \_\_\_\_\_ to \_\_\_\_\_ was appropriate to the task.
  - f. Although there was limited moonlight, there was sufficient light \_\_\_\_\_ allowing FE \_\_\_\_\_ personnel to see \_\_\_\_\_
  - g. Track discipline in the minutes prior to the strike was inadequate in respect to the threat \_\_\_\_\_. This may have been contributed to by a combination of:
    - (1) a sense of urgency and haste given the importance of the mission and the time available;
    - (2) fatigue; and
    - (3) a misapplication of the TTPs concerning track discipline
  - h. Up to \_\_\_\_\_ personnel may have been in a position to stop the unsafe practice \_\_\_\_\_
  - i. The post-incident actions of the \_\_\_\_\_ personnel and the \_\_\_\_\_ were commendable.
129. In respect to notification and repatriation, the Inquiry Officer found that:
- a. the notification of casualty process went smoothly and efficiently; and
  - b. there is merit to the compartmentalised approach suggested by SOTG, of controlling the distribution of sensitive information concerning a fatality to a need to know basis until the PEC/NOK are informed.
  - c. the repatriation of Lieutenant Fussell and his personal effects was carried out in a professional and effective manner;
  - d. there does not appear to exist any substantial weaknesses or deficiencies in Defence systems, policies, equipment, practices and procedures associated with the repatriation of Lieutenant Fussell; and
  - e. there were no substantial shortcomings in Defence's actions and decisions materially relevant to the repatriation of Lieutenant Fussell.

### Recommendations

130. It is recommended that:
- a. the assertions in relation to the leadership of \_\_\_\_\_ be passed to the chain of command for further examination;

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- b. the evidence collected by this Inquiry in respect to personnel failing to stop an unsafe practice be further examined by an appropriate authority within the chain of command, in order to determine appropriate action;
- c. Deputy Secretary People Strategies and Policy (as the policy owner for the Defence Instruction Personnel 11-2) examine:
  - (1) the distribution of FATALCAS information prior to the NOK being informed; and
  - (2) the suggestion of removing the right to self-notify PEC/NOK for WIA soldiers.
- d. the CDF's COI Cell, in consultation with key stakeholders, examine as a matter of urgency the role of ADFIS in relation to deaths on operations, including those that appear to have been caused by enemy action; and
- e. a COI into the death of Lieutenant Fussell on 27 November 2008 is not warranted

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**Binders:**

- 1.
- 2.

**Annexes:**

- A.
- B.
  
- C.
- D.
- E.
- F.
- G.
- H.
- I.
  
- J.
  
- K.
- L.
- M.
- N.
- O.
- P.