INQUIRY OFFICER INQUIRY REPORT – MATTER CONCERNING JOINT OPERATIONS COMMAND
FOREWORD

I was appointed to conduct an Inquiry Officer inquiry under the Defence (Inquiry) Regulations 1985 by General David John Hurley, AC, DSC, Chief of the Defence Force in his Instrument of Appointment dated 11 November 2011.

For the purposes of this inquiry, I inquired into a matter concerning Joint Operations Command, namely an incident in Afghanistan on or about 29 October 2011 that resulted in the deaths of three ADF members, injuries to other ADF members of other persons and the death of a purported member of the Afghan National Army (ANA), as well as an incident in Afghanistan on or about 8 November 2011 that resulted in injuries to ADF and ANA members.

On 3 April 2012 I submitted a report containing my specific findings and recommendations resulting from the inquiry.

On 30 May 2012 the Chief of the Defence Force directed me to re-open the inquiry and consider certain additional matters regarding my findings in relation to the Defence Intelligence System.

My specific findings and recommendations resulting from the inquiry, including my consideration of the additional matters, are contained in this further report.

Colonel

July 2012
CONTENTS
FOREWORD ............................................................................................................................... 2
PART A – INTRODUCTION........................................................................................................ 5
Introduction .............................................................................................................................. 5
PART B – METHODOLOGY ...................................................................................................... 6
Methodology ............................................................................................................................ 6
Inquiry Chronology ................................................................................................................ 7
PART C – PROCEDURE .......................................................................................................... 8
Serious or Complex Inquiry .................................................................................................... 8
Legal Review ............................................................................................................................ 8
Quick Assessment ................................................................................................................... 8
Selection of the Appropriate Appointing Officer .................................................................. 8
Jurisdiction ............................................................................................................................ 8
Type of Inquiry Selected ......................................................................................................... 8
Eligibility for Appointment ..................................................................................................... 8
Appointment of Inquiry Officer .............................................................................................. 8
Impartiality and Independence ............................................................................................... 9
Terms of Reference ................................................................................................................ 9
Scoping and Planning ............................................................................................................. 9
Notification of Inquiry ........................................................................................................... 9
Procedure ............................................................................................................................... 9
Inquiry Assistant .................................................................................................................... 9
Conduct .................................................................................................................................. 9
Taking of Evidence ................................................................................................................ 9
Refusal by Witnesses ............................................................................................................ 9
Time and Place of Inquiry ..................................................................................................... 9
Informal Procedures ............................................................................................................... 10
False Evidence ..................................................................................................................... 10
Contempt ............................................................................................................................... 10
Witness Expenses ................................................................................................................... 10
Rights and Obligations ........................................................................................................... 10
Notification of Terms of Reference ........................................................................................ 10
Legal Assistance .................................................................................................................... 10
PART A – INTRODUCTION

Introduction
This inquiry was an Inquiry Officer inquiry instituted pursuant to the *Defence (Inquiry) Regulations 1985*.

The authority by which the inquiry was conducted was the Instrument of Appointment signed by the Chief of the Defence Force (CDF) on 11 Nov 11 and the Terms of Reference at Annex A thereto.

The incidents inquired into comprised recent shooting incidents in Afghanistan, namely:

1. an incident on or about 29 October 2011 that resulted in the deaths of three ADF members, injuries to ADF members and other persons and the death of a purported member of the Afghan National Army ("ANA"); and

2. an incident on or about 8 November 2011 that resulted in injuries to ADF members and members of the ANA ("the shooting incidents").
PART B – METHODOLOGY

Methodology
The methods I adopted to conduct the inquiry consisted of:

1. Inquiry Briefings by CDF Commission Of Inquiry (COI) Directorate and Headquarters Joint Operations Command personnel.

2. Inquiry Scoping Phase – The conduct of inquiry planning to develop an evidence collection strategy and a timeline to cover the requirement for evidence assessment and completion of the draft inquiry report.

3. Evidence collection phase – The interviewing of witnesses and obtaining applicable orders and instructions, policies and other relevant documents across the Middle East Area of Operations and Defence Agencies across Australia.

4. Evidence assessment phase – The analysis of evidence and establishment of initial findings relevant to the Terms of Reference.

5. Preparing a draft inquiry report setting out my findings and recommendations.

6. Sending the draft inquiry report to the CDF COI Directorate, for legal review.

7. Considering comments and advice provided following the legal review and preparing the final inquiry report.

8. Sending the final inquiry report to CDF.

9. Re-opening the inquiry as directed by CDF on 30 May 2012 and considering certain additional matters regarding my findings in relation to the Defence Intelligence System.

10. Preparing a draft further inquiry report setting out my findings and recommendations.

11. Sending the draft further inquiry report to the CDF COI Directorate, for legal review.

12. Considering comments and advice provided following the legal review and preparing the final further inquiry report to CDF.

13. Sending the final further inquiry report to CDF.

A comprehensive list of the Annexes and Attachments is at [link]. The methodology adopted for this inquiry was consistent with the Instrument of Appointment and Terms of Reference which specified, amongst other requirements, that:

a. the inquiry is not intended to be a substitute for a Commission of Inquiry;

b. the inquiry be conducted with regard to operational reports and documentary evidence that are materially relevant to the circumstances surrounding the incident;
c. the inquiry be conducted with a methodology consistent with the need to complete the inquiry in a timely manner and which, so far as is practicable, minimises adverse impact on the conduct of ADF Operations in the Middle East Area of Operations.

Inquiry Chronology
A running sheet which sets out the steps and actions taken in the course of the inquiry is at [redacted] to this report. The associated witness schedule is at [redacted].
PART C – PROCEDURE

Serious or Complex Inquiry
As the incident which is the subject of this inquiry involves the deaths of members of the ADF, it is considered to be serious or complex (See [ ] of CDF Directive 04/2010).

Legal Review
This inquiry has been subject to legal review by a Legal Officer who was not appointed as the Inquiry Assistant to the inquiry (See [ ] of CDF Directive 04/2010 for serious and complex inquiries).

Quick Assessment
Quick assessments were conducted by the units concerned prior to the commencement of the inquiry (See [ ] of IGADF – Quick Assessments).

Selection of the Appropriate Appointing Officer
The most appropriate Appointing Officer to conduct the inquiry was selected - the Chief of the Defence Force is the Appointing Officer for the inquiry (See [ ] of CDF Directive 04/2010).

