



**CHIEF OF THE
DEFENCE FORCE**

INQUIRY OFFICER INQUIRY REPORT

**INTO THE DEATH OF
CORPORAL SCOTT JAMES SMITH
IN AFGHANISTAN
ON 21 OCTOBER 2012**

19 APRIL 2013

**Report Redacted for
public release**

S# = Soldier #



[REDACTED]

**INQUIRY OFFICERS REPORT INTO THE DEATH OF [REDACTED] CPL SCOTT
JAMES SMITH IN AFGHANISTAN ON 21 OCT 12**

References:

- A. CDF Instrument of Appointment and Terms of Reference dated 1 Nov 12
- B. CDF Terms of Reference dated 1 Nov 12
- C. SOTG XVII/[REDACTED] Quick Assessment for CO SOTG – SOTG FATALCAS – [REDACTED] CPL Scott James Smith – 21 Oct 12 [REDACTED]
- D. ADFP 06.1.4 – *Administrative Inquiries Manual* dated June 2006
- E. DI(G) PERS 11-2 *Notification of Australian Defence Force and Non-Australian Defence Force Casualties* dated 20 May 08
- F. ADFP 1.1.1 *Mortuary Affairs Edition 2* dated August 2008
- G. DI(G) PERS 20-6 *Death of Australian Defence Force Personnel* dated 20 May 08
- H. DI(G) ADMIN 45-2 *The Reporting and Management of Notifiable Incidents*

Appointment and Terms of Reference

1. I, [REDACTED] COL [REDACTED] having been duly appointed by GEN D.J. Hurley, AC, DSC, Chief of the Defence Force, to inquire into the circumstances and facts surrounding the death of [REDACTED] CPL S.J. Smith in accordance with the Terms of Reference attached to the Instrument of Appointment, herein submit my report.

Inquiry Team

2. The Inquiry Team consisted of me as the Inquiry Officer and [REDACTED] CAPT [REDACTED], as the Assistant Inquiry Officer.

Introduction

3. Over the period 20-23 Oct 12 the Provincial Response Company-Uruzgan (PRC-U)³, enabled by a Force Element (FE [REDACTED]) of the Special Operations Task Group (SOTG), conducted a [REDACTED] operation in the [REDACTED] region of the [REDACTED] District of Helmand province. The operation was aimed at [REDACTED] insurgent's ability to [REDACTED] operations against GIROA³ and ISAF forces [REDACTED]. During the course of the operation, on 21 Oct 12, CPL S.J. Smith was killed in action (the incident).

Methodology and Approach

4. The Inquiry team deployed to [REDACTED] and to Multinational Base – Tarin Kowt (MNB-TK) on 11 Nov 12 to gather evidence. It redeployed to [REDACTED] and returned to Australia on 28 Nov 12.

5. The Inquiry Team was not able to visit the actual site of the incident due to the high security risk. This was not considered to be a significant impediment due to the availability of imagery of the site. A satisfactory appraisal of the incident site was able

[REDACTED]

³ Government of the Islamic Republic of Afghanistan.

[REDACTED]

to be conducted through the examination of maps, diagrams, and both still and video imagery.

6. The Australian Defence Force Investigative Service (ADFIS) had already prepared an investigation report and brief for the New South Wales Coroner. A copy of their report was provided to me prior to departing Australia and I have annexed relevant documents to my report. The ADFIS report was clear and concise and meant that I was able to speak with a number of personnel and clarify their existing statements without the need to conduct further recorded interviews with them.

7. All witnesses interviewed for the purpose of this Inquiry were provided with copies of:

- a. My Instrument of Appointment and Terms of Reference,
- b. My and the Inquiry Assistants Statement of Impartiality, which they then signed, ■
- c. Annex D to Chapter 6 of ADFP 06.1.4, and
- d. A Privacy notice which they then signed. ■

8. **Correspondence with the Appointing Authority.** I corresponded twice with the appointing authority during the course of the Inquiry. ■ Both pieces of correspondence occurred after I had submitted my original report to the CDF Commissions of Inquiry Coordination Cell on 20 Feb 13. The outcome of the correspondence resulted in the resubmission of my report, on 18 Apr 13, with some extra detail added in the section on '*Selection and Use of the Mine Detector*' (paragraph 53 onwards).

