INQUIRY OFFICER INQUIRY
INTO THE FACTS AND CIRCUMSTANCES ASSOCIATED WITH AN INCIDENT
THAT RESULTED IN THE DEATH OF
LANCE CORPORAL ANDREW GORDON JONES
IN AFGHANISTAN
ON 30 MAY 2011

References:
A. CDF Instrument of Appointment and Terms of Reference dated 20 Jul 11
B. CDF Instrument of Addition and Terms of Reference dated 15 Nov 11
C. Appointment of MAJ [redacted] as Inquiry Assistant dated 29 Nov 11
D. Statements of Impartiality and Independence [redacted] Lieutenant Colonel [redacted], Wing Commander [redacted], and Major [redacted]
E. DI(G) ADMIN 45-2 – Administrative Reporting and Investigation of Alleged Offences within the Australian Defence Organisation dated 26 Mar 10
F. DI(G) PERS 20-6 – Death of Australian Defence Force Personnel dated 20 May 08
G. DI(G) PERS 11-2 – Notification of Australian Defence force and non-Australian Defence Force Casualties dated 20 May 08
I. ADFP 06.1.4 – Administrative Inquiries Manual
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INTRODUCTION

1. Reference A appointed me as an Inquiry Officer pursuant to Part V1 of the Defence (Inquiry) Regulations 1988 (Cth) for the purpose of inquiring into the facts and circumstances associated with an incident that resulted in the death of Lance Corporal (LCPL) Andrew Gordon Jones, as specified in the Terms of Reference (TOR) forming part of Reference A and Reference B.

Overview

2. LCPL Andrew Gordon Jones was born in Melbourne, Victoria on 22 Apr 86. He joined the Army on 6 Apr 04. After recruit training he completed initial employment training as a cook and was posted to Catering Platoon of the 1st Battalion, the Royal Australian Regiment. He was posted to 9th Force Support Battalion in 2008. LCPL Jones completed a number of military courses throughout his career, including catering/hospitality courses, soldier skills courses such as communications and various weapon systems and junior leader courses.

3. LCPL Jones' first operational deployment was to East Timor from 16 Jul 08 to 24 Oct 08. His second operational deployment was to Afghanistan from 28 Nov 10.

4. While on his first deployment to Afghanistan, LCPL Jones was employed as a cook in the Force Support Unit (FSU), and was attached to the Mentoring Task Force 2 (MTF 2) to provide valuable support to a joint Australian (AS) and Afghanistan National Army (ANA) outpost, referred to as Company Outpost (COP) MASHAL, in the Baluchi Valley, Uruzgan Province.

5. On 30 May 11 at approximately 0819, LCPL Jones was deliberately shot by a rogue ANA soldier, Shafied Ullah, while inside the confines and perceived security of COP MASHAL. While there were no witnesses to the shooting, the Inquiry is satisfied that after due consideration of all the available physical, circumstantial and eyewitness evidence, Shafied Ullah shot LCPL Jones for reasons that were not able to be gleaned.

6. Following the shooting, LCPL Jones' Australian colleagues provided immediate first aid to him while simultaneously calling for aero medical evacuation (AME) support. Through the efforts of LCPL Jones' colleagues, LCPL Jones was sustained long enough to be successfully handed over to the AME medical team and flown to the Multi National Base – Tarin Kowt Role 2 Medical Facility where surgeons operated on LCPL Jones' significant injuries. Despite the best efforts of the medical team, LCPL succumbed to his injuries and died. At 1239 on 30 May 2011, LCPL Jones tragically lost his life from wounds received while serving his country. He was returned home to Australia and laid to rest on 11 Jun 11.

7. I take the opportunity to thank all Defence members for the ready support, cooperation and assistance that was extended to the Inquiry Team. In particular I wish to acknowledge the assistance of the members of MTF 2 and the Australian Defence Force Investigation Service (ADFIS) during the course of this inquiry.
8. I submit my Inquiry Report as follows.

**TERMS OF REFERENCE (TOR)**

9. Building on the evidence obtained in reporting on the TOR at Ref A, this Inquiry is to provide CDF with a report detailing, with reasons, the findings of the Inquiry Officer as follows:

a. **TOR 1**: the circumstances surrounding the incident for the purpose of identifying whether any weaknesses or deficiencies (isolated or systemic) exist in Defence systems, policies, equipment practices, procedures and training.

b. **TOR 2**: any shortcomings in relevant Defence actions and decisions, both prior to and immediately subsequent to the incident.

c. **TOR 3**: whether the circumstances of LCPL Jones' death warrant the appointment of a COI.

**METHODOLOGY**

**Key Documents**

10. A list of all Annexes containing key documents relevant to this report is enclosed at Ref A.

**Appointment**

11. Reference A appointed [redacted] Lieutenant Colonel [redacted] as an Inquiry Officer pursuant to Part VI of the *Defence (Inquiry) Regulations 1988* (Cth) for the purpose of inquiring into the facts and circumstances associated with an incident that resulted in the death of [redacted] Lance Corporal (LCPL) Andrew Gordon Jones, as specified in the Terms of Reference (TOR) forming part of Ref A and Ref B.

12. Ref A and C appointed [redacted] Wing Commander [redacted] and [redacted] Major [redacted] as my Assistant Inquiry Officers. Wing Commander [redacted] Major [redacted] and I signed Statements of Impartiality and Independence prior to commencing the Inquiry and nothing arose during the Inquiry that directly or indirectly affected our impartiality and independence. Ref A-D, containing relevant Instruments of Appointment, TORs and Statements of Impartiality are enclosed at [redacted].

**Inquiry Chronology**

13. The inquiry officer maintained a running sheet which is attached at [redacted] as a chronology of the inquiry.
Timings

14. All timings in this report (unless otherwise identified) are local time Afghanistan, Time Zone DE which is GMT + 4 ½ hours and 5 ½ hours behind Australian Eastern Standard Time (AEST).

Overview of methodology

15. The methodology adopted in the conduct of this inquiry, and a summary of the legal procedural aspects of this inquiry, are enclosed at

16. This inquiry was conducted in two phases, with the first phase being directed to occur as a 'desktop analysis' of existing documentary evidence. The second phase was initiated as a result of recommendations made in the first phase, specifically, recommendations that a more detailed Inquiry (beyond the scope of a desktop analysis) was required in order to satisfy the questions raised in the TOR.

17. The phase one inquiry report contained known records and accounts at the time of writing, however, in the fullness of further investigation, the phase one report should now be considered incomplete, and as such is merely a supporting annex to this report. This phase two report draws on the phase one report where appropriate and should be considered the final report into this matter. Both phases of the inquiry were scoped and planned in detail by the Inquiry team.

18. The Inquiry team did not deploy to the MEAO. This was due to a combination of operational considerations, the rotation out of key witnesses, and in the later phase, due to the incident site no longer being a joint AS and ANA base. The Inquiry team assess that despite the lack of a first hand assessment of events on the ground, they were able to gather sufficient evidence from deployed sources to satisfy the TOR. The Inquiry had access to aerial imagery and site photographs that were adequate for the Inquiry team to gain an appropriate level of spatial awareness of the incident site.

Finding 1: The TOR's were able to be met through the methodology adopted by the Inquiry.

19. All significant documents such as operational orders, reports and statements were formally adopted during the process of this inquiry by having witnesses identify and adopt the documents, as well as indicating their role in developing or implementing such.

20. This report stands alone, and while all supporting documents and evidence have been included in attachments for completeness, there is no requirement for most readers to review these documents. There is extensive use of footnotes throughout this report to reference statements and substantiate findings and recommendations should the reader wish to do so. Some comments or details relating to classified matters have also been footnoted in order to allow the report to better flow, especially after the redaction process.
Witnesses

21. The witnesses were interviewed in a considered order and were supported through the use of maps, documents and images in order to develop a complete understanding of the circumstances surrounding LCPL Jones' death. In a few cases follow up interviews were also required.

22. All witnesses were advised of their rights and obligations prior to interview. No member was found to be adversely affected during the course of the inquiry, or by this report. The inquiry was of the view that all witnesses were reliable and was impressed by the level of maturity and professionalism displayed in their approach to the inquiry.

23. The Inquiry team observed that some witnesses continued to be emotionally affected by the incident and that conducting the inquiry interviews brought some of these emotions to the surface. Some witnesses indicated that they had received, or were continuing to receive, ongoing psychological support on return to Australia. The Inquiry team impressed on each witness that there is support mechanisms available to them should they wish to discuss or receive counselling as a result of their involvement in the Incident.

24. A list of witnesses and AS forces relevant to the Inquiry is enclosed at

Records of Interview

25. Records of Interview (ROI) for this Inquiry have been compiled into a single folder, enclosed at with relevant interview transcripts included as Appendices to this Annex.

Phase One Inquiry Report

26. The Phase One Inquiry Officer report is referred to throughout this report, and is enclosed at The annexes previously listed within the Phase One report have been relabelled as Appendices for ease of review.

THE INCIDENT

Defining the scope of 'the Incident'

27. The Inquiry has defined the scope of 'the Incident' to contain the events and actions that occurred that were relevant to LCPL Jones for the period on 30 May 11 until 1239 on 30 May 11. This period commences with the departure of the morning patrol from COP MASHAL as this activity is believed to have had a bearing on the events of 30 May 11 in relation to the actions of the accused and in regards to the medical response to LCPL Jones' injuries. The period ends with the death of LCPL Jones at the Role 2 Medical Facility at MNB-TK.

Location of the Shooting

28. Overview of COP MASHAL. The shooting of LCPL Jones occurred at COP MASHAL (also referred to as Patrol Base (PB) MASHAL), in the Baluchi Valley, Uruzgan
Province, Afghanistan

A map indicating the location of COP MASHAL is below.

29. COP MASHAL was a joint AS/ANA patrol base and the location of Mentoring Team

The COP has [redacted] plan with guard towers at [redacted].

An aerial image of COP MASHAL is below.
30. **Description of Tower 3.** Tower 3 is the specific location of the Incident. It is located in the [insert location] corner of COP MASHAL and has fields of view ranging from the [insert range]. Tower 3 is constructed of [insert material] and stands approximately [insert height] tall. The view from the tower towards the centre of the COP overlooks an outdoor latrine. The side of Tower 3 is visible from [insert distance] away, however the stairs leading up into the tower are only visible within 20-30m of the tower. An image of the rear of Tower 3 is below.
31. **Description of latrine.** The latrines in the vicinity of Tower 3 are constructed of pipes embedded into the ground and use the principle of ground seepage to remove waste. The latrine area is approximately ___ from Tower 3 and is screened by folded, un-filled, ___ held vertical by steel posts. The screens stand approximately 1.5m. The layout of COP MASHAL was such that the rear of Tower 3 and the nearby latrines were only visible from ground level and from about 20-30 meters away. The latrines were not visible from the other towers and as such the guards in those towers could not have witnessed the incident. An image of the latrines, photographed from Tower 3, is below.
The Incident narrative

32. On the morning of 30 May 11, the Team Leader of MTF [redacted] (i.e., the Patrol Base / COP Commander of COP MASHAL) was on duty in the COP MASHAL Command Post (CP). At [redacted], the COP Commander oversaw the departure of a joint AS/ANA patrol which left COP MASHAL to conduct a search of [redacted] in the vicinity of a nearby village. The patrol was led by the AS [redacted] and included the COP MASHAL medical assistant [redacted]. The number of AS personnel remaining in COP MASHAL was [redacted].

33. That morning, Tower 3 was manned by two ANA soldiers, an [redacted] and [redacted] Shafied Ullah [redacted] [redacted] Manning of the towers by ANA personnel is a normal practice within COPs as [redacted] part of their development and training as a viable security force.
34. At a time shortly before the incident (approx 0810-0819), the Soldier 1 departed the CP to go to the toilets that were located On leaving the toilets he saw the Soldier 2 who was one of the soldiers on duty in Tower 3 heading back towards Tower 3 thinking nothing of this headed back towards the CP.

35. At a time just prior to 0819, LCPL Jones is believed to have moved from his accommodation to the latrines in the vicinity of Tower 3 approximately 20-30m away. There were no witnesses who saw LCPL Jones walk to the latrines in the vicinity of Tower 3. These latrines were the closest and the most convenient to LCPL Jones’ accommodation.

36. At 0819 a burst of gunfire (approximately 3-5 shots) were heard from the vicinity of Tower 3. Based on the evidence gathered it was assessed by the Inquiry team that the shots were fired from an ANA M16. Based on the evidence gathered, including the location of expended ammunition casings and the location of LCPL Jones when found, it was assessed by the Inquiry team that the shots were fired from the top of the stairs at the rear of Tower 3.

37. The gunfire at 0819 was heard by multiple members within COP MASHAL, including the COP Commander who was in the CP, Soldier 1 who had nearly returned to the CP and four members of section who were located in the vicinity of section accommodation, Soldier 2, Soldier 3, Soldier 4, and Soldier 5. The gunfire was reported as an initial burst of 3-5 rounds of automatic fire coming from the direction of Tower 3. This was followed approximately 10-20 seconds later by approximately three to five similar sounding bursts of gunfire.

38. The other on duty at Tower 3 is believed to have been the first person to arrive at the tower following the initial burst of gunfire (noting he had been seen at the toilets between Tower 1 and Tower 3 only a few minutes before). It is believed that he saw Shafied Ullah jumping over the wall. The place where Shafied Ullah is believed to have jumped over the wall is approximately m above the ground.
39. It is believed that an ANA cook arrived at Tower 3 next and mounted the Tower.

40. The COP Commander, on hearing the bursts of fire, moved to Tower 3 to investigate. As he approached Tower 3 he noticed an ANA member in that tower firing un-aimed shots into the air in a manner that was consistent with warning shots. The COP Commander ordered him to stop. The COP Commander commented that the ANA often On mounting Tower 3, the COP Commander noticed an Afghan male running away from the COP in a direction from Tower 3. At this point, the Afghan male was approximately 600m from the COP. The person seen running from the COP was likely to have been the suspect, Shafied Ullah. The COP Commander then started moving towards Tower 3 to get a better understanding of what was happening.

41. The Soldier on hearing the first burst of gunfire paused briefly outside the CP, assessed the situation, and then started moving towards Tower 3. As he approached Tower 3 he saw an ANA member (believed to be the one on duty) at the top of the stairs of Tower 3 firing bursts from an M16 in a direction. It was difficult for the Soldier to ascertain the exact direction or elevation of the shooting, but it is likely that the shooting was outwards from the COP. The shooter was firing one-handed and it was assessed by the Soldier that the firing was not effective or aimed. The Soldier did not get closer than 20-30m from Tower 3.

42. Simultaneously, on hearing gunfire, Soldier 2 and another Sect member put on body armour and moved towards Tower 3 from their accommodation. An Afghan, met them, before they reached Tower 3 and the soldier told them to man the rear wall. Soldier 2 continued towards Tower 3.

43. Soldier 2 on reaching Tower 3, climbed up into Tower 3 where he was met by an ANA member who was pointing down towards the open-air urinals in the vicinity of Tower 3. It was then that Soldier 2’s attention was drawn towards LCPL Jones, laying wounded and bleeding near the urinals. LCPL Jones was wearing wounded and did not have a weapon. Soldier 2 immediately moved away from the tower to assist LCPL Jones. Soldier 2 observed that LCPL Jones had sustained multiple wounds and applied pressure to and simultaneously yelled for assistance. Soldier 2 could not recall which ANA member he had encountered in Tower 3.
44. Approximately 60 seconds later the COP Commander approached Tower 3 where he observed an ANA soldier (later confirmed as the ANA cook) physically assaulting an ANA soldier in the tower, later confirmed to be the ANA soldier who was on duty at Tower 3. As the COP Commander got closer to the scene he heard calling for help and on arrival he observed LCPL Jones with multiple wounds and leaning over him. The soldier was cradling LCPL Jones’ head.

45. The COP Commander and worked together to move LCPL Jones approx 10m away from the urinal area. The COP Commander then sprinted to the Regimental Aid Post to collect, and return with, a stretcher. The COP Commander was joined by (who was also a qualified Combat First Aider) who converged on the scene on hearing the calls for assistance. Together they moved LCPL Jones to the Casualty Collection Point (CCP) in the COP MASHAL next to the Regimental Aid Post, where they were joined by other Combat First Aid qualified members, namely and .

46. As the qualified Combat First Aiders continued to work on stabilising LCPL Jones, the COP Commander ran to the COP MASHAL CP where he immediately informed Headquarters of the situation. He contacted the who had departed in the morning patrol and ordered the immediate return of the COP medical assistant. The COP Commander then returned to the CCP to assist in the continuing treatment of LCPL Jones.

47. Concurrently, the constructed the 9-Liner casualty evacuation report and submitted it to HQ at 0826. The 9-Liner was relayed higher in the chain of command and subsequently received by CP at.

48. By , the Aero Medical Evacuation (AME) helicopter was assigned to the task.

49. At it was reported to that LCPL Jones had become .

50. At approx 0840 the first elements of the morning patrol had returned to COP MASHAL and the COP medical assistant inserted himself into the treatment of LCPL Jones (the indicates that was on site at )
51. At approxim the AME helicopter departed ('wheels up') from MNB-TK. At approximately the AME arrived at COP MASHAL, however, the COP Medic was in the middle of treatment so an ADFN and AFS Medic, who were aboard the AME, were dropped off to assist while the AME helicopter circled the COP. The AME helicopter touched down again at the COP at approximately and LCPL Jones was loaded on.

52. At approx the AME departed COP MASHAL. The AME arrived at the MNB-TK at approx 0906. On arrival at MNB-TK, a team took control of the casualty and continued CPR on LCPL Jones as they moved him from the resuscitation bay to the operating room. Treatment on LCPL Jones continued, with three surgeons working tirelessly to save him. LCPL Jones was in the Operating Room for three hours (0937 to 1239) and in addition to extensive surgery had received.

53. At 1239, after no improvement in his clinical situation, and discussion with the surgeons and the Senior Medical Officer of the CTU, the Regimental Medical Officer declared LCPL Jones dead. Mortuary affairs management then commenced.

Identifying who shot LCPL Jones

54. The Inquiry considered the available evidence in an effort to determine who shot LCPL Jones. The Inquiry noted the following circumstances in relation to the two ANA members on duty in Tower 3 on the morning of 30 May 11:

55. a. The ANAT was on duty with Shafied Ullah on the morning of the incident;

b. Prior to the shooting, the ANAT departed the tower so he could use the toilets located mid way between Towers and 3;

c. The ANAT was seen by Soldier in the vicinity of the toilets between Tower and 3 heading back to Tower 3;
d. Given the time of the ANA’s absence from Tower 3 and the time required for him to return to the Tower, it is unlikely that he was in a position to encounter LCPL Jones prior to the shooting at 0819;

e. The timing between the first burst of gunfire and the subsequent burst of gunfire, about 20 seconds later, is consistent with the time taken for the ANA to return to the Tower, assess the situation and engage Shafied Ullah;

f. The ANA was seen to be firing in a direction consistent with the egress route of Shafied Ullah;

g. On being questioned the ANA maintained that he was attempting to shoot at Shafied Ullah;

h. The ANA denied involvement in the shooting of LCPL Jones;

i. The ANA’s claim that he was attempting to shoot Shafied Ullah was supported by the physical evidence, namely the location of the expended cartridges and by the eyewitness evidence, namely the account of the firing over the wall at Tower 3;

j. There were no previous concerns regarding the actions of the ANA PTE in the COP and he was a long standing member at the COP; and

k. Given the unplanned timing of LCPL Jones’ use of the urinal it was not feasible for Shafied Ullah and the ANA to orchestrate or execute a joint plan to shoot LCPL Jones.

**Finding 2:** The other ANA on duty with Shafied Ullah was not present in Tower 3 at the time of the incident nor involved in the shooting of LCPL Jones.

56. Shafied Ullah:

a. Shafied Ullah’s weapon was located, abandoned at the scene;

b. Shafied Ullah’s weapon had discharged a number of rounds and that 20 expended 5.56mm cartridges recovered from the vicinity of the tower had been fired from that weapon;

c. The expended cartridges located at the scene were consistent with 3 to 4 rounds being fired from the top of the stairs towards the location of the urinal and 16 to 17 rounds being fired towards the most likely egress route taken by Shafied Ullah;

d. Shafied Ullah fled the scene immediately following the shooting;

e. Shafied Ullah was new to the COP having been there for 9 days;

f. Shafied Ullah had been in the ANA for 4 months;
g. Shafied Ullah had the opportunity to observe that LCPL Jones was not carrying his weapon or wearing PPE at the time he was shot;

h. Shafied Ullah was alone at the time of the shooting;

i. Shafied Ullah position provided protection from observation and return fire as well as providing an element of surprise;

j. Shafied Ullah would have been aware that a joint patrol was operating away from the COP and therefore a reduced opportunity for AS forces to respond;

k. Shafied Ullah was at a close distance to observe and provide effective fire towards the urinals;

l. Shafied Ullah made no effort to contact people in authority or come forward to clear his name;

57. Based on these facts, the Inquiry is satisfied on the available evidence that Shafied Ullah shot LCPL Jones.

**Finding 3: Shafied Ullah shot LCPL Jones.**

Date, Time, Locations and Firing Details

58. Based on the evidence reviewed by the Inquiry team, LCPL Jones was shot by Shafied Ullah. The following analysis of evidence, although repeating some information from earlier paragraphs, provides information of the broader circumstances and details pertaining to the shooting of LCPL Jones by Shafied Ullah.

59. Based on the examination of the scene by ADFIS and supported by their assessment made in the ADFIS Final Report at the events described in which Shafied Ullah fired on LCPL Jones from Tower 3 were consistent with that environment and the location of recovered ammunition casings and evidence. Furthermore the as witnessed by Investigators and the ADF Medical Officer during the Post Mortem is consistent with LCPL Jones being in position at the urinal at the time of the attack. The suggests that LCPL Jones was engaged with a single burst of three to four rounds of automatic fire having been fired on from a raised position, in this case, Tower 3.

60. In addition, the recovery of the cartridge cases at the scene is consistent with a single burst of three to four rounds being fired from inside Tower 3 in the direction of the urinal at which CPL Jones was standing. This is further supported by the round from the location in which LCPL Jones fell. The remainder of the cartridge cases collected by ADFIS are assessed as having fallen in a position consistent with the other having used the same weapon to fire from Tower 3, at, or over, Shafied Ullah as he fled COP MASHAL.
61. ADFIS can conclusively prove that the M16 rifle seized by ADFIS, fired the 20 x 5.56mm rounds recovered from the scene, within the vicinity of Tower 3 and that weapon, from verbal testimony provided by ANA, was issued to Shafied Ullah. Furthermore, it has been proven that the fragmentation were consistent with rounds fired from a rifle of the type used by Shafied Ullah.

63. The ADFIS findings and evidence detailed above is consistent with subsequent interviews and assessments made by the Inquiry.

Finding 4: That LCPL Jones was shot and subsequently died from injuries received whilst in the vicinity of the urinals at the base of Tower 3 at 0819 on 30 May 2011.

Finding 5: That the rounds that struck and killed LCPL Jones were discharged from the direction and elevation consistent with being fired from the top of the stairs at Tower 3.

Finding 6: That the weapon used to kill LCPL Jones was an M16.

Finding 7: The M16 assigned to Shafied Ullah was the same weapon that had been used to fire 20 rounds from Tower 3 and in a manner that is consistent with one burst of rounds inwards towards the urinals and subsequent bursts fired over the wall outwards from the COP.

Finding 8: That Shafied Ullah was standing at the top of the stairs of Tower 3 when he shot LCPL Jones.

Finding 9: Shafied Ullah fled the scene after firing one 3-4 round burst at LCPL Jones.

KEY CIRCUMSTANCES SURROUNDING THE INCIDENT

Defining the scope of ‘circumstances surrounding the Incident’

64. The Inquiry reviewed all the relevant events and actions that surrounded the Incident with a view to identifying whether any weaknesses or deficiencies (isolated or systemic) exist in Defence systems, policies, equipment practices, procedures and training. As a result, the scope of the ‘circumstances surrounding the Incident’ encompass a range of issues and discussion that includes briefs on force protection developed in Jul 10 through to recent investigative actions (including the ADFIS Final Report at and evidence collection relevant to the Incident.
Other Australian Forces Involved

65. Details of the Force Element and key members involved in the incident are listed at Annex E.

Timeline

66. The timeline for the incident has been drawn from the witness statements and operational logs. Key timings are contained in the narrative above, and in detailed timings at

Medical response and actions

67. Medical Treatment. LCPL Jones’ medical treatment occurred as follows:

a. Treatment in the field. Immediate first aid was provided to LCPL Jones by Soldier2. Soldier4 stated he provided immediate pressure to the wound in LCPL Jones’ leg. The next AS member to arrive and assist with first aid was the COP Commander. Together they continued to provide pressure to wounds and, with the assistance of Soldier5, moved LCPL Jones to the CCP. At the CCP LCPL Jones continued to be treated by three qualified combat first aid members, namely Soldier6, Soldier7, and Soldier8. On his return from the morning patrol at 0840 the COP medical assistant inserted himself into the treatment of LCPL Jones, and the combat first aid members continued treating LCPL Jones’ wounds and at were joined by the medic that were dropped off by the AME helicopter.

b. Treatment en route to MNB-TK. LCPL Jones departed COP MASHAL on the AME helicopter at and continued to be treated by the AME medics until his arrival at MNB-TK Role 2 Medical Facility at 0906.

c. Treatment at MNB-TK Role 2 Medical Facility. On arrival at MNB-TK, a team took control of the casualty and continued CPR on LCPL Jones as they moved him from the resuscitation bay to the operating room. Treatment on LCPL Jones continued, with three surgeons working tirelessly to save him. LCPL Jones was in the Operating Room for three hours (0937 to 1239) and, in addition to the surgery, Details of the treatment are contained in

68. An assessment by the RMO stated that the treatment of LCPL Jones in the field, en route and on arrival in the resuscitation bay at MNB-TK was ‘appropriate’. The RMO further stated that ‘at every step the treatment and training was appropriate’.
69. Pending the release of the Coronial Report the Inquiry did not discover any weaknesses, deficiencies or shortcomings in the manner in which LCPL Jones wounds were treated or in the manner in which he was evacuated.

**Finding 10:** That the treatment of LCPL Jones by the first responders contributed to his successful repatriation to the Role Two medical facility at Tarin Kowt.

70. Until the release of the Coroners report it is not possible to make a finding on the Cause of Death of LCPL Jones.

71. **Aero Medical Evacuation (AME).** The Aero Medical Evacuation (AME) helicopter was assigned to the task by just minutes after received the 9-liner report. At the AME helicopter departed (‘wheels up’) from MNB-TK. At approximately the AME arrived at COP MASHAL, however, the COP medical assistant was in the middle of treatment so an Air and Combat Medic, who were aboard the AME, were dropped off to assist while the AME helicopter circled the COP. The AME helicopter touched down again at the COP at approx and LCPL Jones was loaded on. At approx the AME departed COP MASHAL and arrived at MNB-TK at 0906.

72. The inquiry did not identify any concerns with the AME support provided to LCPL Jones, nor with the siting of the AME landing zone.

73. **Access to Medical Support.** Medical support within COP MASHAL is provided through a combination of members. First aid equipment is contained in the Regimental Aid Post (RAP) and in the Casualty Collection Point (CCP) located at the. These facilities are central and, are all within easy access to the members. In the absence of the , the RAP is locked, but the keys are held in the. All CFAs know the location of the RAP keys and can access the RAP whenever they require additional medical supplies or equipment.

74. During the interview with the he highlighted that he also had easy communications with the more experienced medics in the higher HQ at and could call on medical support if required. Of note, he revealed that he had participated in approximately patrols (out of approx patrols) during his time at COP MASHAL. This impressed on the Inquiry team the level of commitment and professionalism that had displayed throughout his tour. He also indicated that following the evacuation of LCPL Jones he then set about reassuring the combat first aid qualified members, replenishing stores and cleaning the CCP. The Inquiry team was left with
a positive impression of the [soldierABC] and his high level of maturity and dedication. Other members interviewed by the Inquiry team all spoke very highly of the [soldierABC] (also referred to as ‘doc’).

75. The combat first aid members who were interviewed indicated that they had each dealt with casualties and trauma throughout their tour, and had developed some level of experience in first aid. They had indicated that they had on occasions treated wounds on AS, ANA and local Afghans.

**Finding 11:** The inquiry did not discover any weaknesses, deficiencies or shortcomings in the manner in which the AS forces responded to the incident.

**Post Incident Procedures**

76. **Casualty Notification.** Notification of casualty and all other administrative reports and returns including Fatal Casualty Signal (FATALCAS), AD 604 - Confirmation of Death, and AC 563 - Defence OHS Incident Report were submitted in accordance with current guidelines in a timely and efficient manner. LCPL Jones’ NOK was notified [Details redacted].

DCO Melbourne provided a Bereavement Support Team to assist the family.

77. [Details redacted] was enforced by JTF633 in accordance with JTF633 Standing Instructions.

78. **Mortuary and repatriation procedures.** The small ADFIS detachment in the MEAO is responsible for identifying, taking custody of, and escorting the remains of ADF personnel back to Australia.

79. Positive identification was made by QC Force Support Team at 1327 on 30 May 11 at the MNB-TK Role 2 Medical Facility. The ADFIS Team was present during the identification of LCPL Jones’ remains which were then secured in the mortuary.

80. Memorial services and ramp ceremonies to farewell LCPL Jones were conducted in Tarin Kowt on 5 Jun 11. The ceremony in Tarin Kowt was well received by all Coalition Force participants, and included a piper that greatly added to the ceremony. Witnesses reported that the ceremony, as well as the opportunity to stand vigil outside the morgue prior to the ceremony, allowed them time to reflect upon their fallen comrade. LCPL Jones’
remains were repatriated by C17 aircraft which departed Al Minhad Air Base (AMAB), Dubai UAE, at 5 Jun 11 on route to Tullamarine Airport, Melbourne, VIC.

81. LCPL Jones was treated with respect and dignity during his repatriation.

82. **Post-Incident personnel support.** The MTF 2 psychologist and the Padre were both dispatched in order to provide personnel support to the members COP MASHAL. They arrived at COP MASHAL at 30 May 11. Key witnesses have indicated that the post-incident support provided by the psychologist and padre was invaluable.

83. Ongoing psychological and spiritual support has been provided to the members of COP MASHAL who have been affected by the death of LCPL Jones. Interviews conducted in early Dec 11 with key members of COP MASHAL highlighted that some members are still deeply affected by LCPL Jones' death. Recounting the specific details of the incident caused varying degrees of distress to each witness. During each interview witnesses were reminded that there are avenues to discuss and cope with the distress of the incident and ongoing support was offered. Following the interviews further assurances were given to the affected members that Defence has mechanisms and support staff that can assist the members with coping with the trauma of this incident.

84. For the record, the inquiry noted that some ADFIS personnel in theatre had officiated in multiple repatriations. The inquiry wishes to emphasise that the impacts on these personnel of carrying out their duties should be recognised and monitored over time.

**AS Investigative actions**

85. **Incident Site management.** The statement by the COP Commander indicated that he tasked the soldier to establish a crime scene around Tower 3 and the latrine area shortly after LCPL Jones was evacuated. An examination of COP Commander's statement and the suggests it occurred between when the AME departed and prior to 0920 when the ANA commander returned to COP MASHAL. The entry recorded at 0920 stated that the Incident site had been taped off. A statement made by ADFIS on 14 Sep 11 indicated that when ADFIS arrived at the scene at that the site was cordoned off and that soldiers were manning an alternate gun position of Tower 3 in order to preserve the scene.

86. **ADFIS.** The ADFIS detachment based in undertook an ADFIS Investigation into LCPL Jones’ death in accordance with Reference E. The unique nature of
the ‘green on blue’ incident at the time meant that there was some complexity in ADFIS’s dealings with the ANA as there were some perceived jurisdiction issues however these issues were clarified and did not impact on ADFIS gathering forensic evidence.

87. The Inquiry noted that at the time of the Incident ADFIS were already heavily committed to mortuary and repatriation duties for other operational deaths, specifically. This, combined with operational constraints, meant that ADFIS had limited time at the incident site before being recalled to. However, in the time available ADFIS deployed investigators to the scene, together with the ADFIS member from. The ADFIS elements conducted the following immediate actions at COP MASHAL;

a. Scene Examination. A scene examination was conducted and physical evidence collected; including spent ammunition cases, projectiles and swabs from apparent blood staining. The scene was recorded using digital photography and measured for subsequent mapping and plans. A photographic supplement, together with a sketch plan of the scene is included in the ADFIS Final Report;

b. Search. The room occupied by Shafied Ullah was examined and physical evidence collected;

c. Seizure. Investigators recovered all items of evidential value at COP MASHAL; and

d. Interviews. Limited interviews were able to be conducted at the scene as investigators were unable to remain in location for an extended period due to operational requirements, including completing the pre-coronal and repatriation responsibilities associated with the death of LCPL Jones and

88. The Inquiry is aware that the collection, transportation and subsequent securing of evidence in theatre meant that there was some delay in processing the evidence. Other factors such as the death of Shafied Ullah on 19 Jun 11, the deaths and subsequent mortuary and repatriation actions and rotation out of personnel in 11 all slowed the processing of evidence and the finalisation of the ADFIS case. The ADFIS report was not finalised in time to be included in the Phase One Inquiry Officers report.

89. Following the initiation of the second phase of this Inquiry the Inquiry team was able to re-establish communications with the new ADFIS staff at ADFIS MEAO, and was able to develop a very effective and collegiate approach to gathering the remaining evidence and finalising the respective reports. The Inquiry team is of the opinion that the current ADFIS staff in the MEAO has displayed a high degree of professionalism, perseverance and tenacity
in reinvigorating the case and in gathering the final pieces of forensic and ballistic evidence. Their support to this Inquiry has been particularly noteworthy as they have been able to acquire additional documentary evidence that was not found by HQ JOC during the earlier phase of the Inquiry.

90. The Inquiry is of the opinion that early attendance at the incident scene by ADFIS is invaluable, however they require a sustained period at the site and ready access to witnesses in order to adequately capture evidence before it is lost. This sustained effort by ADFIS should be reinforced through ready access to interpreters, and a clear mandate supported by the Chain of Command, in order to assist in their investigation. This Inquiry is of the opinion that there is considerable risk to the completeness and timeliness of both ADFIS investigations and Inquiries Officer Inquiries if there are constraints placed on ADFIS when capturing the initial evidence. The Inquiry is of the opinion that the relevance and role of both ADFIS and Inquiry teams, working in a collegiate manner, is worthy of reinforcing during IG ADF Inquiry Officer courses and during pre-deployment briefings.

91. A careful review of the file, and related ADFIS interviews, did not disclose any issues for further inquiry.

92. **Coroner.** The Victorian State Coroner conducted a full autopsy on LCPL Jones' human remains (HR) on 7 Jun 11. At the time of the submission of this report the Coroners report was not yet available.

93. The Coroners autopsy was observed by an ADF Medical Officer who provided a report on her observations. This inquiry drew upon this report to make reasonable assumptions upon what the Coroner may conclude.

**ANA Response to the Incident**

94. **Immediate ANA reaction.** The statement by the COP Commander indicated that immediately following the incident the ANA at COP MASHAL showed obvious distress that an ANA member could shoot an AS soldier. The ANA willingly participated in a joint AS/ANA patrol to pursue Shafied Ullah and worked closely with the AS forces for a protracted patrol period (m.). This activity went some way to rebuild the perished relationship and trust between the AS and ANA forces. The ANA Commander of 4 Bde, indicated at the time that the ANA would take all measures to support the capture of the Shafied Ullah. By all account, this pledge was supported at every level.

**Finding 13:** The ANA response to the shooting of LCPL Jones was immediate and significant and was of a calibre that indicated the capture of Shafied Ullah was the highest priority.

**Finding 14:** The decision to conduct joint patrols immediately following the death of LCPL Jones contributed to the restoration of a workable level of trust between AS and ANA soldiers at COP MASHAL.
95. **ANA Support to the Investigation.** The statement by the COP Commander indicated that the ANA commander at COP MASHAL asked to conduct joint questioning of the ANA on duty at Tower 3 at the time. The ANA at COP MASHAL supported the ADFIS investigation, however, according to the ADFIS investigator, there were issues with the manner in which questioning was conducted. Specifically, questioning was done through an interpreter to a witness.

There was no indication whether this approach to questioning was as a result of a desire to intentionally influence the answers or merely a cultural difference in the manner in which investigations are conducted.

96. The ANA Inspector General team visited COP MASHAL on accompanied by an ADFIS investigator, the and the . The visit lasted for six hours and both the IG Team and the Senior ADFIS investigator interviewed all of the key personnel. The sat in on each of the interviews conducted with ADF personnel. The reported that the details of the shooting were scrutinised in some detail, as were the relations between the ANA and AS in the COP as a whole.

97. unlikely after the findings in this Inquiry.
OTHER CIRCUMSTANCES AND FACTORS

Mentoring Mission

98. The purpose of the mentoring mission is to develop the 4th Bde/205 Corps (4/205 Bde) of the ANA and other Uruzgan Province based elements of the Afghan National Security Forces (ANSF) to assume security responsibility in Uruzgan Province. Specifically, the mission is focussed on mentoring the 4th Bde to assume responsibility as the lead security apparatus for the Government of the Islamic Republic of Afghanistan (GIROA) within Uruzgan Province. This includes developing ANA 4/205 Bde so that its Tolays (companies) are capable of independent framework activities that are executed with sufficient frequency and sophistication to continue to neutralise the insurgency. The MTF seeks to progress the capacity of the 4th Bde to conceive, plan, lead, execute and sustain security operations/activities on behalf of GIROA in Uruzgan Province.

Combat Outpost (COP) Routine and AS/ANA Relationships

99. In order to achieve the mentoring mission detailed above, AS mentors live and work alongside their partnered ANA units in order to foster mutual rapport, trust, confidence and loyalty. These traits are essential components of AS mentoring and are direct contributors to the ongoing development of ANA operational capability. Within patrol bases the AS and ANA force elements live in close proximity, work together in Command Posts, train together and patrol together outside the wire (OTW). However, they do not live in the same facilities under a common roof. Most patrol bases have separate areas for AS and ANA. This was the case in COP MASHAL.

100. At COP MASHAL, the routine between AS and ANA included daily meetings between the COP Commander and the ANA commander. These meetings were often conducted over a cup of tea/chai and both commanders used these opportunities to discuss the progress of the relationship between AS and ANA and to raise any issues of concern. Similar parallel mentoring relationships existed in the COP, for example between the AND and the ANA. The COP Commander indicated that he had a very close and open working relationship with the ANA Commander and that he was confident that any issues of concern would have been raised with him.

Finding 15: That there was a strong and workable relationship between the AS and ANA forces in the COP.

101. The CO MTF2 highlighted that it was ‘accepted wisdom’ that the best way to train other armies was to work closely with them and if necessary be exposed to many of the same
risks, such as those experienced on joint patrols. This was necessary to gain the trust of the people that are being trained.

102. Within COP MASHAL opportunities to improve AS/ANA relationships were encouraged, and this included sporting activities such as cricket.

LCPL Jones’ routine and ANA relationship

103. LCPL Jones’ routine. As a cook, LCPL Jones followed a different daily routine to other members of the COP. LCPL Jones would often work at unusual hours in order to prepare meals for incoming or outgoing patrols. This also meant that his normal reveille time was subject to variations, based on whether he had worked the previous night, or when patrols were due to return. On 30 May 11, LCPL Jones was rising late due to previous shifts and was rising at a time that enabled him to provide a late breakfast for the patrol when it was due to return. His dress (PT attire) at the time of the incident was consistent with him only just rising for the day before preparing for his daily duties.

104. LCPL Jones’ relationship with ANA. Statements by key witnesses attest to the positive attitude and demeanour of LCPL Jones. He was described as ‘a fair dinkum bloke, always out to have a laugh’ and was well liked by his AS colleagues and thought of fondly by those who worked closest with him. LCPL Jones’ routine and responsibilities also meant that he had less contact with the ANA than other MTF members as he was not required to provide a mentoring role. Statement by key witnesses indicated that LCPL Jones had regular contact with the ANA cook in order to exchange ingredients and recipes, but was unlikely to have ever had significant contact with other ANA, especially Shafied Ullah who had only recently arrived in COP MASHAL.

Finding 16: LCPL Jones was not antagonistic to ANA members at COP MASHAL.

Finding 17: On the available evidence there is no indication that LCPL Jones was known by Shafied Ullah or specifically targeted by Shafied Ullah.

Force Protections within COP MASHAL

105. Extant Orders. Standing Orders and Standing Instructions relevant to force protection within COP MASHAL were implemented and in place. These instructions include actions for responding to incidents such as but do not specifically address a ‘green on blue’ scenario. Copies of these
instructions were requested from JTF633, however they were contained on blank at the time this report was written. However, the Inquiry is satisfied with the description of these orders by the COP Commander and the indication by other COP members interviewed that they were aware of and complied with these orders. Based on statements by the COP Commander, the personal equipment, location and activities of LCPL Jones at the time of the incident were consistent with the relevant COP Standing Orders and Instructions. The reaction of key members within the COP on hearing the gunfire, and their subsequent actions were also consistent with the relevant COP Standing Orders and Instructions. Interviews with key witnesses indicated that they were all aware of the various COP orders and their understanding of their force protection requirements was commonly understood.

106. There is no evidence to suggest that COP orders or instructions were deficient or contributed to the incident.

107. and describe the key aspects of force protection applied to COP MASHAL applicable in mid 2010. It was briefed that force protection measures included the need for night should be maintained by and in some locations, documents that detailed ‘green on blue’ force protection measures that may have been applicable at the time of the incident.

108. Statement by the COP Commander confirm that many of the force protection measures listed in mid 2010 were applied within COP MASHAL, although it noted by the Inquiry team that, over time, had been tailored to the threat, to mean within the COP. The COP Commander indicated that force protection was regularly reviewed, with ISAF initiating (in the form of checklists) on at least three occasions during the COP Commander’s tour.

109. CO MTF2 further indicated that security and that this should be translated to include COPs. CO MTF2 had indicated that he had regularly visited COP
MASHAL, considered it to be a well run and established COP, and had not indicated any concerns regarding the adopted level of force protection.

**Personal Protective Equipment (PPE)**

110. The dress and weapons carriage guidance within COP MASHAL was

111. LCPL Jones was not wearing body armour at the time of the incident. LCPL Jones and that he was conforming to the intent of the weapon carriage requirements at the time of the incident.

112. While the Coroner is yet to make a formal finding on the cause of death, the Inquiry was able to examine

None of body armour would have covered the areas in which the rounds struck LCPL Jones.

Finding 18: At the time LCPL Jones was shot he was not carrying his personal weapon or wearing his PPE.

Finding 19: Pending the formal findings from the Coroner, the injuries received by LCPL Jones appear to be outside the range of body armour.

**General threat from ANA soldiers and mitigation of threat**

113. Statements by the COP Commander and the CO MTF2 highlight that there is a constant, but manageable tension between AS and ANA forces, especially within mentoring locations. Tensions existed due to cultural differences and due to different levels of professionalism. These tensions were mitigated through the close working relationship of the AS and ANA COP Commanders, the lead-by-example nature of joint patrols and through conducting social/sporting activities.
areas were segregated in order to cater for AS and ANA cultural differences.

114. At the time of the incident there had not yet been ‘green on blue’ threats or incidents involving AS forces and therefore there were no specific ‘green on blue’ force protection measures beyond the extant arrangements. The extant protection measures, combined with the close working relationship between AS and ANA COP Commanders, would have been considered an appropriate threat mitigation for a potential threat had one been detected.

115. The Inquiry noted that LCPL Jones was not carrying his weapon at the time he was shot. On the evidence it would appear that Shafied Ullah may have considered the timing and the target of his act before making a decision to engage LCPL Jones. Relevantly, Shafied Ullah waited until his ANA colleague was absent from Tower 3 before targeting LCPL Jones. He chose to target LCPL Jones at close distance and with the advantage of surprise. Shafied Ullah fired from an elevated position which provided protection from return fire. Shafied Ullah would have noticed that LCPL Jones was unarmed and not wearing any form of PPE. It is highly likely that Shafied Ullah would have been aware that故On balance it is highly likely that Shafied Ullah carefully chose the timing of his attack so as to maximise his prospects of escaping unscathed.

116. The Inquiry considered whether in these circumstances the wearing of PPE and the carriage of individual weapons would have provided a deterrent to opportunistic attack which was presented to Shafied Ullah on the morning of 30 May 2011. In the Inquiry's view it would have. However, the Inquiry is also of the view that the decision at the time of the attack is one that is sound and backed by a sensible appreciation of the risk.

117. The importance of developing trust and confidence between the AS and ANA forces is central to the overall success of the mentoring role for the 4th Brigade. As noted above, the approach to mentoring is to live and work along side partnered ANA units in order to foster mutual rapport, trust, confidence and loyalty. The Inquiry accepts that the decision to adopt the force protection measures that were in place on 30 May 2011 took into account the extant threat and the need for positive and constructive relationships. The cumulative effects of the measures to build trust and confidence between the AS and ANA forces were such that it positively contributed to the force protection of the COP as a whole. On balance the Inquiry is of the view that the force protection measures were right.

118. Due to the close and integrated nature of the COP daily routine there is always the possibility for a ‘green on blue’ attack to occur. It is fundamental to the mentoring process that the ANA assume the lead role for security of the COP and in doing so they will be armed. While the carrying of weapons and wearing of PPE may mitigate against short term risks to AS forces from rogue ANA, it will not engender the trust and subsequent force protection that trust brings with it, to manage the longer term risks and ultimately mission success.

Finding 20: That the force protection measures employed at the COP at the time of LCPL Jones' death were consistent with the known threat.
Specific threat from key individuals in COP MASHAL

119. Statements by key members present at COP MASHAL indicate that there were no prior indicators in the months leading to the incident. Relationships between AS and ANA troops were sound, with the exception of one ANA who was removed from COP MASHAL at the ANA's request, the day prior to the incident. Specific details on Shafied Ullah and the ANA removed the day prior are below:

a. Shafied Ullah. Shafied Ullah was posted to COP MASHAL on the 21 May 11. Shafied Ullah was on duty at Tower 3 on the morning of the Incident. According to ANA reports Shafied Ullah was relatively new to the ANA and was a 'newly trained soldier' who had 'served in the 4th Brigade as an ANA soldier for 9 days'. ANA reports compiled after the Incident, detail that Shafied Ullah 'has a history of some sort of one of his brothers and also, reports show that another brother was shot and killed inside the village by coalition forces'. As a result of the allegations made by the and cook who were first at the incident scene, Shafied Ullah was named as the primary suspect in the death of LCPL Jones and therefore his belongings were examined and a diary was recovered. A translation of the diary is as follows: The diary contained some statements that could be considered patriotic but nothing that provides any clear indication that Shafied Ullah had links with the Taliban or intended harm on Coalition forces. Combined ANA and Coalition operations were undertaken following the Incident to capture Shafied Ullah. Throughout these operations no clear evidence emerged that linked Shafied Ullah with insurgents prior to the Incident. Shafied Ullah was subsequently located at km from COP MASHAL. While attempting to capture Shafied Ullah he was shot and killed by a combined Afghan Special Forces team in Province Afghanistan on 19 Jun. Fingerprint evidence from Shafied Ullah’s possessions left at COP MASHAL, and photographs, were subsequently used as a cross-reference to biometrically confirm that Shafied Ullah had been the Afghan male killed by the Afghan Special Forces team. A Defence Media Release on the matter was promulgated on 20 Jun.
**Finding 21:** There were no prior indicators or warnings that identified Shafied Ullah as a specific threat.

**Finding 22:** There was no evidence recovered from Shafied Ullah's belongings that indicate that he had prior links to insurgents or had made any preparations to commit a violent act against AS forces.

**Finding 23:** Shafied Ullah was killed in a coalition operation on 19 June 2011.

b. ANA[4] In [4][4] and referred to as [4] in some witness statements), was posted to COP MASHAL. Approximately [4][4] later [4], was posted away from COP MASHAL due to an allegation that he was [4]. On May 11, [4] was again posted to COP MASHAL (same day as Shafied Ullah). [4] was considered to be a poor mentor subject as he failed to follow orders, was considered unsafe on patrols and was a disrupting influence on other more junior ANA members. On 26 May 11, it is alleged that [4] was [4].

The COP Commander indicated in his statement that he supported the removal of [4] due to the fact he was unsafe on patrol and disruptive to the mentoring effort and not because he believed [4]. [4] was subsequently questioned regarding the Incident however he maintained that he had not instigated or been involved in Shafied Ullah's actions.

120. The inquiry found that there was no evidence directly linking the removal of [4] and the actions of Shafied Ullah the following day.
**Finding 24:** There was no prior intelligence or indication within COP MASHAL to warn of the possible attack against an Australian soldier on 30 May 2011.

**Finding 25:** That had the ANA commander been aware of a risk to coalition operations or personnel that this would have been communicated to the COP MASHAL Commander.

**Motives**

121. The Inquiry reviewed all available evidence to determine a motive for the shooting of LCPL Jones. A review of Shafied Ullah’s belongings and personal diary did not reveal any evidence that Shafied Ullah had links to insurgents or was considered hostile towards AS forces. A review of the circumstances surrounding the removal of the ANA from the COP the day before the Incident and the subsequent analysis of the ANA’s belongings did not reveal any indications that the ANA orchestrated or influenced the shooting of LCPL Jones. A review of the ANA Investigation, indicating that Shafied Ullah ‘has a history of some sort of one of his brothers’ and also reports show that another brother was shot and killed inside the village by coalition forces may suggest motives of ‘insanity’ or revenge, however in the Inquiry’s opinion, a lack of similar indicators in Shafied Ullah’s diary and a lack of reported abnormal behaviour by Shafied Ullah within COP MASHAL did not support this assessment. A review of some areas of potential cultural sensitivity regarding the use of the urinals in the vicinity of Tower 3 did not reveal that the issue was of particular concern to the current ANA commander to warrant mentioning, and there is no evidence to determine if Shafied Ullah was offended by the use or proximity of these urinals. A review of LCPL Jones demeanour and known interaction with the ANA did not reveal any personal contact or conflict between LCPL Jones or Shafied Ullah. The Inquiry considered all the evidence and circumstances and was not able to determine the motive behind the shooting of LCPL Jones.

**Finding 26:** That the motive for Shafied Ullah shooting LCPL Jones is unable to be determined.

**Other Factors**

122. **Rules of Engagement.** The Inquiry reviewed the evidence and determined that at no point did AS soldiers attempt to engage Shafied Ullah at the time of the incident or immediately following his escape. The only AS member to see Shafied Ullah fleeing was the COP Commander and at the time he was not aware of who or why the Afghan male was running away from the direction of the COP. There was no evidence to suggest that there were any issues regarding rules of engagement in the subsequent operations to apprehend Shafied Ullah. On review of the available evidence, the Inquiry did not discover any weaknesses, deficiencies or shortcomings in the manner in which the ROE was applied in the incident.
123. **Communications.** The Inquiry reviewed the operations logs and messages from the time of the incident and discussed the effectiveness of communications with key witnesses, including the MTF2 21C. The Inquiry are aware that there was some initial confusion about the nature of the incident, however, regular contact between COP MASHAL and higher HQs was maintained appropriately throughout and following the incident. There was no evidence to suggest that communications equipment failed to perform as designed. The Inquiry did not discover any weaknesses, deficiencies or shortcomings in the manner in which the incident was communicated.

124. **Operational Conditions.** The Inquiry did not discover any operational conditions that contributed to the incident. The Inquiry is aware that on the same day there was another AS fatality and that due to this incident the ADFIS team were tasked with mortuary affairs activities for multiple people. This may have also been a factor in the delay in getting a critical incident management team ( ) to COP MASHAL, however, this team was still able to get to COP MASHAL by on 30 May 11.
129. **Environmental Conditions.** The Inquiry reviewed the nature of the incident and there is no evidence to suggest that visibility was a factor. The incident happened in daylight (0819) and visibility was such that the COP Commander could clearly see Tower 3 from Tower a and a fleeing Afghan male approximately 600m away. It is the Inquiry’s opinion that from the vantage point and close proximity of Tower 3 there would have been no environmental impediments that would have prevented Shafied Ullah from seeing and positively identifying LCPL Jones as an AS soldier. There was no indication that environmental factors impacted on the timely arrival and transit of the AME helicopter. There were no environmental factors that the Inquiry considered relevant to the incident or the subsequent treatment and evacuation of LCPL Jones.

130. **Members Training, Qualifications and preparation for Operations.** Based on completed pre-deployment training over the period As part of the force element (FE), LCPL Jones was certified to conduct operations
Members of the FE required to provide integral support to the MTF, such as are required to complete further advanced tactical training. These training requirements focus on employment and practice of the SOPs.

131. The [ ] training package drew on the expertise from members of [ ] as well as input from the [ ] to ensure relevance and currency of the force protection requirements. The development of training packages for force protection is guided by the adherence to the current in-theatre SOPs that counter threats to the specific FE. These training packages are informed by drawing on expertise from previous rotations. [ ] also routinely review post operational reporting to further inform the mission specific training requirements for all FE.

132. It should be noted that AS had not yet experienced a ‘green on blue’ incident prior to the death of LCPL Jones. It is therefore reasonable to expect that mission specific force preparation training for [ ] did not contain specific ‘green on blue’ aspects, but did contain the relevant force protection measures necessary to be deemed competent to work within a patrol base.

133. The Inquiry did not find any weakness or shortcomings in the force preparation of [ ] or LCPL Jones that are relevant to this incident.

Finding 28: LCPL Jones was appropriately trained and qualified to undertake work outside the wire at COP MASHAL.

134. Fatigue and Rest. The Inquiry reviewed the evidence and there is no indication that the fatigue or rest was a contributing factor to Shafied Ullah’s actions. Similarly, a review of the response to the incident by members of COP MASHAL and by the MTF2 did not indicate that fatigue impacted on their timely and appropriate actions. The Inquiry did not discover any factors relating to fatigue or lack of rest that contributed to this incident or affected the ADF response to the incident.

135. Drugs and Alcohol. Pending the release of the toxicology results in a Coronial report, there is no evidence to indicate that LCPL Jones was under the influence of drugs and alcohol at the time of his death. While it was expressed that ANA soldiers [ ] there was no direct evidence to determine if Shafied Ullah was under the influence of drugs or alcohol at the time of the shooting.

Finding 29: Pending the release of toxicology results, it is unlikely that alcohol or drugs were a factor in the death of LCPL Jones.

136. Command and Control. An interview with [ ] highlighted that there was a brief moment when the incident was first notified when HQ MTF2 could not locate LCPL Jones’ details. This was due to LCPL Jones being part of [ ]
and embedded in MTF2 and therefore having his details recorded on a different list. indicated that this initial administrative confusion was only short and did not impact on the timely processing of incident.

137. also indicated that due to LCPL Jones being a member, there was a desire by the to take on a lead role in the repatriation of LCPL Jones. This resulted in the MTF2, who were experienced and practiced in repatriation, handing over the responsibility to a less experienced unit. indicated that although this resulted in a number of requests for information relating to repatriation coming to the MTF2 that required redirecting to the this did not impact on the overall repatriation process.

138. There were no factors relating to command and control that contributed to or hampered the incident.

SPECIFIC TOR FINDINGS

139. The inquiry is satisfied that there are no circumstances or other matters, not disclosed to it, affecting its TOR. Defence and LCPL Jones’ family may have confidence in my report.

140. The inquiry was at all times provided with the available evidence in a timely manner (considering the other operational priorities at the time and the methodology adopted by the Inquiry) and at no time was there reason to believe that available evidence was being withheld, or that witnesses were colluding.

141. The inquiry believes that this report, and its annexes, is a comprehensive summary of all the pertinent evidence relating to LCPL Jones' death. While the death of LCPL Jones was extremely unfortunate the inquiry does not find it to be anything other than a tragic death in unforeseeable circumstances. Based upon the experience of the inquiry officer, the inquiry does not believe that a CDF Commission of Inquiry would be in any better position to inquire into this matter, or discover anything further.

142. The Inquiry is aware that other ‘green on blue’ incidents are being Inquired into and believe that the findings in this Inquiry should be considered in conjunction with the other Inquiry.

Finding 30: That there are no identified weaknesses or deficiencies (isolated of systemic) that existed in Defence systems, policies, equipment practices, procedures and training which contributed directly or indirectly to the death of LCPL Jones.

Finding 31: That there are no identified shortcomings in relevant Defence actions and decisions, both prior to and immediately subsequent to the incident which contributed to the death of LCPL Jones.

Finding 32: That there are no identified circumstances surrounding the death of LCPL Jones which would warrant the appointment of a COI.
Recomnendation 2: That the CDF recommends to the Minister for Defence that a Commission of Inquiry (COI) into the death of LCPL Jones is not warranted.

CONCLUSION

143. LCPL Jones was a well regarded soldier who, without warning or provocation, was shot by a rogue ANA soldier by the name of Shafied Ullah. LCPL Jones was trained, equipped and led appropriately. The decisions and actions of his Army colleagues prior to, throughout, and immediately following the incident were professionally executed and in keeping with the high standards of the ADF.

144. A review of the mentoring methodology and COP routines applied by the MTF2 and specifically those at COP MASHAL, highlighted that the relationship between the ANA and AS mentors is complex, multi-dimensional and interdependent. The inquiry was of the opinion that the application of appropriate force protection for AS soldiers required a careful balance between physical protection offered by PPE and weapon readiness and the ‘social and behavioural’ force protection offered by developing close working, trustful and productive relationships with the ANA. The Inquiry is of the opinion that the excessive wearing of PPE and carriage of weapons while inside a secure COP may be counterproductive to the relationship between AS and ANA, and in turn negatively impact on force protection. Responsibility for understanding, monitoring and adjusting this balance most appropriately rests with the COP Commander. The Inquiry believes that the actions and decisions of the COP commander, and the force protection measures adopted at the time, were entirely appropriate.

145. While Defence should not forget the nature of LCPL Jones’ sacrifice, the Inquiry did not find any weakness or deficiencies in Defence policies, equipment practices, procedures, training, actions or decisions which contributed directly or indirectly to LCPL Jones’ death.

146. The tragic loss of LCPL Jones, particularly under the circumstances detailed in this Inquiry Report, continues to be deeply felt by his colleagues and those who knew him.

SUMMARY OF FINDINGS

147. After due consideration of all evidence collected and assistance by expert personnel, the following findings are made:

**Finding 1:** The TOR’s were able to be met through the methodology adopted by the Inquiry.

**Finding 2:** The other ANA soldier on duty with Shafied Ullah was not present in Tower 3 at the time of the incident nor involved in the shooting of LCPL Jones.

**Finding 3:** Shafied Ullah shot LCPL Jones.

**Finding 4:** That LCPL Jones was shot and subsequently died from injuries received whilst in the vicinity of the urinals at the base of Tower 3 at 0819 on 30 May 2011.
Finding 5: That the rounds that struck and killed LCPL Jones were discharged from the direction and elevation consistent with being fired from the top of the stairs at Tower 3.

Finding 6: That the weapon used to kill LCPL Jones was an M16.

Finding 7: The M16 assigned to Shafied Ullah was the same weapon that had been used to fire 20 rounds from Tower 3 and in a manner that is consistent with one burst of rounds inwards towards the urinals and subsequent bursts fired over the wall outwards from the COP.

Finding 8: That Shafied Ullah was standing at the top of the stairs of Tower 3 when he shot LCPL Jones.

Finding 9: Shafied Ullah fled the scene after firing one 3-4 round burst at LCPL Jones.

Finding 10: That the treatment of LCPL Jones by the first responders contributed to his successful repatriation to the Role Two medical facility at Tarin Kowt.

Finding 11: The inquiry did not discover any weaknesses, deficiencies or shortcomings in the manner in which the AS forces responded to the incident.

Finding 12: That the notification, repatriation, and mortuary affairs procedures concerning the death of LCPL Jones were appropriate.

Finding 13: The ANA response to the shooting of LCPL Jones was immediate and significant and was of a calibre that indicated the capture of Shafied Ullah was the highest priority.

Finding 14: The decision to conduct joint patrols immediately following the death of LCPL Jones contributed to the restoration of a workable level of trust between AS and ANA soldiers at COP MASHAL.

Finding 15: That there was a strong and workable relationship between the AS and ANA forces in the COP.

Finding 16: LCPL Jones was not antagonistic to ANA members at COP MASHAL.

Finding 17: On the available evidence there is no indication that LCPL Jones was known by Shafied Ullah or specifically targeted by Shafied Ullah.

Finding 18: At the time LCPL Jones was shot he was not carrying his personal weapon or wearing his PPE.

Finding 19: The injuries received by LCPL Jones were outside the range of his PPE.

Finding 20: That the force protection measures employed at the COP at the time of LCPL Jones' death were consistent with the known threat.

Finding 21: There were no prior indicators or warnings that identified Shafied Ullah as a specific threat.
Finding 22: There was no evidence recovered from Shafied Ullah’s belongings that indicate that he had prior links to insurgents or had made any preparations to commit a violent act against AS forces.

Finding 23: Shafied Ullah was killed in a coalition operation on 19 June 2011.

Finding 24: There was no prior intelligence or indication within COP MASHAL to warn of the possible attack against an Australian soldier on 30 May 2011.

Finding 25: That had the ANA commander been aware of a risk to coalition operations or personnel that this would have been communicated to the COP MASHAL Commander.

Finding 26: That the motive for Shafied Ullah shooting LCPL Jones is unable to be determined.

Finding 28: LCPL Jones was appropriately trained and qualified to undertake work outside the wire at COP MASHAL.

Finding 29: Pending the release of toxicology results, it is unlikely that alcohol or drugs were a factor in the death of LCPL Jones.

Finding 30: That there are no identified weaknesses or deficiencies (isolated of systemic) that existed in Defence systems, policies, equipment practices, procedures and training which contributed directly or indirectly to the death of LCPL Jones.

Finding 31: That there are no identified shortcomings in relevant Defence actions and decisions, both prior to and immediately subsequent to the incident which contributed to the death of LCPL Jones.

Finding 32: That there are no identified circumstances surrounding the death of LCPL Jones which would warrant the appointment of a COI.
148. After due consideration of all findings, the Inquiry Officer recommends the following:

| Recommendation 2: | That the CDF recommends to the Minister for Defence that a Commission of Inquiry (COI) into the death of LCPL Jones is not warranted. |

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LIEUTENANT COLONEL
Inquiry Officer

March 2012