Jurisdiction
Since the Appointing Officer is the Chief of the Defence Force, the inquiry is into a matter concerning the part of the Defence Force that is under the command or control of the appointing officer [See Regulation 70A of the Defence (Inquiry) Regulations].

Type of Inquiry Selected
The type of inquiry selected, an Inquiry Officer inquiry under the Defence (Inquiry) Regulations 1985, was appropriate in all the circumstances, noting that this inquiry has the same statutory authority to enforce its evidence gathering powers as a Court of Inquiry.

Eligibility for Appointment
The Inquiry Officer and Inquiry Assistant were eligible for appointment as they are both officers and they have completed an IGADF Inquiry Officer familiarisation course [See Regulation 70 of the Defence (Inquiry) Regulations and [ ] of CDF Directive 04/2010].

Appointment of Inquiry Officer
The Inquiry Officer and the Inquiry Assistant were properly appointed, as they were appointed by the Chief of the Defence Force, who is an officer who holds an appointment superior to that of a commanding officer in the Defence Force [See Regulation 70A of the Defence (Inquiry) Regulations].
Impartiality and Independence
The Inquiry Officer and Inquiry Assistant conducted the inquiry with absolute impartiality and independence at all times.

Statements of impartiality and independence were raised for the Inquiry Officer and Inquiry Assistant at the beginning and at the end of the inquiry.

Terms of Reference
The terms of reference were relevant to the subject matter of the inquiry. The Appointing Officer obtained comment and advice on the draft terms of reference.

The terms of reference for the inquiry were not added to or varied during the conduct of the inquiry [See Regulation 70B(2) of the Defence (Inquiry) Regulations]

The Inquiry Officer has complied with his terms of reference.

Scoping and Planning
Scoping and planning were conducted at the commencement of and during the inquiry. The Inquiry Officer’s inquiry plan was reviewed on behalf of the Appointing Officer.

Notification of Inquiry
This inquiry did not involve any complainant, respondent, or potentially adversely affected persons (See CDF Directive 04/2010).

Procedure
The Inquiry Officer complied with the procedures directed by the Appointing Officer [See Regulation 71 of the Defence (Inquiry) Regulations].

Inquiry Assistant
The Inquiry Assistant complied with his requirement to assist the Inquiry Officer by gathering evidence and providing it to the Inquiry Officer [See Regulation 70C of the Defence (Inquiry) Regulations].

Conduct
The inquiry was conducted in private [See Regulation 72 of the Defence (Inquiry) Regulations].

Taking of Evidence
Evidence was not taken on oath or affirmation [See Regulation 73 of the Defence (Inquiry) Regulations].

Refusal by Witnesses
No witnesses refused to answer questions or to produce documents and Articles [See Regulations 53, 74 and 74A of the Defence (Inquiry) Regulations].

Time and Place of Inquiry
The inquiry was conducted at such times and places as directed by the Appointing Officer.
Informal Procedures
While the inquiry was not subject to legal form or the rules of evidence and although the Inquiry Officer informed himself on any matter relevant to the inquiry, the Inquiry Officer did use the rules of evidence to analyse the evidence before making findings and recommendations [See Regulation 50 of the Defence (Inquiry) Regulations].

False Evidence
It is considered that no person gave false evidence during the inquiry [See Regulation 56 of the Defence (Inquiry) Regulations].

Contempt
It is considered that no person was in contempt of the inquiry [See Regulation 57 of the Defence (Inquiry) Regulations].

Witness Expenses
No person is entitled to the payment of witness expenses in relation to this inquiry [See Regulations 78, 60(5) and 60(6) of the Defence (Inquiry) Regulations].

Rights and Obligations
All witnesses were informed of their rights and obligations before taking evidence from them.

Notification of Terms of Reference
All witnesses were shown that part of the terms of reference concerning the evidence they were to give before taking evidence from them.

Legal Assistance
No witness was precluded from seeking legal advice or from having a legal officer assist them during their interview [See Paragraph 14 of CDF Directive 04/2010].

Privacy Notices
All witnesses were provided with privacy notices and they all signed these [See Paragraph 15 of CDF Directive 04/2010].

Advice or Assistance
Neither of the Inquiry officer or the Inquiry Assistant sought specialist advice or assistance on the inquiry process or any legal issues [See Paragraph 12 of CDF Directive 04/2010].

Confidentiality
No witness was given a guarantee of confidentiality concerning their evidence and this was made clear to all witnesses before giving evidence.

Immunity from Prosecution
No witness was given a guarantee of immunity from prosecution concerning their evidence and this was made clear to all witnesses before giving evidence.
Procedural Fairness
As there were no witnesses involved in this inquiry who were potentially adversely affected, there was no requirement to specifically address issues of procedural fairness, nor was there a need to issue any letters of notification of potential adverse findings.

Influence
The Appointing Officer did not attempt to influence the Inquiry Officer or the Inquiry Assistant concerning the outcome of the inquiry.

Recommendations
The Inquiry Officer believes that any recommendations made are open and flow logically from the evidence.

Standard of Proof
The Inquiry Officer used the balance of probabilities as the standard of proof when making his findings.

Reliability
The Inquiry Officer does not believe there are any impediments to the Appointing Officer relying on the findings or recommendations contained in the report.

Documentation
All the documents required by the terms of reference to be included with the report have been included.

Time
The report has been submitted in the time required by the terms of reference.

Report
The Inquiry Officer is satisfied that all information relevant to the inquiry that is practicable to obtain has been obtained, that the report has been prepared setting out the findings and recommendations and the report is now furnished to the Appointing Officer with all the evidence obtained, including transcripts or other record of any oral evidence taken and documents received and accepted as evidence [See Regulation 75 of the Defence (Inquiry) Regulations].

Completion of Inquiry
In providing the report to the Appointing Officer the inquiry is now complete [See Regulation 75A of the Defence (Inquiry) Regulations].

Re-Opening of Inquiry
If there is any reason to re-open the inquiry, it must be done within two months of the completion of the inquiry [See Regulation 76 of the Defence (Inquiry) Regulations].

Protection afforded to Inquiry
There are certain protections afforded to inquiry officer inquiries, namely:
- the Inquiry Officer and the Inquiry Assistant have, in the exercise of their duties, the same protection and immunity as a Justice of the High Court;

- a person authorized to appear before an Inquiry Officer or Inquiry Assistant has the same protection and immunity as a barrister appearing for a party in proceedings in the High Court; and

- a witness appearing before an Inquiry Officer or Inquiry Assistant has the same protection as a witness in proceedings in the High Court [See Regulations 78 and 61 of the Defence (Inquiry) Regulations].