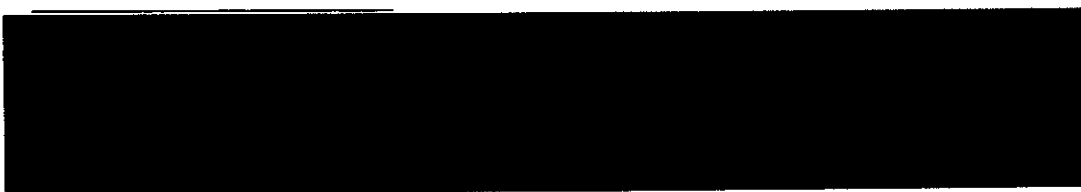
Report Basics

9. To ensure the maintenance of the protected identity of SOTG members involved in the incident they are identified throughout the main body of this report by their call sign only. An identity matrix detailing call signs to actual names is attached at ■
■ All dates and times in this report, unless otherwise stated are in Afghanistan local time. ■

Sequence of Events

Operation Planning and Approval

10. The planning development and approval process followed by FE ■ for the operation was no different to the standard practice. The operation was developed under ■ Concept of Operations (CONOP)



[REDACTED] It was a [REDACTED] out of province, partnered operation which involved [REDACTED] Afghan members of the PRC-U partnered with [REDACTED] members of FE [REDACTED]

11. The broad concept for the operation was that the PRC-U enabled by FE [REDACTED] (the force) conduct a [REDACTED] insertion into the vicinity of the [REDACTED] side of the [REDACTED]. The force would then commence an [REDACTED] clearance of identified compounds of interest (COI) and insurgent high activity zones. After insertion the force was to marry up with [REDACTED] ISAF [REDACTED] who would then support, along with other [REDACTED] ISAF [REDACTED] elements, an [REDACTED] clearance of locations across the [REDACTED]. The force was to be supported by [REDACTED] ISAF Air [REDACTED] assets from [REDACTED] who would provide [REDACTED] [REDACTED] capabilities.

12. Appropriate approvals for the operation were received. The CONOPS [REDACTED] was approved by the [REDACTED]. Both [REDACTED] [REDACTED] and [REDACTED] concurred with the operation, and the Helmand Provincial Governor and Chief of Police were notified prior to the operation commencing. [REDACTED] HQ JTF 633 was informed when the operation commenced.

13. **Finding** – The operation was appropriately planned and the necessary approvals gained.

Commencement of the Operation up until the Incident

14. The force departed [REDACTED] from [REDACTED] hrs on 20 Oct 12 in a combination of [REDACTED]. By [REDACTED] their insertion [REDACTED] in the vicinity of [REDACTED] was complete. The force then began to clear assigned COI and insurgent high activity zones. Initial clearances by the force had limited success, although there were intermittent direct fire engagements and a number of insurgents were engaged and killed. By [REDACTED] that morning the [REDACTED] major force elements were clearing [REDACTED] and [REDACTED]. The process of 'marrying up' with the supporting [REDACTED] ISAF [REDACTED] elements had also commenced.

15. By [REDACTED] hrs on 21 Oct 12 [REDACTED] platoon had completed its clearance of [REDACTED] and shifted its focus to supporting the clearance of [REDACTED] by clearing the village of [REDACTED]



Synopsis of the Incident

16. At approximately 1300hrs a [REDACTED] comprising [REDACTED] with CPL Smith as its attached engineer, [REDACTED] with S11 as its attached engineer, and [REDACTED] PRC-U personnel with an interpreter, mounted [REDACTED]. The section was led by [REDACTED] Soldier 4. The [REDACTED] transported the team approximately [REDACTED] km to a position just [REDACTED] of a compound designated as COI X. After dismounting [REDACTED] Soldier 4 issued confirmatory orders for the section to clear COI X. After conducting a [REDACTED] the section began to enter the compound with CPL Smith and S11 in the lead.

17. COI X was a large four walled compound approximately [REDACTED] by [REDACTED] which had six rooms in the [REDACTED] corner ([REDACTED] rooms). The six rooms were built in parallel from [REDACTED] and for the purpose of this report are referred to as room one (most [REDACTED]) to six (most [REDACTED]). The compound had an area of [REDACTED] positioned roughly in its centre and was situated on high ground which sloped down to the [REDACTED]. This made movement in the [REDACTED] portion of the compound susceptible to observation and direct fire from the low ground to the [REDACTED]. The compound was littered with metallic and non metallic rubbish.

18. After their initial entry CPL Smith and S11 began to move towards the [REDACTED] rooms while [REDACTED] Soldiers provided security due to the threat afforded from anyone observing from the [REDACTED]. At this stage the PRC-U members also entered the compound. [REDACTED] of the PRC-U and the interpreter halted just inside the compound entrance, while two members remained just outside the same entrance to provide security.

19. After arriving at the [REDACTED] rooms CPL Smith immediately identified a suspected, and later confirmed [REDACTED] IED at the entrance to room one, and informed S4. While CPL Smith investigated the pressure plate S11 discovered a large quantity of IED [REDACTED] components in room 2. Further exploitation of the other [REDACTED] rooms by CPL Smith and S11 identified large quantities of IED making components including [REDACTED]. Of note S11 also identified, and reported to CPL Smith that he had found a number of [REDACTED]. At this stage CPL Smith and S11 believed they had found an insurgent IED factory [REDACTED] and S11 began [REDACTED] gathering evidence.

20. CPL Smith then began moving back to S4 location to provide a detailed description of the [REDACTED] room's contents. However, after moving only a couple of metres he received [REDACTED] rounds of accurate small arms fire (SAF) which landed approximately one to three meters from him and halted his movement. The

point of origin of the SAF was observed by S15 and assessed as [redacted] m to the [redacted] of the compound. S4 then [redacted] to alert them of the [redacted] IED CPL Smith had found in the doorway. He then ensured the PRC-U members were aware of the increased IED threat and directed all movement within the compound to be minimised.

21. Following a break in the SAF CPL Smith and S11 moved back to the compound entrance and S11 then cleared an area in the [redacted] around the PRC-U before clearing a route [redacted]. This allowed [redacted] members to move safely to [redacted]. Once in that position [redacted] members [redacted] giving themselves observation and firing positions out to the [redacted]. Following the creation of the observation positions [redacted] elements withdrew back to the compound entrance. They were then ordered by S4 to prepare to move to a compound a further [redacted] m to the [redacted]. This was in order to minimise the number of personnel in COI X and to [redacted] so that [redacted] could withdraw from the compound.

22. After briefing S4 on the detailed contents of the [redacted] rooms and the potential threat to the force, CPL Smith also recommended that S4 request the [redacted] ISAF which was situated [redacted] of the compound, [redacted] as an additional safety precaution against any possible [redacted]. S4 agreed and then moved around the cleared route within the compound walls to a position [redacted] and requested [redacted] ISAF [redacted] which he did.

23. CPL Smith then attempted to return to the [redacted] rooms however was halted when a further [redacted] rounds of deliberate SAF were again directed toward him. Unable to move to the [redacted] rooms he then cleared a route from the compound entrance toward the [redacted] centre of the compound. This allowed [redacted] Soldiers [redacted] to occupy a position behind the [redacted] and provide observation to the [redacted].

24. At this time [redacted] accompanied by S11 began their move to the southern compound. S4 then tasked CPL Smith to inspect [redacted] in the vicinity of the [redacted]. The search was completed with nothing unusual found.

25. S4 then directed CPL Smith to commence clearing routes [redacted] to exit the compound. Beginning from the compound entrance CPL Smith cleared [redacted] a route to the rear of S5 and S7 position to facilitate their safe withdrawal. From there he then began clearing a route towards the [redacted] rooms so he could recover his rifle and pack, which he had earlier placed down during the initial search of the [redacted] rooms. After clearing approximately three metres CPL Smith [redacted] IED.

26. After the IED blast S4 directed all team members to report in. All personnel were then accounted for except CPL Smith. S4 reported to [redacted] Headquarters [redacted] that an IED strike had occurred in their location and all

personnel were accounted for except CPL Smith. S4 then asked S5 whether he could see CPL Smith. S5 replied he could identify [REDACTED] CPL Smith. S4 then advised [REDACTED] HQ that they had one friendly killed in action – CPL Smith. S4 then recorded the time of the IED blast as 1355hrs, and ordered all team personnel, the PRC-U members and the interpreter to evacuate the compound, via the previously cleared routes.

27. After all personnel had exited the compound S4 was contacted by S15 and asked if he required assistance. S4 advised S15 that no assistance was required and his call sign was to remain in the support by fire location at southern compound and to minimise all unnecessary movement.

Post Incident

28. After being informed of CPL Smith's fatality the [REDACTED] Commander S1, [REDACTED] Sergeant S2, Medical Assistant S3, [REDACTED] (engineer) [REDACTED] Commander S10, and Explosive Detection Dog Handler S12, moved to COI X on a [REDACTED] ISAF. On arrival S4 briefed S1 on the situation and it was decided it was best tactically to [REDACTED] the incident site. S10 also advised that he believed [REDACTED] inside the compound should be [REDACTED] and after [REDACTED] the compound should be destroyed due to the [REDACTED]. A [REDACTED] ISAF was then [REDACTED] to allow [REDACTED] elements of [REDACTED], the [REDACTED] and [REDACTED] to move to a compound [REDACTED] to the [REDACTED] known as [REDACTED]. On their arrival [REDACTED] moved from the [REDACTED] compound and collocated with them in [REDACTED].

29. S2 then took control of the incident site, while S4 maintained command of the tactical situation at COI X. A [REDACTED] ISAF was utilised to help secure the incident site and was positioned with [REDACTED] ISAF on [REDACTED] on the [REDACTED] side of COI X. During the [REDACTED] recovery of CPL Smith's remains and mission essential items, [REDACTED] ISAF received sporadic [REDACTED] fire.

30. A coordinated search of the area for [REDACTED] was undertaken. The search encompassed an area [REDACTED] compound [REDACTED]. While the search of [REDACTED] side of the compound was conducted in some detail, searching of the other sides of the compound was limited as COI X was still under insurgent observation. Movement on the [REDACTED] sides of the compound resulted in insurgents directing small arms, [REDACTED] and [REDACTED] fire toward the searchers.

31. As the search was being undertaken outside the compound, both Soldiers 11 & 12 moved inside the compound and cleared a route from the entrance to the [REDACTED] rooms

[REDACTED]

[REDACTED]

[REDACTED]
7

and recovered CPL Smith's rifle and pack. Whilst recovering the equipment they saw

[REDACTED]

They then withdrew from the compound. Later S10 organised a hole [REDACTED] to access room one and recover [REDACTED]. No other movement occurred inside COI X that day.

32. Following the search S3 prepared CPL Smith's remains and they were then moved in a ISAF vehicle, accompanied by Soldiers 2, 4 & 11 to a waiting aero-medical evacuation (AME) helicopter. CPL Smith's remains, accompanied by S11 departed on the AME helicopter for the Role 2 Medical facility at Forward Operating Base (FOB) [REDACTED] hrs.

33. At this stage there were still a number of CPL Smith's mission essential items that had still not been located including [REDACTED]. However, with the continuing threat of insurgent fire, and night fall approaching, HQ, [REDACTED] and [REDACTED] consolidated in [REDACTED]. That night they, along with ISAF, provided overwatch of COI X. During the night it was learnt that a [REDACTED] had been approved on COI X for the following day. Initially, it was thought that the strike was planned for [REDACTED] hrs. This would have allowed time to continue the search and also [REDACTED] rooms [REDACTED] additional entry holes in the [REDACTED] walls. At around [REDACTED] hrs on 22 Oct 12 [REDACTED] HQ learned that the time on target for the [REDACTED] strike was to be [REDACTED] hrs.

34. At around [REDACTED] hrs [REDACTED] HQ coordinated the resumption of the search with members of [REDACTED] and [REDACTED] conducting a wider sweep around COI X. S10 also conducted a [REDACTED] of the IED blast site as well as [REDACTED] ISAF [REDACTED] and using it to [REDACTED] recover items. At [REDACTED] hrs, after recovering [REDACTED] the search halted and the forces withdrew back to [REDACTED]. The recovered items were moved by helicopter back to [REDACTED] later that day.

35. At [REDACTED] on COI X and destroyed the walls in the [REDACTED] corner of the compound and the majority of rooms one to five. Following the strike both S10 & 12, as well as [REDACTED] ISAF [REDACTED] technicians returned to COI X to assess [REDACTED]. During the [REDACTED] from the IED blast site. An [REDACTED] IED in the doorway to room one was also found - confirming CPL Smith's original find. This was [REDACTED] along with other IED components that were found in the compound.

[REDACTED]

[REDACTED]

36. With the completion of the [REDACTED] of COI [REDACTED] following its partial destruction by the [REDACTED] strike, the incident in which CPL Smith was killed was complete.

37. **Finding** - CPL S.J. Smith, was killed in action at 1355 hrs on 21 Oct 12 as a result of [REDACTED] IED. The approximate location of CPL Smith when he was killed in action was GR [REDACTED].

38. **Finding** - There were no other injuries to Australian service personnel as a result of this incident.

Evacuation

39. **FOB [REDACTED]**. CPL Smith's remains arrived via the AME helicopter at the [REDACTED] ISAF Role 2 [REDACTED] medical facility at FOB [REDACTED] Helmand Province at 1530hrs on 21 Oct 12. On arrival they were inspected by Dr [REDACTED] of [REDACTED] ISAF [REDACTED]. Dr [REDACTED] was satisfied that CPL Smith's injuries were instantly fatal. At approximately 1720hrs, Dr [REDACTED] related this information by [REDACTED] to the SOTG RMO. [REDACTED]

40. **FOB [REDACTED] to MNB-TK**. CPL Smith's remains, escorted by [REDACTED] S11 departed FOB [REDACTED] at [REDACTED] hrs on 21 Oct 12 on a [REDACTED] ISAF aircraft. They arrived at MNB-TK at [REDACTED] hrs.

41. On arrival at MNB-TK the SOTG RMO met and escorted [REDACTED] S11 and CPL Smith's remains to the Role 2 [REDACTED] Medical facility. On arrival at the Role 2 [REDACTED] CPL Smith's remains were examined, and his death confirmed. CPL Smith's remains were then [REDACTED] [REDACTED] and positively identified. [REDACTED]

42. CPL Smith was given Last Rites by the SOTG Padre in the company of the SOTG Commanding Officer and Regimental Sergeant Major along with the medical staff who had been assisting. CPL Smith's remains were then formally handed over into the custody of ADFIS.

43. ADFIS investigators then conducted the forensic processing of the CPL Smith's remains, and collected the relevant pieces of his equipment. His remains were then placed in the mortuary at the Role 2 [REDACTED] medical facility. An honour guard from SOTG was posted at the mortuary as soon as CPL Smith was interned there. [REDACTED]

44. A sequence of events, including key timings, is at [REDACTED].

Pre and Post Blast Analysis

[REDACTED]

[REDACTED]

45. A [redacted] report covering the IED cache find in COI [redacted] and the [redacted] of the IED that killed CPL Smith was compiled by [redacted] on completion of the operation [redacted]. The report was written by [redacted] S10 and utilised:

- a. Information and assessments from [redacted] S11 including [redacted];
- b. Information, including [redacted] gathered by [redacted] Soldiers 10, 11 & 12 after the IED blast but before the [redacted] strike on COI [redacted] X
- c. Information collected by [redacted] S10 & 12 and the [redacted] ISAF [redacted] after the [redacted] strike.

46. Assessments from the report pertinent to COI [redacted] X include:

- a. *It is assessed as certain that the compound was used to manufacture and store IEDs and components;*
- b. *It is assessed as possible that [redacted]*

47. Facts from the report pertinent to the IED that killed CPL Smith include:

- a.
- b.
- c.
- d.

[redacted]

48. Assessments from the report pertinent to the IED that killed by CPL Smith include:

- a.
- b.
- c.

[redacted]

[redacted]

[redacted]

d. [REDACTED]

49. **Finding** – The facts and assessments contained in the site exploitation report, about COI [REDACTED] and the IED that killed CPL Smith, are not contradicted by any other evidence collected by the Inquiry Team.

50. **Finding** – The exact nature and composition of the IED that killed CPL Smith is [REDACTED]

Relevant Procedures and Processes

51. The conduct of the operation and the actions following the incident were governed by a number of requirements. Those pertinent to this inquiry, and the manner in which they were followed, are addressed below.

Counter IED Procedures

Compliance with FE [REDACTED] SOPs

52. CPL Smith and [REDACTED] conducted a number of counter IED drills and procedures from time that they entered COI [REDACTED] up until CPL Smith was killed by the IED blast. The Inquiry reviewed the relevant FE [REDACTED] Standard Operating Procedures (SOPS) and found that CPL Smith's and [REDACTED] actions, as reported, complied with FE [REDACTED] SOPs.

Selection and Use of the Mine Detector

53. CPL Smith was utilising a [REDACTED] Detector [REDACTED] to clear a path for himself when he [REDACTED] killed by, the IED. CPL Smith, like all [REDACTED] authorised Army mine detectors – the [REDACTED] [REDACTED] CPL Smith, and other FE [REDACTED] members, were also qualified on, and had available for use, the [REDACTED] [REDACTED]. CPL Smith was qualified on [REDACTED] mine detectors as well as [REDACTED]

54. Due to the [REDACTED] CPL Smith obtained his [REDACTED] qualification when he entered Theatre. In Theatre training [REDACTED]

[REDACTED]

[REDACTED]

on operational specific equipment is not unusual and has also occurred in relation to other mission specific capabilities such as [REDACTED]. [REDACTED] CPL Smith was formally trained to operate the [REDACTED] and received a Record of Attainment for the training. [REDACTED] The Inquiry found no indication that the training received on the [REDACTED], in Theatre, was deficient.

55. **Finding** – CPL Smith was fully qualified on the HHMD [REDACTED] that he was operating at the time of his death.

56. The inquiry heard evidence that, unless specifically directed by FE [REDACTED] HQ, FE [REDACTED] members were able to chose which detection equipment [REDACTED] to employ on operations. It was stated that FE [REDACTED] members were aware of all of the detection equipment's capabilities and limitations, and chose which detection equipment to utilise based on a number of factors. These factors [REDACTED] FE [REDACTED] members stated that CPL Smith (and all FE- [REDACTED] members) chose to employ the [REDACTED] on this operation based on:

- a.
- b.
- c.
- d.

[REDACTED]

57. Given that all of the available detection equipment was authorised for use in Theatre, and that CPL Smith was qualified on all of the equipment (and therefore aware of each equipments use and limitations), his selection to use the [REDACTED] after considering the operational factors was reasonable. His choice was consistent with all other elements of FE [REDACTED] who chose [REDACTED] for this operation and in accordance with unit SOPs, which provide the reasonable degree of flexibility that is essential to allow tactical considerations to be accommodated when selecting mission equipment..

58. **Finding** – The selection and use of the [REDACTED] for the operation by FE [REDACTED] elements was reasonable and in accordance with FE [REDACTED] SOPs.

Post Incident Procedures

59. **Casualty Notification.** Notification of casualty and all other administrative reports and returns, including the Fatal Casualty Signal (FATACAS) [REDACTED] and the AD604

[REDACTED]

[REDACTED] Confirmation of Death were submitted in accordance with current guidelines in a timely manner.

60. **Primary Emergency Contact (PEC) Notification.** CPL Smith's PEC, his [REDACTED] was notified of CPL Smith's death, in [REDACTED] by an Army notification team at 0155hrs 22 Oct 12. [REDACTED]

61. **Next of Kin (NOK) Notification.** CPL Smith's NOK, his [REDACTED] [REDACTED] was notified of CPL Smith's death, in [REDACTED] by an Army notification team at 0449hrs 22 Oct 12. [REDACTED] It did take some time, and a deal of effort by Army Headquarters, to locate [REDACTED] because [REDACTED] contact details, as CPL Smith's NOK, on PMKEYS were incorrect. [REDACTED]

62. **Finding - Reporting and casualty notification procedures** were carried out in accordance with the relevant references.

63. **Mortuary and Repatriation Procedures.** The MEAO ADFIS detachment were responsible for identifying, taking custody of, and escorting CPL Smith back to Australia. They also prepared the brief for the coroner.

64. Identification of CPL Smith's remains was made by SSM FE [REDACTED] who had known him for 4 years. [REDACTED]

65. CPL Smith was repatriated from Tarin Kowt to [REDACTED], [REDACTED] by [REDACTED] aircraft on 26 Oct 12. A memorial ceremony was held at MNB-TK before his departure and a ramp ceremony conducted. He was subsequently repatriated by C17 aircraft from [REDACTED] to RAAF Richmond, Australia on 27 Oct 12, arriving on 28 Oct 12.

66. At all times after his death CPL Smith's remains were treated with dignity and respect. An honour guard was placed on his remains from the time they were released from the hospital at MNB-TK until he was repatriated. He returned to Australia accompanied by one of his mates from FE [REDACTED]

67. **Pathologist / Coroner.** (To be added if relevant – currently awaiting the coroners report [REDACTED] **Not available at time of Report** [REDACTED])

68. **Finding – Mortuary and repatriation procedures** were carried out in accordance with the relevant references.

Protective Equipment

[REDACTED]

⁴⁰ It should be noted that the maintenance of correct NOK details on PMKEYS is an individual responsibility. CPL Smith's unit had CPL Smith confirm a number of times, prior to his deployment, that his recorded NOK details were correct however; at the time of his KIA they were incorrect. [REDACTED]

69. CPL Smith was wearing his issued ballistic combat helmet and combat body armour system with plates fitted front and rear. He was also wearing and employing [REDACTED] CPL Smith died instantly when the IED exploded. [REDACTED]

70. **Finding** - The protective equipment that CPL Smith wore was appropriate to the task and the tactical situation and was not a contributing factor to his death.

Witnesses

71. Statements were obtained from the following witnesses:

- a. OC FE [REDACTED] FE [REDACTED] Commander, [REDACTED]
- b. **Soldier 10 (Engineer)** [REDACTED] Commander, [REDACTED]
- c. **Soldier 11 (Engineer)** [REDACTED] assigned to [REDACTED]
- d. **Soldier 1** [REDACTED] Commander, [REDACTED]
- e. **Soldier 2** [REDACTED] Sergeant, [REDACTED]
- f. **Soldier 3** [REDACTED] Medic, [REDACTED]
- g. **Soldier 4** [REDACTED]
- h. **Soldier 5** [REDACTED]
- i. **Soldier 7** [REDACTED]

72. Statements were taken by ADFIS [REDACTED] from the following members:

- a. SOTG RMO: SOTG Regimental Medical Officer; and
- b. SSM FE [REDACTED] Squadron Sergeant Major FE [REDACTED]

[REDACTED]

Performance of Duty

73. The operation was conducted in accordance with issued orders and established tactics, techniques and operating procedures.

74. There was no evidence of personnel failing in any aspect of their performance of duty. I found that all personnel carried out their duties to the highest level.

75. I particularly note the following:

- a. the strong and effective leadership of S4 throughout the incident. S4 maintained positive control and influence on throughout the incident. Evidence clearly indicated his professionalism along with his care for his team and that of the attached partner force. His reaction in extracting his team and maintaining control of the situation following the IED blast, that occurred approximately m away from him, was commendable.
- b. all personnel involved in the recovery of CPL Smith's remains and mission essential items did so under extreme personnel duress and whilst under hostile indirect and direct fire. They did everything humanly possible, given the tactical situation, to ensure CPL Smith's remains were recovered, and repatriated.

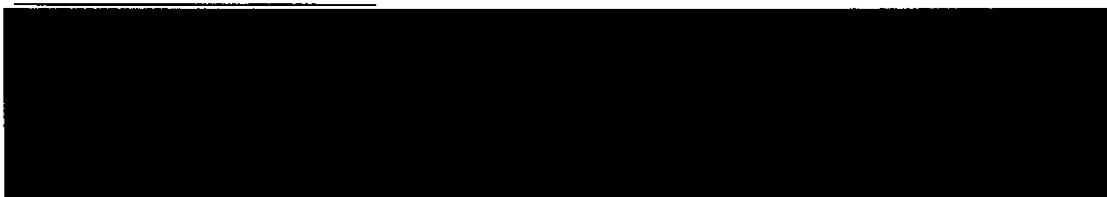
76. **Finding** - The orders, procedures and the performance of duty of those personal involved in the incident were not a contributing factor to CPL Smith's death. All personnel involved in the incident carried out their duties to the highest level.

Other Issues

Discrepancies with Reporting of the Incident

77. After inquiring into the incident I note the following discrepancies between the facts that I have ascertained and those initially reported, and subsequently used, in relation to the incident:

- a. that the time of the IED explosion, and CPL Smith's subsequent death, on the 21 Oct 12 was approximately 1355hrs not 1402hrs, and
- b. CPL Smith was not "*the last individual to exit the COI when an improvised explosive device (IED) killing him instantly*". At



the time of CPL Smith's death the COI was occupied by [REDACTED] members of [REDACTED] as well as [REDACTED] PRC-U members and [REDACTED]

78. The discrepancies are minor and understandable given the operation was still ongoing at the time initial reports were raised and personnel were not available to confirm exact timings / facts. The discrepancies had no bearing on post incident procedures.

Selection and Use of Hand Held Mine Detectors (HHMD)

79. During the course of the inquiry it became apparent that the selection and use of HHMD in Theatre is a contested area. There have been numerous research papers and other studies written on the issue, both in Theatre and in Australia. [REDACTED] The results of the papers when considered together seem unclear. This is a highly technical area and one where this inquiry team was not qualified to make a definitive finding.

80. What is clear to the inquiry team is that there needs to be a balanced approach to any further testing and doctrinal development on the selection and use of HHMD. This approach needs to weigh the views of the technicians and theorists with those of the operators. In my view any development needs to take into account the following:

- a. [REDACTED]
- b. [REDACTED]
- c. [REDACTED]

81. It should be noted that the above is not an exhaustive list but is representative of the types of considerations that need to be viewed collectively.

82. **Finding** – There are competing views on the appropriateness of different HHMD capabilities which have been subject to a variety of testing and research, none of which appears to prove a single system to be superior in all circumstances.

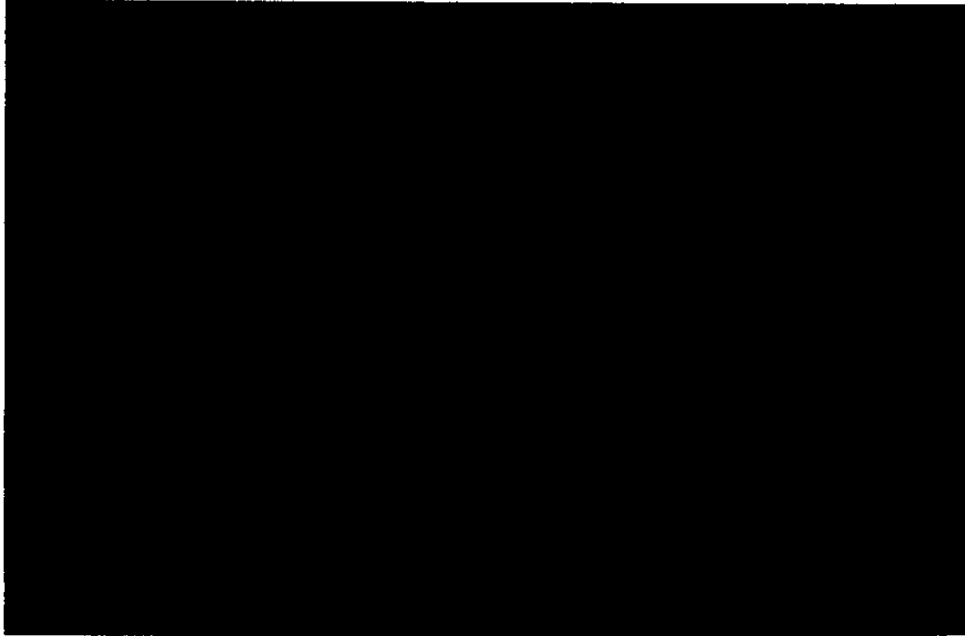
ADF [REDACTED] Form [REDACTED]

83. Another issue which arose during the course of this inquiry related to the inconsistent approach to completion of the ADF [REDACTED] Form. While this did not contribute to the incident which resulted in the death of CPL Smith, nor did it affect post incident administration in this case, there was the potential for post incident confusion. It is apparent that there is some variation in the way the [REDACTED] form is administered both at unit level and within theatre. Issues include:

[REDACTED]

[REDACTED]

- a.
- b.
- c.
- d.
- e.
- f.



84. **Finding** – There is a level of confusion and an inconsistent approach to how the [REDACTED] Form [REDACTED] is completed, classified and stored for operations.

Outcomes of the Operation

85. With the return of FE [REDACTED] to [REDACTED] at [REDACTED] hrs on [REDACTED] Oct 12 OP [REDACTED] [REDACTED] was completed. The operation was successful in denuding the insurgents ability to [REDACTED] operations in Northern Helmand and Uruzgan as it resulted in:

- a. the removal of [REDACTED] insurgents from the battlefield;
- b. the destruction or capture of numerous enemy weapons, including [REDACTED];
- c. the discovery and liberation of a Taliban jail containing [REDACTED] prisoners;
- d. the destruction of approximately [REDACTED] rounds of small arms [REDACTED] and other types of ammunition,
- e. the destruction of over [REDACTED] of home made explosive, [REDACTED] home made grenades, numerous IED components and [REDACTED] [REDACTED];
- f. the discovery and destruction of an suspected IED factory;
- g. the destruction of approximately [REDACTED] of narcotics as well as associated equipment for its production and distribution; and
- h. valuable intelligence on various aspects of insurgent operations. [REDACTED]



Conclusion

86. CPL Smith was killed in action on 21 Oct 12 [REDACTED] IED whilst clearing a path for himself. CPL Smith died instantly due to the size and vicinity of the IED blast. CPL Smith's death occurred in straightforward circumstances of combat.

Findings

87. The operation was appropriately planned and the necessary approvals gained.

88. CPL S.J. Smith, was killed in action at 1355 hrs on 21 Oct 12 as a result of activating a [REDACTED] IED. The approximate location of CPL Smith when he was killed in action was GR [REDACTED]

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

90. The facts and assessments contained in the site exploitation report, about COI [REDACTED] and the IED that killed CPL Smith, are not contradicted by any other evidence collected by the Inquiry Team.

91. The exact nature and composition of the IED that killed CPL Smith is [REDACTED]

92. CPL Smith was fully qualified on the HHMD [REDACTED] that he was operating at the time of his death.

93. The selection and use of the [REDACTED] for the operation by FE [REDACTED] elements was reasonable and in accordance with FE [REDACTED] SOPs.

94. Reporting and casualty notification procedures were carried out in accordance with the relevant references.

95. Mortuary and repatriation procedures were carried out in accordance with the relevant references.

96. The protective equipment that CPL Smith wore was appropriate to the task and the tactical situation and was not a contributing factor to his death.

97. The orders, procedures and the performance of duty of those personal involved in the incident were not a contributing factor to CPL Smith's death. All personnel involved in the incident carried out their duties to the highest level.

98. There are competing views on the appropriateness of different HHMD capabilities which have been subject to a variety of testing and research, none of which appears to prove a single system to be superior in all circumstances.

99. There is a level of confusion and an inconsistent approach to how the [REDACTED] Form [REDACTED] is completed, classified and stored for operations.



100. There are no other contributing factors to this incident.

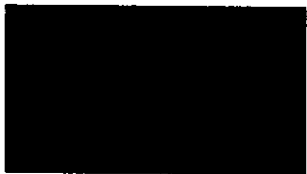
101. I have discovered no issues which would benefit from further examination by a CDF Commission of Inquiry (COI). A CDF COI is unlikely to discover any additional evidence or information which would make any material difference to the conclusions contained in this report.

Recommendations

102. There needs to be a balanced approach to any further testing and doctrinal development on the selection and use of HHMD and the role of [REDACTED]. This approach needs to weigh up the views of the technicians and theorists with those of the operators, while taking into account environmental considerations in which the equipment will be employed.

103. That HQJOC review the current requirement and instructions for [REDACTED] Form [REDACTED] completion and storage for deployed personnel.

104. It is recommended that the appointment of a CDF COI into the death of [REDACTED] CPL S.J. Smith is not warranted.



Colonel
Inquiry Officer

19 Apr 13

Annexes:

