Good morning ladies and gentlemen. I am here this morning to release the findings of the Inquiry Officer's report into Sergeant Brett Till's death in Afghanistan on March 19, 2009.

The Chief of the Defence Force conducts inquiries into all combat deaths on operations. An Inquiry Officer is appointed to determine the facts and circumstances surrounding an incident so that an informed decision may be taken about the action required to avoid a recurrence. Releasing this report is part of that process.

Before I discuss the Inquiry Officer's findings I would like to say Defence acknowledges the delay in releasing this report. The Inquiry Officer identified some matters which required further examination and Defence has undertaken a number of reviews in the 18 months since Sergeant Till's death. I understand the anxiety this delay must have caused Sergeant Till's family and friends but it was essential that the issues identified by the Inquiry Officer were examined in critical detail to safeguard other Explosive Ordnance Disposal Technicians and our counter IED capability.

Sergeant Till was a highly respected soldier and a very capable EOD Technician from the Incident Response Regiment based at Holsworthy Barracks in Sydney. He spent eight years in the Royal Australian Engineers and was a fully qualified EOD Technician. Having successfully completed both the Special Operations Task Group and the IED specific Mission Rehearsal Exercises, Sergeant Till was certified for deployment. In addition to these qualifications, Sergeant Till's colleagues expressed a high degree of confidence in his abilities.

In the days leading up to the incident, Sergeant Till was part of an EOD Team which had successfully completed multiple IED clearances and ground searches. On 18 and 19 March 2009, Sergeant Till was leading an EOD Team as part of a route clearance operation. The Team was operating in open ground, in a narrow valley, surrounded by rugged, mountainous terrain. Intelligence confirmed there was a heightened threat of IEDs for this mission. Sergeant Till's team was part of a large Force Element and Sergeant Till was backed up by another highly qualified and experienced EOD Technician.

At approximately 0645 hours on the 19th, a member of Sergeant Till's team located an IED. The searchers gave a hand-over brief to Sergeant Till, providing information on the location of the IED components including the pressure plate and the main charge. Sergeant Till conducted a brief investigation of the IED. While Sergeant Till was at the IED location, the Officer Commanding the Force Element was informed of the situation and directed that the
IED be destroyed. Sergeant Till indicated this was his intent and proceeded to deal with the IED, setting an initial charge before returning to cover behind his Protected Mobility Vehicle. The charge exploded and Sergeant Till waited before moving forward to inspect the results. Having assessed the results, he went back to his vehicle, retrieved some equipment and returned to the IED. Sergeant Till was kneeling next to the main charge when it detonated, killing him instantly.

The Inquiry Officer found that there was insufficient evidence to determine what initiated the detonation. However we do know there are numerous ways to trigger an IED including remote control and anti-handling devices, inadvertent circuit completion, a timer or victim operated trigger.

At the time of the incident, Sergeant Till was wearing his combat body armour and helmet, and not the current in-service EOD suit. An EOD robot was not used during this operation. The rationale for not using an EOD suit or robot has been redacted from the report to preserve techniques, training and procedures, however, the Inquiry Officer determined that these equipment choices were soundly based and reasonable given operational circumstances.

The Inquiry Officer examined pre-operation planning and preparation for the mission along with command and control of the operation and found no weaknesses. Members of the Force Element had varying opportunities to rest during the mission, but the Inquiry Officer could not determine how much rest Sergeant Till had over the 18th and 19th of March. In the absence of clear evidence, the Inquiry Officer cannot rule out fatigue as a contributing factor to the incident however, all military personnel are trained to operate under stressful, tiring and demanding conditions for extended periods.

As I mentioned earlier, the Inquiry Officer raised some matters that required further examination. In particular, the Inquiry Officer's report identified that the manning and composition of EOD Teams may have been a weakness. In response, the Chief of Army commissioned the Explosive Hazards Review Board to undertake a detailed examination of EOD manning and doctrine with particular attention to the preparation and employment of EOD Teams for the Mentoring Task Force (MTF) and SOTG, including training standards and certification.