**Decision and Implementation**
If the Appointing Officer is satisfied that the evidence supports the findings in this report, the Appointing Officer must decide which recommendations will be implemented, if any, and he will prepare a decision and implementation plan accordingly.

**Notification of Outcome**
As this was not an inquiry into a personnel matter, there is no requirement for the Appointing Officer to provide complainants and witnesses (subject to any privacy considerations) with written notification of the outcome of the inquiry in relation to matters relevant to them.

**Disclosure**
The Inquiry Officer and Inquiry Assistant have complied with the requirements of Regulation 63 of the Defence (Inquiry) Regulations.

**Lessons Learned**
There is a requirement for the Appointing Officer to report any significant systemic issues or serious deficiencies in the quality of an inquiry report or of a legal review [See CDF Directive 04/2010].
PART D – TERMS OF REFERENCE

Under the Terms of Reference (TOR) attached as Annex A to my Instrument of Appointment dated 11 Nov 2011, I was appointed to inquire into a matter concerning Joint Operations Command, being the facts and circumstances surrounding recent shooting incidents in Afghanistan:

1. an incident on or about 29 Oct 11 that resulted in:
   a. the deaths of Captain Bryce Robert Duffy, Corporal Ashley Craig Birt and Lance Corporal Luke Nathan Gavin;
   b. injuries to several Australian soldiers and other person; and
   c. the death of a purported members of the Afghan National Army; and

2. an incident on or about 8 Nov 11 that resulted in injuries to Australian soldiers and members of the Afghan National Army ('the shooting incidents'); and

to provide a written report making findings and recommendations in respect of these matters.

TOR 1—sequence of events: Collect relevant evidence and report on the shooting incidents including the sequence of relevant events leading to the shooting incidents, occurring during the shooting incidents and after the shooting incidents.

TOR 2—potential procedural weaknesses or deficiencies: Ascertain, analyse and determine relevant circumstances surrounding the shooting incidents for the purpose of identifying any weaknesses or deficiencies (isolated or systemic) exist in Defence systems, policies, equipment, practices, procedures and training.

TOR 3—potential shortfalls in actions or decision-making: Identify any shortcomings in relevant Defence actions and decisions, both prior to and subsequent to the shooting incidents, and assess whether any identified shortcomings prior to the shooting incidents may have contributed to the shooting incidents.

TOR 4—positive observations: In the course of answering the preceding terms of reference, identify whether, and if so how, any Defence systems, policies, equipment, practices, procedures, training, actions or decision making had a positive effect in the lead up to, during or after the shooting incidents.

Evidence

The evidence collected in relation to each Term of Reference is listed in the footnotes for that Term of Reference and some evidence is also mentioned within the text for each Term of Reference.
Analysis of Evidence

I have weighed the evidence collected using the rules of evidence and my analysis of the evidence is set out within the text for each Term of Reference.

Findings

My findings in relation to each Term of Reference are set out within the text for that Term of Reference. I consider that they are available on the evidence, on the balance of probabilities.

Recommendations

Where I have made recommendations, these are set out immediately following the relevant Term of Reference. I consider that my recommendations flow logically from the findings.

TOR 1

Sequence of events.

Incident at Patrol Base Sorkh Bed on 29 Oct 11

Date/Time/Place of incident

29 Oct 11, 0820 hrs, ANA parade ground at PB Sorkh Bed.

Circumstances prior to the incident

A number of key personnel from Alpha departed the ADF mentoring compound and formed up on the parade ground as part of a daily routine for the conduct of the morning parade for 6 KDK prior to the commencement of daily duties. The conduct of 6 KDK parade was led by [[redacted]] in absence of the CO who was [[redacted]].

The dress and force protection posture of ADF personnel, including the level of weapon readiness, was consistent with MTF orders and directives, the level of threat and what was a non combat-related activity inside an ANA secured compound.

ADF members were wearing body armour at the time of the incident. This dress was linked to [[redacted]] planned to take place following the parade and not [[redacted]].
Incident

At the completion of the morning parade, ADF personnel remained in the vicinity of their parade location to discuss training activities for the day. An ANA soldier ran from the vicinity of the group of ANA Officers and SNCOs to a point approximately 15 metres from ADF personnel. At a distance of approximately 10-15 metres, the ANA soldier fired several bursts from a squad automatic weapon. 10 ADF members, one ANA member and three ISAF interpreters were shot as a result of the engagement. Evidence indicates two ADF members (possibility of a third) returned fire and killed the ANA shooter.

Three ADF members were killed (CAPT Duffy and CPL Birt were dead on arrival at the Role two medical facility at Tarin Kowt, LCPL Gavin following surgical intervention), seven ADF members were wounded (Soldier 2, Soldier 3, Soldier 4, Soldier 8, Soldier 9, Soldier 10, Soldier 14), one ISAF interpreter was killed (Soldier 5 was dead on arrival), two ISAF interpreters (ISAF 2 and ISAF 3), and one ANA member (ANA Officer 6 KDK) were wounded, one ANA member – the shooter – was killed (Zabit M.Z. Darwesh 6 KDK). Two ADF members (Soldier 9 and Soldier 10) and two ISAF interpreters were unhurt.

Immediate actions

ADF personnel wounded at the incident site applied initial treatment to their own and others' injuries. Personnel from the ADF mentoring compound rapidly relocated casualties to the ANA medical facility and continued treatment. An incident report and an immediate request for AME was sent to MTF Headquarters. Increased force protection measures were implemented within the ADF mentoring compound and to personnel travelling within the wider ANA compound at PB Sorkh Bed.

Subsequent actions

Casualties were evacuated by air in two lifts according to priority and admitted to the US role two hospital in Tarin Kowt. AME was complete by 0955 hrs. All casualties were treated and stabilised prior to movement and admittance to the role three hospital at Kandahar Airfield. By hrs on 30 Oct 11, all casualties had been admitted to the role three
hospital at Bagram Air Base. By 0000 Nov 11, all casualties were re-located and admitted to the hospital at Landstuhl Regional Medical Facility, Germany.

Deaths and injuries

Three autopsies were conducted concurrently by three separate pathologists in Australia. The final autopsy reports are still to be completed. No specific medical documentation was obtained by the inquiry team. An update on the status of surviving casualties was provided to A/CDF in early November which correctly corresponds with information provided by wounded ADF members in their interviews with the Inquiry Officer.

Cause of incident

It is likely the incident at Sorkh Bed was aimed primarily at targeting ADF personnel and Derwish was seizing an opportunity. There is no evidence to indicate a connection between Derwish and an insurgent individual or group prior to the incident. There is evidence to suggest other individuals within were aware of his intent prior to the incident. The degree of association and support is still under review. There is no evidence to suggest that the shooting was connected as part of a broader strategy with other ‘insider threat’ events prior or subsequent to the incident.
Other factors

There were no other environmental or operational factors that had a relevant impact on the events leading up to, during, or subsequent to the incident.

**Finding 1:** The dress and force protection posture of ADF personnel involved in the incident at PB Sorkh Bed was consistent with extant orders and directives from commanders.

**Incident at Patrol Base Nasir on 8 Nov 11**

**Date/Time/Place of incident**

8 Nov 11, 1720 hrs, at PB Nasir.

**Circumstances prior to the incident**

All security towers within PB Nasir and the overwatch position were being manned independently by the ANA. Security arrangements at the time of the incident included a [Redacted]. Leading up to the incident, ADF personnel from callsign [Redacted], were conducting night-routine, including cooking a meal, operating the CP and preparing their equipment for the evening's security activities.

[Soldier 11] was located in the AS accommodation building, lying on his bed, [Redacted], and [Soldier 12] were cooking on a barbeque outside the accommodation area. [Soldier 13] was attending the latrines. [Soldier 14] was in the command post on [Redacted]. [Soldier 15] was also in the command post, speaking with [Soldier 16] and [Soldier 17]. [Soldier 18] was located to the side of the barbeque area watching a movie with two ANA soldiers (the same two ANA soldiers injured in the engagement).

The dress and force protection posture, including the level of weapon readiness, was consistent with MTF orders and directives, the level of threat and what was a non-combat-related activity inside the ADF accommodation area of an ANA secured compound.

**Incident**

The engagement was initiated by a single member of the ANA from PB Nasir occupying the overwatch position [Redacted]. The overwatch position was manned by the ANA as an independent security post to align with the progression towards independent ANA occupation. At the time of the engagement, the overwatch position was occupied by [Redacted] ANA soldiers. The remaining soldiers, not involved in the
engagement, were to the rear of the overwatch position in the designated area. The shooter initially engaged with bursts from a Browning MG.50 cal M2HB machine gun and, as a result of a weapon malfunction, re-engaged with bursts from a squad automatic weapon. The shooter was Mohammad Rozi. No ADF members involved in the incident could identify Mohammad Rozi as the shooter or his specific movements following the engagement.

Soldiers and immediately returned fire and the shooter stopped the engagement. Interviews with ANA personnel highlight the shooter’s withdrawal from the overwatch position and PB Nasir in a stolen ANA HMMWV.

Three ADF members (Soldier 16, Soldier 17, and Soldier 18) and two ANA members were shot and wounded as a result of the engagement. ADF members (Soldiers 151, Soldiers 152) and ANA personnel (Soldiers 153, Soldiers 154) were unhurt.

Immediate actions

ADF personnel wounded at the incident site applied initial treatment to their own and ANA injuries. On completion of the engagement, ADF personnel relocated both ADF and ANA casualties to a casualty collection point, increased force protection measures and provided additional security for casualties. Braver personnel sent an incident report and an immediate request for AME to MTF Headquarters.

Subsequent actions

deployed an Air to the incident site to assist in the search for Mohammad Rozi and the stolen vehicle, supported by two F18s.

Casualties were evacuated by air in two lifts according to priority and admitted to the US role two hospital in Tarin Kowt. All casualties were treated and stabilised prior to movement and admittance to the role three hospital in Kandahar Airfield. On 9 Nov all casualties had been admitted to the role three hospital at Bagram Air Base. On 10 Nov, all casualties were re-located and admitted to the hospital at Landstuhl Regional Medical Facility, Germany.

A from Alpha was reacted from and deployed to PB Nasir. Orders were given to increase force protection and the commenced an initial collection of evidence and disarming of ANA personnel. An Air Weapons Team subsequently found the stolen HMMWV burning in Charmiston.
Injuries

No specific medical documentation was obtained by the inquiry team. A quick assessment conducted within MTF outlines the extent of injuries sustained by ADF personnel and correctly corresponds with information provided by the wounded members in their interviews with the inquiry team and in-theatre reporting.

Cause of incident

The shooting at PB Nasir was aimed primarily at targeting ADF personnel. The shooter had ample opportunity to target the other ANA soldiers at the overwatch position, but did not do so. The shooter was seizing an opportunity He identified the opportunity to attack from the overwatch position at a time of his choosing. The shooter is likely to have received support in order to escape prior to identification and follow up by CF elements. Initial in-theatre assessments indicated that Rozi was The more recent indicate there is insufficient evidence to confirm whether this was the case. The shooting does not appear to be connected as part of a broader strategy with other ‘insider threat’ related incidents

Other factors

There were no other environmental or operational factors that had a relevant impact on the events leading up to, during, or subsequent to the incident.

Finding 2: The dress and force protection posture of ADF personnel involved in the incident at PB Nasir was consistent with extant orders and directives from commanders.

TOR 2

Potential procedural weaknesses or deficiencies.

Defence Intelligence System and addressing new and evolving threats to ADF operations
Finding 3: Defence intelligence agencies provided an adequate level of assessment on the ‘insider threat’ to ADF commanders following the incident involving the death of LCPL Jones and prior to the incident at Sorkh Bed. In making this finding, consideration was given to evidence that highlighted the difficulty experienced by Defence intelligence agencies, as well as ADF commanders and CF partners in Afghanistan, to frame the nature of what is a complex and evolving threat. The cause of each incident can be as a result of a number of contributing factors. Defence intelligence agencies adequately addressed the ‘insider threat’, consistent with the information available, their understanding of the threat and its priority in comparison to other threats to ADF personnel assessed at that time.
Finding 4: In addition to the actions of Defence intelligence agencies to date, there is a need for

Recommendation 1:
ADF Learning in Support of Operations

A CJOPS directive directs evaluating the operational level aspects of lessons drawn from ADF operations. Interviews highlight the cell’s role in contributing to broader learning mechanisms for the Army. The agency retains a large volume of information for general viewing by Defence personnel with only select personnel able to access sensitive information resulting in improvements to force preparation of Army elements. AWB and its deployed element, the Adaptive Warfare Team (AWT), are not required to implement changes to force training on the ‘insider threat’ prior to and following the incident involving the death of LCPL Jones. 

Cell within JTF633 (known as the Adaptive Warfare Team) is co-located with HHL and CTU. The cell had leading up to and following the incident involving death of LCPL Jones, and prior to the incidents at PB Sorkh Bed. The responsibilities of this cell have expanded to evaluate findings of observations from ADF deployed elements across
Following the incidents at PB Sorkh Bed and PB Nasir, HQJOC has coordinated a comprehensive review, supported by a number of Defence agencies, to identify and evaluate observations and findings of incidents involving an ‘insider threat’.

Finding 5: Despite a general awareness of the ‘insider-threat’, the lessons learned cells within HQJOC, HQ 1 DIV (Army) and JTF633 (J8/Adaptive Warfare Team) had not seen the executive director and therefore could not see the incident involving the death of LCPL Jones, in order to recommend to respective commanders, measures to reduce the likelihood of future ‘insider-threat’ incidents occurring.

A culture exists which links responsibility and resources for evaluating ADF lessons on operations to specific ‘lessons learnt’ cells and structures across Defence. These cells and structures are internally focused to the observations and findings of ADF Operations. The presence of these cells did not enhance the effectiveness of ADF command decision making, inherent within command and control architectures and staff functions at the operational and strategic level within the ADF, to adequately identify and evaluate observations and findings of incidents involving an ‘insider threat’ prior to the incidents at PB Sorkh Bed and PB Nasir.

In the 12 months leading up to the incident involving the death of LCPL Jones, HQJOC informed senior ADF Commanders on issues surrounding the nature of the ‘insider threat’ in Afghanistan, drawing evidence from ISAF on previous incidents experienced by other CF partners. In 2010, HQJOC advised on the methodologies by ISAF to determine such threats, with no evidence of ISAF such incidents. Concerns were raised to ADF Commanders on the ADF applying measures that would negate the establishment of trust with the ANSF, the current force protection measures employed by ADF personnel and plans to review these measures in light of interaction with ANSF elements. In 2011, HQJOC advised ADF Commanders of the continued intent by insurgents to penetrate ISAF/ANSF bases, drawing evidence from ISAF on previous incidents.
Deployed ADF agencies experienced difficulty in obtaining information and determining the causal factors surrounding the incident involving the death of LCPL Jones. Assessments provided in the QA lacked supporting evidence. Considerable resources from ADF and ISAF were employed with an aim to capture the individual in order to support this examination. Deployed ADF Commanders attribute the actions of the shooter, acknowledging the absence of any supporting evidence at the time of incident, to the factors of personal grievance and cultural differences. HQJOC requested and received information from ADF deployed agencies following the incident. Deployed ADF Commanders and principal staff within HQJOC, JTF633/JTF633-A and assessed the death of LCPL Jones as an isolated incident. CTU and MTF2 reviewed, at the tactical level, force protection measures and, the cultural implications of residing ADF personnel within ANA bases. MTF3 Commanders and personnel reinforced, at the tactical level, training and education on cultural sensitivities when interacting with ANA personnel prior to deployment. There is no evidence to indicate that HQJOC and supporting Canberra based Defence agencies evaluated the incident further.

Finding 6: HQJOC adequately advised senior ADF Commanders on previous incidents involving an 'insider threat' from other nations prior to the incident involving the death of LCPL Jones.

Following the incident involving LCPL Jones, JTF633, JTF633-A and HQJOC took sufficient steps to obtain information surrounding the incident. It does not appear that HQJOC conducted a specific evaluation of the incident involving the death of LCPL Jones. ADF commanders at the operational and strategic levels required this evaluation, including the consideration of similar incidents involving CF partners in Afghanistan. In making this finding, consideration was given to evidence that highlighted the difficulty experienced by deployed ADF agencies to obtain sufficient information on the causal factors surrounding the shooter’s motives. Noting this difficulty, a comprehensive evaluation by HQJOC was warranted, including a risk assessment, beyond tactical level measures taken by commanders. This assessment would have enhanced decision making by senior ADF commanders to determine what risks and therefore actions could be taken at the operational and strategic level in conjunction with applicable actions of CF coalition partners, and noting the complexity of this threat, to complement tactical actions taken, and potentially reduce the likelihood of similar incidents occurring in the future.

Care of Battle Casualty Competencies within Army.
Interviews from witnesses involved in both incidents and medical personnel assess the immediate actions of Army First Aid (AFA) personnel helped save the lives and reduce the severity of injuries to themselves and others. Haemorrhage control is assessed as the key action required to save lives on the battlefield following incidents similar to those experienced at PBs Sorkh Bed and PB Nasir. Care of Battle Casualty (CBC) competencies are delivered during force preparation training for ADF personnel. The ADF medical officer deployed in Afghanistan assessed this approach as inadequate for Army due to the perishable nature of the skill, the competing force preparation requirements prior to deployment and the increased risk inherent with the nature of duties experienced by Army personnel. The officer, during his previous appointment as, supported the embedding of CBC competencies within Army First Aid (AFA) qualification (currently delivered as part of recruit training). He assesses the need to invest resources to imbue CBC competencies as part of all corps training within Army, whilst maintaining the current approach for ADF personnel across the remaining services deployed on OP SLIPPER. The matter remains under review from Army.

Finding 7: The application of Care of Battle Casualty competencies by AFA qualified ADF personnel involved in the incidents at PBs Sorkh Bed and PB Nasir saved the lives and reduced the severity of injuries to themselves and other personnel.

Recommendation 2: CBC competencies should be delivered as part of all corps training within Army in order to increase the current level of mitigation and to address what remains the primary risk of a fatality for personnel experiencing wounds resulting from similar incidents in the future.

AUSDIL

DCO were unable to establish or maintain a consistent point of contact with HQJOC in order to obtain information on the timeline expected for ADF casualties to remain in Germany prior to re-deployment to Australia. DCO consider this information, consistent with policy requirements, when determining the benefit to wounded personnel should AUSDIL be approved. DCO subsequently requested and received informal advice from Army, via Director of Army Health, outlining a period of two weeks. The initial source of this information or accuracy is unknown. DCO granted approval for AUSDIL based on this information which was communicated to Army, ADF casualties and their families in Australia.

DCO subsequently received updated advice from HQJOC with a different timeline (reduced from that initially advised within Army) expected for ADF casualties to remain in Germany. This timeline would have provided ADF casualties approximately 24 hours contact with family members. DCO cancelled the initial AUSDIL approval, advised Defence agencies and respective families, assisting families with financial and counselling assistance in
preparation for the reception of ADF casualties to Australia. The management of the process and communication between DCO, Army and the families was effective under the circumstances. The issue that arose during the process was the impact on family circumstances resulting from the cancellation of travel on short notice.

A recently reviewed policy framework on AUSDIL (awaiting final endorsement) has received support from groups and Services across Defence, including Army. There remains confusion across HQJOC and the Services on the responsibility for submitting AUSDIL requests for deployed members returning to Australia due to injury.

Finding 8: The absence of a principal point of contact from within HQJOC throughout the AUSDIL process, was the predominant factor that contributed to DCO seeking and receiving conflicting information within Defence agencies on the timeline expected for ADF casualties to remain in Germany prior to re-deployment to Australia. The decision by DCO to cancel AUSDIL, as a result of new information, was reasonable, considered primarily the impact on wounded personnel (consistent with policy) without neglecting the impact on their respective families. DCO and Army key personnel communicated these changes effectively, noting the circumstances.

Finding 9: The policy aspects surrounding the submission of AUSDIL requests are adequate.

Recommendation 3: Additional training and education on the AUSDIL policy and procedures should be provided across services and groups within Defence.

Walking Blood Donor Panel

Interviews with deployed medical personnel highlighted during the treatment of ADF casualties following the Sorkh Bed incident. The blood donations from a large number of ADF personnel during this period provided an increased level of fresh blood to the facility in support of this treatment. This increase supported the protracted surgical intervention involving LCPL Gavin. A walking blood donor panel meets an operational requirement to in Afghanistan. ADF currently the capability in support of ADF Operations. Advice from Senior ADF Medical Officers deployed in Afghanistan and HQJOC is that the operational policies regarding this issue require examination. Joint Health Command are currently reviewing the requirement.
**Finding 10:** The walking blood donor panel capability directly supported the treatment of ADF casualties by medical staff following the incident at Sorkh Bed.

**Recommendation 4:** The effectiveness of an ADF mobile blood bank and pathology capability in support of operations, in specific operational environments, should be examined.

**TOR 3**

Potential shortfalls in actions or decision-making.

The inquiry did not identify, as a result of interviews and the collection and analysis of all relevant documentation, any shortcomings in relevant Defence actions and decisions, both prior and subsequent to the shooting incidents.

**TOR 4**

Positive observations.

Treatment of casualties

Incident at Patrol Base Sorkh Bed on 29 Oct 11

Despite injuries to following the shooting, the member applied first aid treatment to his own wounds and immediate treatment to other casualties at the incident site, followed by co-ordinating all ranks in the management and prioritisation of casualties in preparation for AME. Interviews with casualties and personnel highlighted leadership, as well as the initiative and professionalism of supporting CFA when responding to what were deteriorating medical conditions across multiple casualties. Medical officers assessed the treatment and prioritisation of casualties for AME at both incident sites to be appropriate to the nature and severity of injuries.

**Finding 11:** The leadership and actions of supported by other CFAs, saved the lives and reduced further injury to both himself and other surviving casualties present at the PB Sorkh Bed incident.

The detailed treatment by multiple CFAs at the ANA medical facility, in response to deterioration in the medical condition of LCPL Gavin, prolonged his life prior to the AME. AME aviation and personnel identified signs of life from the member during transit to the role 2 medical facility. The surgical intervention led by over an extended period at the Role 2 medical facility prolonged the life of LCPL Gavin. Interviews with specialist medical personnel and staff indicate that no additional actions or other measures in the immediate treatment and prioritisation of casualties for AME would have further prolonged the life of LCPL Gavin or reduced further injury to other surviving casualties.
Finding 12: All possible treatment was given by both CFAs following the incident to prolong the life of LCPL Gavin prior to his death. It is unlikely that LCPL Gavin would have survived his wounds regardless of the medical treatment provided.

Incident at Patrol Base Nasir on 8 Nov 11

Despite injuries to himself following the shooting, applied first aid treatment to his own wounds, immediate treatment to other casualties at the incident site, followed by coordinating all ranks in the management and prioritisation of casualties in preparation for AME. Interviews with casualties and personnel highlighted the leadership, initiative and technical competence displayed by in the conduct of his duties.

Finding 13: The leadership and actions of supported by the other CFA, reduced further injury to both himself and other casualties present at the PB Nasir incident.

The CFAs involved in the PB Sorkh Bed and PB Nasir incidents and medical staff highlighted the additional skills obtained in primary survey training, (as part of mission specific training) as vital when responding to an incident involving multiple casualties.

Finding 14: The skills applied as a result of mission specific training delivered to CFAs (primary survey training) directly contributed to saving the lives and reducing further injury to ADF casualties in both incidents, and prolonging the life of LCPL Gavin.

Conflict Resolution

MTF Commanders have established and applied an architecture and set of procedures in conjunction with ANA counterparts to formally de-escalate and resolve conflicts that occur during mentoring duties in Afghanistan. The mechanisms have addressed issues involving personal grievances, perceived cultural differences between parties and the professional competence and leadership of ANA Commanders.

Finding 15: ADF commanders at the tactical level have established and applied effective conflict resolution mechanisms to de-escalate conflicts between ADF and ANA personnel, including. These mechanisms have been demonstrated to reduce the likelihood of further conflicts occurring in the future, including potential incidents similar in nature to PB Sorkh Bed and PB Nasir.

Welfare and Support Arrangements
Individuals experienced an increase in morale as a result of attending and participating in the ramp ceremony for the ADF members killed at Sorkh Bed. Interviews with members involved in the incident highlighted the support drawn from peers and leadership from that experience was at least commensurate to ADF supporting agencies. The experience aided individuals when returning to operational duties.³

Finding 16: ADF personnel’s involvement at the ramp ceremony for individuals killed in the Sorkh Bed incident contributed towards maintaining their morale and operational effectiveness.

Interviews with ADF casualties involved in both incidents highlight the comprehensive support given by parent Army units within Australia. Soldier A has effectively coordinated, both within 2RAR and across the staff within parent units, what was an increased level of complexity and sensitivity in casualty management. This included the rehabilitation and welfare of surviving casualties, the management of families of both fatalities and wounded from these incidents in conjunction with DCO, and the tensions for members and their families surrounding the AUSDIL travel issue. These actions had a positive impact on morale, rehabilitation and, in the case of Soldier B, his expedient force preparation for redeployment into theatre.

Finding 17: The response and comprehensive management by parent Army units within Australia of surviving casualties and the families of both fatalities and wounded had a positive impact on morale, rehabilitation and, for specific personnel, their timely redeployment into theatre.
Use of Force

In relation to the incident at PB Sorkh Bed, and possibly engaged the shooter in self-defence. The shooter was killed as a result of the engagement.

In relation to the incident at PB Nasir, engaged the shooter in self-defence. The shooter ceased the engagement and fled the incident site.

Both shooting incidents were unexpected during non-combat related activities, where ADF members were at a non-aggressive posture and in close contact with their ANA partners.

ADF members engaged the respective shooter while under fire in both incidents. The engagement was rapid, accurate and proportional to remove the threat in both cases.

Finding 18: The decisions and actions taken by ADF personnel in engaging an unexpected threat, from their ANA counterparts, was in self-defence, rapid, accurate and proportional to both remove the threat and minimise the number of ADF casualties.

ADF actions following the PB Sorkh Bed and PB Nasir incidents

MTF completed a review of the force protection requirements of all ANA localities where ADF personnel are present. CTU and MTF have implemented a training and education package centred on cultural awareness and identification of ‘persons of interest’ for MTF personnel in support of 4 BDE. MTF have established policy and procedures to outline the possible indicators and actions required on the detection of the ‘insider threat’.

HQ 1 DIV has conducted a tactical review and assessment of TTPs, including our coalition partners, the ‘insider threat’ towards Australian personnel deployed in the MEAO. This review contributes to the broader assessment by HQJOC at the operational level across ADF current force design, counter-intelligence development and an evaluation of incidents from our CF partners, all to reduce the likelihood of future ‘insider threat’ incidents occurring.
Finding 19: HQJOC and ADF deployed agencies have taken measures across the areas of force design, ADF base security, individual force protection, heightened cultural awareness, counter-intelligence and identification of 'persons of interest' following the Sorkh Bed and Nasir incidents to reduce the likelihood of 'insider threat' incidents occurring in the future.
PART D – SUMMARY OF FINDINGS

TOR 1

Sequence of events.

Finding 1: The dress and force protection posture of ADF personnel involved in the incident at PB Sorkh Bed was consistent with extant orders and directives from commanders.

Finding 2: The dress and force protection posture of ADF personnel involved in the incident at PB Nasir was consistent with extant orders and directives from commanders.

TOR 2

Potential procedural weaknesses or deficiencies.

Finding 3: Defence intelligence agencies provided an adequate level of assessment on the ‘insider threat’ to ADF commanders following the incident involving the death of LCPL Jones and prior to the incident at Sorkh Bed. In making this finding, consideration was given to evidence that highlighted the difficulty experienced by Defence intelligence agencies, as well as ADF commanders and CF partners in Afghanistan, to frame the nature of what is a complex and evolving threat. The cause of each incident can be as a result of a number of contributing factors. Defence intelligence agencies adequately addressed the ‘insider threat’, consistent with the information available, their understanding of the threat and its priority in comparison to other threats to ADF personnel assessed at that time.

Finding 4: In addition to the actions of Defence intelligence agencies to date, there is a need for

Finding 5: Despite a general awareness of the ‘insider-threat’, the lessons learned cells within HQJOC, HQ 1 DIV (Army) and JTF633 (J8/Adaptive Warfare Team) had not seen and therefore could not identify partners, as well as the incident involving the death of LCPL Jones, in order to recommend to respective commanders, measures to reduce the likelihood of future ‘insider-threat’ incidents occurring.
A culture exists which links responsibility and resources for evaluating ADF lessons on operations to specific 'lessons learnt' cells and structures across Defence. These cells and structures are internally focused to the observations and findings of ADF Operations. The presence of these cells did not enhance the effectiveness of ADF command decision making, inherent within command and control architectures and staff functions at the operational and strategic level within the ADF, to adequately identify and evaluate observations and findings of incidents involving an 'insider threat' from CF partners in Afghanistan prior to the incidents at PB Sorkh Bed and PB Nasir.

**Finding 6:** HQJOC adequately advised senior ADF Commanders on previous incidents involving an 'insider threat' from other nations prior to the incident involving the death of LCPL Jones.

Following the incident involving LCPL Jones, JTF633, JTF633-A and HQJOC took sufficient steps to obtain information surrounding the incident. It does not appear that HQJOC conducted a specific evaluation of the incident involving the death of LCPL Jones. ADF commanders at the operational and strategic levels required this evaluation, including the consideration of similar incidents involving CF partners in Afghanistan. In making this finding, consideration was given to evidence that highlighted the difficulty experienced by deployed ADF agencies to obtain sufficient information on the causal factors surrounding the shooter's motives. Noting this difficulty, a comprehensive evaluation by HQJOC was warranted, including a risk assessment, beyond tactical level measures taken by commanders. This assessment would have enhanced decision making by senior ADF commanders to determine what risks and therefore actions could be taken at the operational and strategic level in conjunction with applicable actions of CF coalition partners, and noting the complexity of this threat, to complement tactical actions taken, and potentially reduce the likelihood of similar incidents occurring in the future.

**Finding 7:** The application of Care of Battle Casualty competencies by AFA qualified ADF personnel involved in the incidents at PBs Sorkh Bed and PB Nasir saved the lives and reduced the severity of injuries to themselves and other personnel. Delivering CBC competencies as part of all corps training within Army would increase the current level of mitigation, to address what remains the primary risk of a fatality for personnel experiencing wounds resulting from similar incidents in the future.

**Finding 8:** The absence of a principal point of contact from within HQJOC throughout the AUSDIL process, was the predominant factor that contributed to DCO seeking and receiving conflicting information within Defence agencies on the timeline expected for ADF casualties to remain in Germany prior to re-deployment to Australia. The decision by DCO to cancel AUSDIL, occurred as a result of updated information, was reasonable, considered primarily the impact on wounded personnel (consistent with policy) without neglecting the impact on
their respective families. DCO and Army key personnel communicated these changes effectively, noting the circumstances.

**Finding 9:** The policy aspects surrounding the submission of AUSDIL requests are adequate. Additional training and education is required across services and groups within Defence.

**Finding 10:** The walking blood donor panel capability directly supported the treatment of ADF casualties by medical staff following the incident at PB Sorkh Bed. The effectiveness of an ADF mobile blood bank and pathology capability in support of operations in specific operational environments should be examined.

**TOR 4**

Positive observations.

**Finding 11:** The leadership and actions of [soldier], supported by other CFAs, saved the lives and reduced further injury to both himself and other surviving casualties present at the PB Sorkh Bed incident.

**Finding 12:** All possible treatment was given by both CFAs and [soldier] following the incident to prolong the life of LCPL Gavin prior to his death. It is unlikely that LCPL Gavin would have survived his wounds regardless of the medical treatment provided.

**Finding 13:** The leadership and actions of [soldier] supported by the other CFAs, reduced further injury to both himself and other casualties present at the PB Nasir incident.

**Finding 14:** The skills applied as a result of mission specific training delivered to CFAs (primary survey training) directly contributed to saving the lives and reducing further injury to ADF casualties in both incidents, and in the incident at PB Sorkh Bed, prolonging the life of LCPL Gavin.

**Finding 15:** ADF commanders at the tactical level have established and applied effective conflict resolution mechanisms to de-escalate conflicts between ADF and ANA personnel, including. These mechanisms have been demonstrated to reduce the likelihood of further conflicts occurring in the future, including potential incidents similar in nature to PB Sorkh Bed and PB Nasir.
Finding 16: ADF personnel’s involvement at the ramp ceremony for individuals killed in the PB Sorkh Bed incident contributed towards maintaining their morale and operational effectiveness.

Finding 17: The response and comprehensive management by parent Army units within Australia of surviving casualties and the families of both fatalities and wounded had a positive impact on morale, rehabilitation and, for specific personnel, their timely redeployment into theatre.

Finding 18: The decisions and actions taken by ADF personnel in engaging an unexpected threat, from their ANA counterparts, was in self-defence, rapid, accurate and proportional to both remove the threat and minimise the number of ADF casualties.

Finding 19: HQJOC and ADF deployed agencies have taken measures across the areas of force design, ADF base security, individual force protection, heightened cultural awareness, counter-intelligence and identification of ‘persons of interest’ following the Sorkh Bed and Nasir incidents to reduce the likelihood of ‘insider threat’ incidents occurring [black box] in the future.
PART E – SUMMARY OF RECOMMENDATIONS

TOR 2

Potential procedural weaknesses or deficiencies.

Recommendation 1: [Blank]

Recommendation 2: CBC competencies should be delivered as part of all corps training within Army in order to increase the current level of mitigation and to address what remains the primary risk of a fatality for personnel experiencing wounds resulting from similar incidents in the future.

Recommendation 3: Additional training and education on the AUSDIL policy and procedures should be provided across services and groups within Defence.

Recommendation 4: The effectiveness of an ADF mobile blood bank and pathology capability in support of operations, in specific operational environments, should be examined.
PART F – CONCLUSION

The evidence gathered during the inquiry was sufficient to make the findings set out in this report on the balance of probabilities. There were no unresolved conflicts arising out of the evidence and the witnesses all appeared credible and reliable. The evidence revealed the circumstances surrounding the shooting incidents that occurred on 29 Oct 11 and 8 Nov 11, as well as what transpired subsequently.

In particular, the evidence established that:

- The dress and force protection posture of ADF personnel involved in both incidents was consistent with extant orders and directives from commanders. The decisions and actions taken by ADF personnel in engaging an unexpected threat, from their ANA counterparts, was in self-defence, rapid, accurate and proportional to both remove the threat and minimise the number of ADF casualties.

- Defence intelligence agencies provided an adequate level of assessment on the 'insider threat' to ADF commanders following the incident involving the death of LCPL Jones and prior to the incident at Sorkh Bed. In making this finding, consideration was given to evidence that highlighted the difficulty experienced by Defence intelligence agencies, as well as ADF commanders and CF partners in Afghanistan, to frame the nature of what is a complex and evolving threat. The cause of each incident can be as a result of a number of contributing factors. Defence intelligence agencies adequately addressed the 'insider threat', consistent with the information available, their understanding of the threat and its priority in comparison to other threats to ADF personnel assessed at that time.

- In addition to the actions of Defence intelligence agencies to date, there is a need for a

- HQJOC adequately advised senior ADF Commanders on previous incidents involving an ‘insider threat’ from other nations prior to the incident involving the death of LCPL Jones, and took sufficient steps to obtain information following the incident occurring. It does not appear that HQJOC conducted a specific evaluation of the incident involving the death of LCPL Jones, in conjunction with applicable actions of CF coalition partners, and noting the complexity of this threat, to determine what steps could be taken at the operational and strategic level to complement tactical actions and potentially reduce the likelihood of similar incidents occurring in the future.

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The 'lessons learnt' cells and structures across Defence did not enhance the effectiveness of ADF command decision making, to adequately identify and evaluate observations and findings of incidents involving an 'insider threat' prior to the incidents at PB Sorkh Bed and PB Nasir occurring.

HQJOC and ADF deployed agencies have taken initial measures across the areas of force design, ADF base security, individual force protection, heightened cultural awareness, counter-intelligence and identification of 'persons of interest' following the Sorkh Bed and Nasir incidents to reduce the likelihood of 'insider threat' incidents occurring in the future.

The leadership and initiative displayed by CFA qualified ADF personnel involved in the both incidents saved the lives and reduced the severity of injuries to themselves and other personnel. All possible treatment was given by both CFAs following the incident to prolong the life of LCPL Gavin prior to his death.

ADF personnel’s presence and involvement at the ramp ceremony, and the comprehensive management by parent Army units within Australia for surviving casualties and the families of both fatalities and wounded, contributed to maintaining morale and operational effectiveness for personnel remaining in Afghanistan, and the rehabilitation and welfare for casualties returned to Australia.

In the course of this inquiry, the recollections of witnesses have been captured in detailed interviews and collection and analysis of all relevant documentation has been conducted. A CDF Commission of Inquiry (COI) is unlikely to discover any further relevant material, information or evidence in the context of this incident. I have discovered no issues that would benefit from further consideration by a COI.