The Review Board confirmed that the MTF and the SOTG normally conduct different types of missions in different operating environments. The MTF in undertaking the training and partnering of the Afghan National Army operates in the same, relatively defined area in order to provide an overt and persistent presence that reassures the local population and provides security. Conversely, the SOTG operates in a variety of areas in order to conduct missions that usually require high levels of agility and stealth.

The Review Board found that a single, common EOD Team construct would not accommodate the different mission profiles of the MTF and SOTG. Instead, the Review Board determined that the differences in EOD Team composition and training were consistent with Army doctrine. Further, the emphasis SOTG placed on additional training in order to meet its particular operational requirements is regarded as a strength. The Review Board concluded that preserving the tactical flexibility to vary EOD Team composition within the scope of approved doctrine remained essential to mission success. In short, the Review Board determined that the SOTG Team construct was, at the time of Sergeant Till's death, and is currently; appropriate, robust and consistent with doctrine.
As part of this investigation, the Inquiry Officer looked at the techniques and procedures Sergeant Till employed in dealing with the IED. The Inquiry Officer's report states that Sergeant Till began the process to destroy the IED in accordance with the Officer Commanding the Force Element's direction. However, after the first controlled detonation, Sergeant Till appears to have adapted his approach to this task. The Inquiry Officer interpreted Sergeant Till's change of approach to be a change of intent - that is that it appeared Sergeant Till was no longer trying to destroy the IED. However, upon review, there are a number of valid techniques Sergeant Till could have adopted to destroy the IED when he reassessed the situation after the initial explosion. There is no clear evidence to suggest Sergeant Till did not intend to destroy the IED.

Improvised Explosive Devices are not built to specific standards; they are unpredictable and frequently unstable. Dealing with an IED involves a number of steps and each step is dependant on the outcome of the previous one. Consequently, the EOD Technician must continually reassess the situation as it unfolds and adjust his approach accordingly in order to deal with the IED.

The EOD Technician has the most complete understanding of the conditions and hazards at the IED site. So the EOD Technician is the person best placed to decide the most suitable course of action for dealing with the IED. Unfortunately, in Sergeant Till's case there is insufficient evidence for the Inquiry Officer to determine why Sergeant Till adapted his original approach or what detonated the IED. This does not imply Sergeant Till acted contrary to his orders. At all times Sergeant Till applied techniques which were consistent with accepted Tactics, Techniques, and Procedures. And I emphasise that the Inquiry Officer found no evidence of any personnel failing in the performance of their duties.

The Inquiry Officer made two recommendations:

- Firstly that the EOD Team structure used by the MTF be applied to the SOTG. As I explained earlier, a specialist review board examined this recommendation in detail and determined that the current SOTG structure is appropriate, robust and consistent with Army doctrine. Chief of Army has endorsed the Review Board's findings.

- Secondly, the Inquiry Officer recommended that the circumstances associated with the death of Sergeant Till do not warrant the appointment of a Commission of Inquiry.

The Chief of the Defence Force and the former Minister for Defence have accepted this recommendation.

On behalf of the Australian Defence Force and the wider Defence Community, I offer our deepest condolences to Sergeant Till's family and friends. Sergeant Brett Till was a highly respected Explosive Ordnance Disposal Technician. His mates remember him as a selfless bloke who made a difference. Brett's team held him in the highest regard as a professional and dedicated soldier who was killed protecting his mates. An unclassified version of the Inquiry Officer's report will be available on the Defence website following this media conference.

Sections of the report have been redacted to protect tactics, techniques and procedures and to preserve operational security.
I understand many of you may have questions related to the way our soldiers deal with IEDs however, I'm sure you understand I cannot divulge classified information which could be used to compromise the safety of our personnel. That said, I will now take your questions.
INQUIRY OFFICERS REPORT INTO THE DEATH OF
8271447 SERGEANT B.I. TILL
IN AFGHANISTAN ON 19TH MARCH 2009

References:

A. CDF Instrument of Appointment and Terms of Reference dated 24 Mar 09
B. ADFP 06.1.4, Administrative Enquiries Manual, AL1, 2007
C. Map Extract 1:50 000
D. Supplementary Inquiry Officer's Report – Very Serious Injuries Sustained by 8233356 Sergeant Michael John Lyddiard during Operation Afghanistan, dated 5 Sep 08
E. DI(G) Pers 20-6 Death of Australian Defence Force Personnel dated 20 May 08
F. DI(G) Pers 11-2 Notification of Australian Defence Force and non-Australian Defence Force Casualties dated 20 May 08
G. HQ JTF633 SL(Pers) 04-06 MEAO Mortuary Affairs Management dated 22 Sep 08
H. ADFP 06.1.4, Administrative Enquiries Manual, AL1, 2007
I. Land Warfare Procedures – General
J. Land Warfare Procedures – Combat

Appointment and Terms of Reference

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

Inquiry Officer Team

2. The inquiry team consisted of myself as the Inquiry Officer and the following Assistant Inquiry Officers:
   a. Lieutenant Colonel Craig John Barker,
   b. Major Marcos Leonardo Medina, and
   c. Warrant Officer Class Two Paul Michael Paterson.

Methodology

3. Following force preparation in Australia, the Inquiry Team moved to Australia. Following RSO&I, the team moved forward to TARIN KOWT, with an unscheduled two day stop in Kandahar due to bad weather, arriving in TARIN KOWT on the evening of 7 Apr 09. SOTG FE were still deployed on OP at this time. The Inquiry Team then commenced work on the Inquiry into the death of CPL M.R.A. Hopkins before moving to Camp RUSSELL to commence inquiries into the death of SGT Till on 14 Apr 09.
4. After gathering and viewing available evidence the Inquiry Team interviewed witnesses and those involved in planning and support roles over the period 15-18 Apr 09. The Inquiry Team then moved to interview the CO SOTG and staff of the SOTG.

5. On return to Australia the Inquiry Team conducted a further interviews with CO Incident Response Regiment (IRR) on 28 Apr 09 and discussions with FF on 30 Apr 09.

6. I consulted the QA (Annex B) conducted by dated 19 Mar 09.

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

**Introduction**

8. Over the period the FE of SOTG conducted Op. a operation covered areas of and FE were an element of a larger RC(S) SOF operation.

9. 

10. The of the and the more Southern area known as the CHAMBERAK VALLEY, commenced on the evening of 19 Mar 09. At about 0645h on 19 Mar 09 identified a possible Pressure Plate Improvised Explosive Device (PPIED) and SGT Till moved forward to examine the IED. During the subsequent activity to the IED the main charge of the IED detonated, killing SGT Till instantly.

**Date, Time and Place of the Incident**

11. The incident took place on the 19 Mar 09 at approximately 0715h local Afghanistan time (1315h AEDT) in an area known as the CHAMBARAK VALLEY. This location is approximately North of the SOTG Base at Camp RUSSELL, TARIN KOWT.

**Forces Involved**

12. **Australian.**

   a. **General.** FE of SOTG led by MAJ was conducting Op. at the time of the incident. FE is based on and supporting elements. At the time of the incident FE was a considerable force package.
b. **Engineer Assets.** The engineers involved in the operation were SO Command soldiers from the IRR, trained to perform their specialist engineer duties within an SO context. The engineers with FE were broken into Each was lead by an supported by a number of I and was lead by WO2 SGT Till.

13. **Afghan.** There were a small number of ANA soldiers attached to FE at the time of the incident while they were not actively involved in the incident.

14. **Coalition.** The following Coalition Forces were involved:
   a. One Blackhawk AME helicopter provided AME support.
   b. The Dutch Role 2 Medical Facility at Camp HOLLAND, TARIN KOWT, where SGT Till’s body was initially received and where his repatriation commenced.
   c. The Theatre Mortuary Affairs Evacuation Point for mortuary support

**Synopsis of the Incident**

15. Clearance of the commenced on the Mar 09 at The operation being conducted was the threat picture identified that INS were likely to lay IED/mines. Given this, the decision was made to In the view of the OC and his supporting this provided a defined route.

16.

17. The operation continued through the night and,

18. At approximately 0645h on 19 Mar 09, of FE had just crossed through a Wadi when the searcher, LCPL identified an IED
LCPL [redacted] identified what he believed to be the pressure plate (PP) of an IED, and also identified the location of the MC. SPR [redacted] also identified what he believed to be the location of the MC.

The searchers gave a hand-over brief to SGT Till consisting of information on the location of the IED components (PP and MC) and

19. Following this brief, SGT Till made his and conducted a brief investigation of the IED. It was during this period when SGT Till was at the IED location that OC FCT, having been apprised of the situation, passed the order to SGT Till also appears to have made the decision to and indicated that this was his intent. SGT Till is then seen to provided by his PMV, the charge exploded and SGT Till waited before moving forward.

20. SGT Till and inspected the results of the detonated explosive charge. SGT Till returned to his vehicle and then made retired to the dead ground in the creek line (some 30m to the East).

21. SGT Till made his SGT Till moved to a position next to the MC, knelt on his left knee and was seen to possibly attempt to the MC itself. The MC detonated while SGT Till was kneeling next to it.

22. Following the explosion the remaining members of the to approach the incident site. Over the next, the wider area surrounding the incident site was cleared to allow medical staff to recover SGT Till’s remains. During this period

23. Due to operational prioritisation medivac helicopter support was not immediately available to evacuate SGT Till’s remains. SGT Till’s remains were consolidated into a body bag and placed into the PMV and the operation continued. Medivac support became available later that afternoon, with SGT Till’s remains being evacuated in the late afternoon and subsequently arriving at the CAMP HOLLAND at approximately 1620h.

24. Attached is a copy of the SOTG Storyboard (Annex C), the SOTG Ops Log (Annex D) and the SOTG (Annex E). It covers the period from the discovery of the IED to the immediate aftermath of the explosion.
Authority to Conduct the Operation

25. As a result of Op[REDACTED] URUZGAN Province CDF’s agreement for the conduct of Op[REDACTED] was provided on [REDACTED]

26. ISAF approval for the conduct of Op[REDACTED] was provided by the issue of Frago [REDACTED] of 29 Jan 09 (Annex G).

Involvement by Civil and Service Authorities

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

28. The NSW Coroner conducted an autopsy on SGT Till’s remains on 27 Mar 09. The Coroner’s Report is yet to be received.

Involvement by Civilians

29. There is no apparent involvement by civilians in this incident.

Deaths and Injuries

30. **Deaths.** Sergeant Brett Ian Till was killed as a result of this incident. The explosion that killed SGT Till resulted in catastrophic injuries that would have caused death instantly. Given the circumstances of the explosion and the injuries sustained, I am satisfied that SGT Till’s death occurred as a result of a PPIED that had been laid by INS detonating.

31. The RMO [REDACTED] determined SGT Till’s was dead at the scene while the official confirmation of death was declared by the RMO [REDACTED] at CAMP HOLLAND at 1700h, 19 Mar 09. Notwithstanding this, the available evidence supports SGT Till’s time of death as being at approximately 0715h, 19 Mar 09.

32. An autopsy was conducted by the NSW Coroner on 27 Mar 09 and this was attended by Joint Operations Command. While the Coroner’s Report was not available to the Inquiry Team, [REDACTED] provided observations from the autopsy (Annex H). [REDACTED] assessed that SGT Till sustained a catastrophic trauma affecting his whole body and that the nature and extent of the injuries meant the explosion was not survivable.

33. At all times following his death, SGT Till’s remains were treated with dignity and respect by his comrades. Following his return to Camp HOLLAND, SOTG placed a guard at the Dutch Role 2 Medical Facility until the ramp ceremony and the departure of SGT Till’s
remains for ___________. Prior to the ramp ceremony, a church service was conducted by SOTG and attended by Coalition allies.

34. **Injuries.** There were no known additional injuries to Australian personnel as a result of this incident.

**Loss and Damage to Service Property**

35. There was extensive damage to SGT Till’s Helmet, Body Armour and personnel equipment. His 9mm pistol was returned with his remains and it is unknown as to whether this item is serviceable. Parts of SGT Till’s ____________ were recovered at the scene and this equipment is considered to have been destroyed.

36. Required write offs and adjustments will occur through normal unit process.

**Witnesses**

37. Statements and/or interviews were conducted with the following witnesses or others involved in the incident:

[Blacked out]
Environmental Conditions

38. **Terrain.** The terrain in which the operation of [ITALIC] was being conducted was characterised by rugged mountainous terrain intersected by narrow valleys and passes. Elevation was 1100-1200m in the valley/pass floors rising up to a peak of 1950m on the surrounding mountain peaks. Within the areas described as valleys the width of the ground is up to 2km across between steeply rising terrain.

39. **Incident Site.** The incident occurred in the region known as the CHAMBARAK VALLEY. At this point the valley floor is approximately 1km wide before it starts to slope steeply. The ground is open without tree vegetation. A creek line runs up the centre of the valley with a rough track following and, at a number of points, crossing the creek line. The incident site was approximately 15m on the Northern side. The track at the incident site was firm with a sandy covering and the ground around was littered with small to medium sized rocks. Attached is

40. **Weather.** The incident occurred in the early morning. The weather was fine, cool and clear at the time of the incident.

41. **Visibility.** Visibility was good and out to the terrain visual distance at the time of the incident.
42. **Cultural Environment.** Limited operations have been conducted by Coalition Forces in the CHAMBERAK VALLEY had over the previous two years. There were no areas of human habitation in the vicinity of the incident site.

43. **Human Activity.** The only sign of human activity in the vicinity of the incident site was a goat herder to the South-West tending his animals. SOTG personnel assess that the individual was not involved in the incident.

44. **Contribution of Environmental Conditions to the Incident.** Environmental conditions do not appear to have contributed adversely to the outcome of the incident in any direct way.

**Operational Conditions and Factors**

45. **Pre-operation Intelligence.**

a. **General.**

b. **EO Device Intelligence.**

(Annex KK)

46. **Pre-operation Planning.** Planning for the operation was a deliberate planning process undertaken at various levels by RC(S), SOTG and FE. The planning process appears to have been sound and there were no obvious weaknesses identified.

47. **Orders.**

a. **General.** Orders for the overall operation were suitable for the operation. Orders from SOTG to FE were provided in writing. Following further planning by FE, orders were delivered verbally to FE in a centralised setting and supported by extensive power point slides.

b. **Orders relating to EO Devices.** Specific reference to the EO device threat was made in FE orders. The orders for stated that the action on IED/mine was a part of the OC FE. When appraised
This decision appears sound based on the tactical situation.

48. **Command and Control.**

   a. **General.** Command and control throughout the activity, the conduct of the clearance of the IED by SGT Till and the subsequent recovery all appear to be sound. There is no evidence of any weakness in the command and control of the operation.

   b. **Control of the Advance and EO Device Clearance.** The command group of FE were specific that the pace of the advance was to be set by and the decisions . The acknowledged that there was no command pressure to hurry either the advance or time pressure placed on the clearance of the EO devices.

49. **Contribution of Operational Conditions and Factors to the Incident.** FE entered the operation with an understanding of the threat faced, were provided with appropriate orders that articulated the actions to be taken and that the actions taken were as planned and articulated. There are no factors in the operational conditions or factors that impacted adversely to the outcome of the incident.

**Training and Procedures**

50. **Training.** SGT Till’s role required the skills and training of an EOD Technician. After reviewing the relevant PMKeyS entries, I am satisfied that SGT Till was fully qualified in this role. Additionally, SGT Till undertook both the general SOTG Mission Rehearsal Exercise (MRE) and the Army Explosives Hazard Centre (ExHC) IED specific MRE. At the conclusion of the IED specific MRE SGT Till was certified competent for deployment. Additionally, witness statements indicate a high degree of confidence in SGT Till’s abilities within FE.

51. **Use of Equipment.**

   a. **EOD Suit.** At the time of his death SGT Till was wearing his combat body armour and helmet but was not utilising the current in-service EOD suit. Given the tactical requirements this is considered a reasonable decision to be made by the operators.

   b. **EOD Robot.** The EOD Technicians did not employ this equipment during Op because of:
Given the decision, the in-service robot is considered a reasonable decision to be made by the operators.

c. 

52. **Techniques and Procedures Employed in the IED Clearance.** SGT Till was ordered the IED and also indicated that this was his intent. During the clearance the following actions took place:

a. LCPL discovered what he believed to be an IED, and also identified what he believed to be the MC of the IED. He then moved back to report to SGT Till.

b. identified what he believed to be the MC. He then also reported to SGT Till.

c. The OC FE gave the instruction to the IED.

d. SGT Till indicate he was about to the IED.

e. SGT Till placed an explosive charge.

f. Following the detonation of this charge, SGT Till

g. SGT Till approached the IED and knelt where SGT Till appears to attempt to at which time the MC detonated.

The actions undertaken in sub-paragraphs e. to g. are contrary to those expected of an EOD Technician when undertaking In this instance, the actions appear to be consistent with Throughout the conduct of the clearance SGT Till had little contact with the remainder of the and did not pass information to his team on his detailed intent or actions. Therefore, it cannot be ascertained why SGT Till undertook the clearance in the manner that he did.
53. **Fatigue.** At the time of the incident the [REDACTED] had been operating [REDACTED] While each of the [REDACTED] had the opportunity for rest, witnesses indicated that the amount of individual rest was variable. There was no evidence available to indicate the amount of rest SGT Till got over the night of 18/19 Mar 09. Therefore fatigue cannot be ruled out as a contributing factor to the incident.

54. **Cause of Main Charge Detonation.** From analysis of available evidence, it is not possible to definitively ascertain the cause of the detonation of the MC, but some conclusions may be drawn:

a. The following methods of detonation are not considered responsible for the detonation that killed SGT Till:

- [REDACTED]
- [REDACTED]
- [REDACTED]

b. The following methods of initiation are considered possibilities for the detonation of the MC:

- [REDACTED]
- [REDACTED]

Whilst there are two possible causes for the MC detonating, there is no conclusive evidence to support either possibility.

- [REDACTED]
55. **Organisation.**

a. The OMD for the SOTG articulates the structure of the IRR Engineer asset to support SOTG. This OMD appears to be unchanged since Jul 07. The allocated manning provides...

b. Since this OMD was implemented the Engineer elements have... to produce... to support SOTG operations, without amendment to the OMD.

c. Current doctrine at Ref 1 states that EOD Teams conducting Counter IED operations... have...

d. ...

e. ...

f. ...

g. ...
h. Current EOD Technician Manning for SOTG is drawn from IRR asset and not the wider Army EOD community. This occurs due to a stated requirement that for EOD Technicians to conduct operations with SOTG they require additional skills sets that necessitate a significant degree of training.

i. The lack of a [REDACTED] is considered a weakness [REDACTED]. While it is not possible to say whether the lack of a [REDACTED] contributed to the death of SGT Till, the presence of such support may have identified that SGT Till’s actions were contrary to the established procedures for a [REDACTED] and resulted in a difference approach to the task.

**Previous Supplementary Inquiry Officer Report into [REDACTED]**

56. Ref D is a Supplementary Report by the Commander CIEDTF, BRIG P. Winter, into the serious wounding of SGT Lyddiard by an IED in Nov 07, while he was conducting Counter IED operations as part of RTF-3. This Report made a number of recommendations into the conduct of Counter IED operations in Afghanistan, in particular the [REDACTED] Areas which are relevant to matters under inquiry. The pertinent recommendations from BRIG Winter’s Report are as follows:

a. **The following review of existing and future unit-level EOD SOPs is conducted:**

1. [REDACTED]

2. [REDACTED]
(1) Permanently assigned:

(2) Temporarily assigned for task duration (drawn from supporting CE elements):

C. Deployed units who are assigned [redacted] employ a permanently manned [redacted] and that this [redacted] performs a role based on doctrine guidance (References E and F) including:

(1)

D. The manning of an [redacted] also serve as the unit’s [redacted]

E. [redacted]

F. HQ JOC and HQ JTF 633 takes action to review the current basis of provisioning and performance of [redacted] allocated to Operation SLIPPER elements with the view to identifying any deficiencies for RA action.

57. The HQ JTF 633 feedback on the implementation of these recommendations is attached (Annex NN). From this, and additional feedback received as a result of an RFI, it appears that
the implementation of the recommendations from the Winter Report were focused on the operations of the RTF, and subsequent MRTF, and were not analysed for their application in the context of SOTG operations. It is clear from the recommendations that they are equally applicable to the future construct of both MRTF and SOTG Teams. This apparent oversight in implementation is considered a weakness.

**Post Incident Events and Factors**

58. **Medical Treatment.** It has been ascertained that SGT Till was killed instantly and that no medical intervention would have changed the outcome. However, it is considered that the actions taken by medical staff from the time of the incident to the arrival at the Dutch Role 2 Medical Facility, where SGT Till was formally pronounced dead, were appropriate.

59. **CASEVAC.** Once it was ascertained that SGT Till was dead the priority for his medical evacuation was reduced in the line with the urgency for evacuation. During the hours following SGT Till’s death there were weather issues that impacted on the ability of the medivac helicopters to operate safely. Additionally, Coalition troops were in contact elsewhere within the Province and these elements were provided a higher priority for support. As a consequence of these factors the evacuation of SGT Till’s remains did not occur until approximately after 1600h on 19 Mar 09, with his arrival at CAMP HOLLAND being approximately 1621h. Under the tactical situation and ISAF priorities for support and evacuation this is not considered to be a weakness or inappropriate.

60. **Identification of SGT Till’s Remains.** While there was no doubt the remains were those of SGT Till the formal legal requirement for identification remains. RSM SOTG, in conjunction with deployed ADFIS personnel, undertook a series of actions to provide evidence to support the formal identification of SGT Till. These actions were logical in order to support the autopsy process. The nature of SGT Till’s injuries and the issues with identification support the requirement for the ADF DNA repository and the need to encourage soldiers in high risk areas to provide samples to this repository.

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

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

**Other Factors.**

63. **Requirement for**

However, there is no indication that the requirement for produced any form of pressure rather than deal with the situation as dictated by the tactical situation.

64. **Drugs and Alcohol.** There is no evidence that drugs or alcohol were involved or contributed to SGT Till’s death.
65. **Other.** There were no other factors contributing to the incident.

**Performance of Duty**

66. From assessing the evidence and gathering witness statements there was no evidence of any personnel failing in the performance of their duties.

**Conclusion**

67. SGT Till was killed in action as a result of an INS emplaced IED exploding in close proximity while he was attempting to [redacted] the IED. SGT Till suffered catastrophic wounds that were instantly fatal. His death was a direct result of INS actions [redacted].

68. SGT Till was directed to [redacted] the IED and indicated that this was his intent. His subsequent actions did not align with the established techniques for the disposal of an IED. As result of limited interaction with the remainder of his Team it is not possible to determine his detailed reasons for conducting the task in the manner he did.

69. Training, intelligence, planning and orders were all sufficient prior to the incident and there were no shortfalls in this area that contributed to SGT Till’s death. The decisions taken by the EOD Technicians on their equipment requirements and the tactical decisions made by the FE [redacted] command elements all appear to be soundly based and reasonable.

70. The current organisational structure of the IRR elements supporting the SOTG [redacted].

71. The current unit establishment and manning of the IRR from which the EOD capability is drawn to support SOTG appears [redacted] CO IRR to provide [redacted] to an augmented OMD. [redacted] IRR [redacted]. It was not clear why solutions from the wider Army have not been sought. The OMD of the SOTG requires amendment to ensure [redacted] available. As part of this the process by which the wider EOD community is able to feed the IRR to support this level of commitment needs to be examined.

72. The recommendations covered in ref D referred generally to EOD/IED operations being conducted by all deployed Australian elements. However, implementation of the recommendations from ref D appears focussed on the [redacted].

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

74. I find that the circumstances associated with the death of SGT Till do not warrant the appointment of a COI.

Recommendations

75. I recommend that:

a. The appointment of a COI into this matter is not warranted.

b. The recommendations contained within para 47, as highlighted within para 56, be applied to SOTG.

W.R. HANLON
Colonel
Inquiry Officer

22 May 09

Annexes: