INQUIRY OFFICER'S REPORT INTO THE DEATH OF
TROOPER JASON THOMAS BROWN
IN AFGHANISTAN ON 13 AUGUST 2010

References:
A. CDF Instrument of Appointment and Terms of Reference dated 24 August 2010
B. ADFP 06.1.4 Administrative Inquiries Manual, AL1, 2007
C. Oruzgan Planning Map, Afghanistan,
D. SOTG PowerPoint File
E. CIOPS Decision Brief for CDF Approval to Conduct Operations During the Period to
dated
F. ISAF ROE
G. DI(G) Pers 20-6 Death of Australian Defence Force Personnel
H. DI(G) Pers 11-2 Notification of Australian Defence Force and non-Australian Defence
Force Casualties
I. HQ JTF633 SI(Pers) 04-06 MEAO Mortuary Affairs Management dated 22 Sep 08

Appointment and Terms of Reference
1. I, [Redacted], having been duly appointed by Air Chief Marshal Allan Grant Houston, AC, AFC, Chief of the Defence Force, to inquire into the death of [Redacted] Trooper Jason Thomas Brown in accordance with the Terms of Reference attached to the Instrument of Appointment (reference A and annex A), herein submit my report.

Inquiry Team
2. The Inquiry Team consisted of myself as the Inquiry Officer and the following Inquiry Assistants:
   a. [Redacted]
   b. [Redacted]
   c. [Redacted]

Methodology
3. Following force preparation in Australia, the Inquiry Team moved to the UAE via the weekly sustainment A330, arriving in the UAE on the morning of [Redacted] Sep 10. Following RSO&I, the team moved forward to TARIN KOT, arriving on the afternoon of [Redacted] Sep 10.

4. On arrival, the team commenced reading the evidence pack provided to them by HQ SOTG and prepared a schedule of interviewees. The primary personnel to be interviewed were centrally pre-briefed and provided copies of the Instrument of Appointment, Terms of Reference and Annex D to Chap 6 of ref B. HQ SOTG personnel involved in planning, intelligence and support roles were also interviewed at TARIN KOT. The Inquiry Team
finished gathering evidence at TARIN KOT on 27 Sep 10 and returned to Australia via the UAE.

5. The Inquiry Team was unable to visit the site of the incident due to the security situation. A satisfactory appraisal of the incident site was conducted through the examination of maps (reference C) and imagery (annex B) provided by the

Narrative

6. Between Jul and Aug 2010, the Australian SOTG conducted OP in the regions of Northern Kandahar. The operation was in support of an on-going ISAF operation - aimed at

7. On 13 Aug 10 at approximately 1830 Troop (Tp) of Force Element – (FE) was conducting a disruption operation on a suspected The area had been cleared; no INS found and the Tp was preparing for extraction. Patrol was South of the village and was moving West alongside the river seeking to secure a crossing point for the remainder of the Tp. The patrol had just passed a particularly dense thicket of vegetation when they were engaged by a belt-fed weapon at a range of several metres. TPR Brown was struck by multiple bullets and fell in the first seconds of the battle. The patrol reacted immediately, saturated the thicket with fire and extracted the unconscious TPR Brown to a less exposed position where they applied trauma aid. A second patrol arrived from the North. Their patrol medic assisted with CPR and EAR and the two patrols extracted TPR Brown to a helicopter landing zone (HLZ). Despite the absence of vital signs both medics continued to provide CPR and EAR until TPR Brown was extracted.

8. The Troop Commander (Tp COMD) called for an immediate aero-medical evacuation (AME) which arrived at 1915 TPR Brown had no vital signs at that time and was pronounced dead on arrival at Kandahar Airfield.

9. CO SOTG commissioned a Quick Assessment (QA) and a subsequent Addendum to the QA (annexes C and D). CDF Commissioned this Inquiry on 24 Aug 10.

Background

10. The SOTG currently comprises these elements:
   a. 
   b. 
   c. 
   d. 
   e. 
   f. 
   g. 
   h. 
   i. 
   j. 
   k. 
   l. 
   m. 
   n. 
   o. 
   p. 
   q. 
   r. 
   s. 
   t. 
   u. 
   v. 
   w. 
   x. 
   y. 
   z.
11. At the time of OP [REDACTED], the SOTG had been routinely working with US helicopter Task Forces for AME;

12. Operation [REDACTED] is the Commander Regional Command (South) (COMD RC(S)) main effort support of OP [REDACTED]. The aim of the operation was to conduct a mission in the North of Kandahar city. OP [REDACTED] was a series of missions spanning a period from [REDACTED] to [REDACTED]. On the 13 Aug 10, the operation was

13. The planning of the mission was conducted over a period of weeks by SOTG HQ. CO SOTG’s intent for the conduct of OP [REDACTED] is contained in reference D and his method statement is as follows:

   **TF 66 will undertake**

   **These operations will utilise RW support**

   **The operation will take place over the period**

14. CO SOTG’s rationale for conducting the operation was as follows:
Authority to Conduct the Operation

15. The incident occurred during the conduct of OP [redacted], an approved operation in support of RC(S) OP [redacted]. Australian participation in the ongoing operation was briefed to [redacted] and approved by [redacted]. The overarching plan was approved by [redacted] on [redacted].

16. OP [redacted] was a [redacted] operation. It was planned by [redacted] and conducted by [redacted]. The commander for the mission was approved by [redacted].

Date, Time and Place of the Incident

17. The patrol was inserted around [redacted] the village [redacted] on 13 Aug 2010. The village is approximately [redacted] km South-South-West of Multi-National Base - Tarin Kot (MNB-TK). The contact that resulted in the death of TPR Brown took place at [redacted] around 1825 hrs (shortly before 13 Aug 10 AEST).

Friendly Forces Involved

18. Australian. OP [redacted] was a [redacted] operation. It was conducted by [redacted]. The patrol is typically commanded by [redacted] and includes [redacted]. TPR Brown was a member of Patrol [redacted]. The other members were:

a. Soldier 1
b. Soldier 2
c. Soldier 3

19. Afghan. [redacted] accompanied throughout the operation, but were [redacted].

20. ISAF. The ISAF forces involved in the incident were:

a. [redacted]
b. a US UH-60 Blackhawk AME helicopter from

c.

d.

e.

f. the ISAF Medical Facility at KANDAHAR Airfield, where TPR Brown’s body was initially received and where his repatriation commenced.

Rules of Engagement

21. The extant Rules of Engagement (ROE) for the mission conducted on 13 Aug 10 were

The mission was conducted in compliance with the ROE.

Synopsis of the Incident

22. Tp departed TARIN KOT on UH-60 Blackhawks at on 13 Aug 10. The helicopter landing zones (HLZ) around had been selected during planning for the mission.

23. TPR Brown’s patrol, inserted West of the village, moved East-South-East to South of the village.

24. The concluded and the Tp began to move toward the planned extraction HLZs. The PtL was moving looking for a suitable crossing point. The PtL encountered a large and particularly dense thicket of vegetation on the river bank and moved around it to the North. Turning back towards the river, the patrol was spread out over a slightly raised footpad. TPR Brown was third in the line of march, behind Soldier 4 and Soldier 1 and in front of Soldier 3. Soldiers 4 and 1 were planning the Tp crossing when there was a burst of fire from a distance of five to ten metres from within the thicket to the patrol’s left. TPR Brown was hit by numerous bullets and fell immediately.

25. All patrol members immediately returned fire and sought cover. Due to the proximity of the enemy weapon, all patrol members reported initial difficulty estimating where the fire originated, however, felt safe in assuming it was from within the thicket. Soldiers 4 and
2. Outside the killing ground at the front and back of the patrol respectively, were able to take cover behind berm. **SOLDIER 1** and **SOLDIER 3** both had to move initially to cover closer to the **SOLDIERS 2 & 4**.

26. The remaining members of the patrol continued to return fire and throw grenades on what was now thought to be at least two INS in the thicket. **SOLDIER 4** was firing across the front of the patrol and also at an insurgent rifleman to his direct front. **SOLDIER 2**, at the end of the patrol, **SOLDIER 1** then went forward under fire to retrieve TPR Brown. While attempting to drag TPR Brown away, there was a burst of fire and **SOLDIER 1** thought **SOLDIER 1** had been hit and killed, however this was not the case. **SOLDIER 1** began to return fire from alongside TPR Brown and called one dead enemy on the machine gun. **SOLDIER 3** then moved forward and both men removed TPR Brown's unconscious body to a position of relative safety whilst covered their withdrawal.

27. At this time, Patrol **SOLDIER 4** arrived from the North and laid down fire that allowed **SOLDIER 4** to extract himself from his exposed position by using a small berm paralleling the river. **SOLDIER 2** coordinated close air support from **AH-64** and directed fire onto the far side of the thicket and then rejoined his patrol.

28. **SOLDIER 3** and **SOLDIER 1** had begun providing immediate trauma aid and, in the absence of vital signs, began CPR and EAR. The patrol medic from **SOLDIER 1** arrived and took over CPR from **SOLDIER 1**. **SOLDIER 1** relayed medical information to the Tp Signaller to facilitate a nine-liner. **SOLDIER 1** had also arrived with and carried a portable stretcher which was assembled and used to move TPR Brown to a HLZ about **SOLDIER 4** in dead ground to the West of **SOLDIER 1**. Both medics, assisted by other members of the Tp, continued to provide CPR and EAR until the AME helicopter arrived at 1915DE.

29. The AME was launched from KAF before the nine-liner was transmitted. At the time the nine-liner was initiated the HLZ was still receiving sporadic fire. One witness indicated this may have been overshot from the contact still going on South of the village. As the nine-liner indicated the LZ was “hot” the AME crew requested support before landing. The situation was resolved **SOLDIER 1** and The AME team landed and extracted TPR Brown. At the time of extraction the LZ was not hot.

30. TPR Brown was declared dead on arrival at Kandahar Airfield.

31. Due to dust storms and an already dusty HLZ, only one patrol was successfully extracted (on the third attempt) after the AME. The remainder of the Tp secured the site **SOLDIER 4**. The Tp then moved off to higher ground in the vicinity of HLZ to await extraction. The Tp was extracted early the following afternoon.

32. The contact occurred approximately 90 minutes after insertion. The time from the contact to AME extraction was approximately 50 minutes. TPR Brown had been displaying
no vital signs from the time SOLDIER 3 first reached him (assessed by SOLDIER 1 and soldier 3, as between four and eight minutes after he had been shot.)

33. Attached at annex G is a graphic drawn by SOLDIER 1 that depicts the route of patrol, the contact site and the MEDEVAC site. The SOTG Storyboard is at annex H.

Witnesses

34. Statements and/or interviews were obtained from/conducted with the following witnesses or others involved with the incident:

   a. 

   b. 

   c. 

   d. 

   e. 

   f. 

   g. 

   h. 

   i. 

   j. 

Operational Conditions

35. **Pre-Patrol Intelligence.**

   All members of FE expected contact with INS during the mission. There was no understatement of the threat.

   a. **Previous Patrolling Activity.** According to witness statements, SOTG had conducted no operations in the area previously.

   b. **Passage of Intelligence.** All members of the Tp were comprehensively briefed on available intelligence and environmental conditions and felt they were well prepared for the mission. The dissemination of intelligence through the SOTG order's process appears robust and I assess that the process supports the conduct of operations.
c. **Understanding of the Intelligence.** All witnesses indicated they knew [redacted] was a suspected [redacted] and there appears to be a common understanding of the possible INS strength in and around [redacted]. All witnesses agreed they were thoroughly briefed and aware of the purpose, mission and end-state for the operation.

36. **Pre-patrol Planning.** FE-missions are characteristically planned in detail by all participants. Plans are prepared at Tp level and approved by the chain of command. Theatre and national approval is obtained prior to any mission being conducted. This methodology is robust and has been used successfully and extensively.

a. **Intent for Operations.** CO SOTG provided his intent for the operation vide annex S.

b. **Planning for 13 Aug 10.** Planning for the operation was conducted in a methodical manner. Tp HQ planned the operation in conjunction with the Patrol Commanders and supporting elements. The plan was then approved at the Sqn and Task Group level. All available intelligence was considered in the planning process. The quality of the planning is evidenced by the calm and methodical manner in which all actions were carried out during the contact, withdrawal, AME was repurposing. This included relatively minor issues such as accounting for mission essential items (MEI) and internal resupply.

37. **Orders.** [redacted] delivered detailed orders immediately prior to departing for the mission. Those present described the orders as clear and all said they had a good understanding of the mission. There is no reason to believe otherwise. The orders brief is at annex T.

38. **Command and Control.** From witness statements it is apparent the patrol commander of quickly took control of the contact and reacted as trained. It is also apparent the Tp COMD maintained solid command and control throughout the incident. From the operations logs taken at the time, Tp HQ concurrently coordinated additional support to the troops in contact, aerial fire support, AME, and the extraction of TPR Brown to the HLZ. Analysis of the Operations Logs shows the supported the operation throughout and coordinated the AME through rotary wing LOs at Task Forces and The SOP for casualty management was immediately implemented, with priority given to the organisation of AME.

39. **Theatre AME Support.** The orders for the mission contained details of all available AME assets. As stated previously, the AME helicopter launched from KAF immediately on receipt of a reported casualty and before a nine-liner was received.

40. **Equipment.** At the time of his death, TPR Brown was wearing ballistic helmet, body armour with front and back plates and carrying his personal weapon and equipment. I am satisfied his dress and equipment provided a good compromise between protection and mobility and was suitable for the task he was undertaking at the time. Whilst TPR Brown's fatal wounds were sustained around his body armour, it is worth noting that at least one bullet was deflected from his chest plate, probably causing a significant bruise on his left chest. The Defence Material Organisation has requested the return of his equipment for analysis.
41. **Contribution of Operational Conditions to the Incident.** There are no other factors in the operational conditions that impacted adversely on the conduct of the operation.

**Environmental Conditions**

42. **Terrain.** The terrain to the North of ___ was open dasht, with good visibility, however, the operation was conducted primarily around and through the green belt to the South of the village. The village itself comprises numerous walled compounds (*qalas*) situated primarily North of the green belt on the edge of the dasht. At the time of the incident, the green belt consisted of orchards (*mainly* pomegranates) and vineyards, and cultivated fields with numerous intersecting irrigation ditches. Witnesses' statements reflect it was the densest vegetation they had been exposed to in Afghanistan. Unlike normal orchards, the witnesses stated the orchards were in full bloom with dense secondary undergrowth. In many cases the fields were surrounded by mud walls which were themselves overgrown with vegetation. This further reduced visibility, in some case down to 10 – 20 m. Irrigation ditches made going difficult, however numerous formed footpads offered better going, but also canalised any movement in the area. The vegetation that comprised the thicket from which the contact was initiated was described by the witnesses as "impenetrable".

43. **Incident Site.** The contact occurred ___ the main part of the village of ___. Annex B depicts the site.

44. **Weather.** The weather at the time of the incident was fine and clear. Dust storms were expected and being monitored during the course of the clearance and contact through the fixed and rotary-wing LOs at the __ and KAF. Incident logs record ongoing weather updates throughout the period in question.

45. **Visibility.** The visibility at the time of the incident was considered to be good, although thick vegetation in the orchards and fields South and West of the village along the river reduced visibility to less than 20 m in places.

46. **Human Environment and Activity.** At the time of the incident ___ was suspected of being ___ and the operation was designed to disrupt activities in the area. There were numerous movements within and around the village in the days prior to the operation and elements of ___ operating North of the village had assessed that ___ with which they had been in contact.

47. **Contribution of Environmental Conditions to the Incident.** The contact occurred within complex terrain: open dasht, human habitation in walled *qalas*, dense orchards, and a number of cultivated fields. Despite the unusually dense undergrowth, witnesses indicated SOTG is very experienced in operating in diverse environments such as this and the initial plan was adapted on the ground to exploit natural cover while clearing the village. In short, the environmental conditions did not contribute adversely to the outcome of the incident in any way.
48. **Training.** All personnel were trained and qualified for the roles they undertook. All witnesses were adamant that they were well prepared and trained for the missions they were undertaking. FE had undergone an extensive individual and collective training cycle in Australia before deploying. Patrol had been working together since early 2010 and had participated in mission specific training (MST) and mission rehearsal exercises (MRE). FE and the had conducted numerous similar missions in both training and operations and were individually and collectively well-prepared for the situation as it unfolded.

49. **Tactics, Techniques and Procedures.** The TTPs employed, particularly the action on contact and the casualty procedure, were appropriate to the task and were well executed throughout the incident.

50. **Contribution of Training and TTPs to the Incident.** The level of training and the immediate application of appropriate TTPs allowed the patrol to maintain good order under significant pressure and subsequently extract itself from the area of contact. The actions carried out by the remainder of the Tp during and after the contact were well considered and tactically sound. Once the Tp was collocated at the extraction HLZ and it was found the planned extraction could not go ahead, the Tp conducted an appreciation of the situation, repostured and moved tactically to a more secure area to await extraction. In short: the contact, subsequent AME and reposturing were conducted in an extremely professional manner under difficult combat conditions.

51. **Passage of Information.** From an examination of operations and radio logs, it is apparent information was passed in a timely manner CO SOTG provided updates to CJTF 633 during the incident.

**Post Incident Administration**

52. **Communications lockdown (CLP).** Communications across the MEAO were locked down following receipt of on 13 Aug 10. The lockdown was lifted after receipt of on 14 Aug 10 (see annex U). The CLP was instigated in accordance with JTF 633 SOP. There is no evidence to indicate there was any communications leak after the incident.

53. **Notification Procedures.** The incident was reported in accordance with references G and H. The notification of the NOK occurred in accordance with reference G. There is no evidence to indicate these procedures were not thoroughly and completely applied.

54. **Loss and Damage to Service Property.** After the AME and as part of the SOP, all mission essential items carried by TPR Brown were located and secured. His helmet and body armour were subsequently returned to Australia and are currently with the WA Coroner's Office pending release to the Defence Materiel Organisation for analysis.

**Involvement by Civil and Service Authorities**

55. The incident falls under the category of a ‘notifiable’ incident and the local ADFIS representative opened an ADFIS investigation into the incident.
With the exception of the reports mentioned below, there have been no other known Australian, local or ISAF investigations or inquiries into this incident.

56. TPR Brown’s remains were handed over to the West Australian Coroner by the ADFIS representative in Perth, SGT . An autopsy was conducted on 20 Aug 10 in the presence of two ADF members. An autopsy and toxicology report were prepared and have been sighted by the Inquiry Team. They revealed no abnormalities and confirmed death by multiple gunshot wounds. Advice received from the Registry Manager of the Coroner’s Court is that the WA Coroner is likely to convene a ‘Paper Coronial’ by way of a ‘hand-up brief’ in which a redacted version of this Inquiry Report may be considered. Whether or not a coronial investigation is conducted by the WA Coroner in relation to TPR Brown’s death is beyond the Terms of Reference of this Inquiry.

57. **Other Involvement by Civilians.** While there was evidence of normal pattern of life movements around during the operation, there is no evidence of involvement by civilians in this incident, other than the INS, nor have there been any reports of civilian casualties as a result of the contact.

**Post Mortem Procedures**

58. TPR Brown was evacuated from the battlefield to a Medical Facility at Kandahar Air Field (KAF) by rotary wing AME. He was examined by a Medical Officer, who certified the time of death as 1945 DE on 13 Aug 10 (annex V). The recorded cause of death was ‘Multiple GSW’. TPR Brown’s remains were picqueted by Australian personnel.

59. On 14 Aug 10, TPR Brown’s remains were transferred to the Role 2 Hospital, MNB-TK where they were picqueted by SOTG personnel. The remains were positively identified by Tp Medic for (annex W); a Medical Officer, revised the cause of death to ‘Tension Pneumothorax (on Xray), multiple GSW’ (annex Y).

60. TPR Brown’s remains were then conveyed to the mortuary at the TK Medical facility. ADFIS Investigators, and inspected TPR Brown’s remains at the mortuary of the Role 2 Medical facility at TK and commenced forensic processing of the remains. This included documenting, fingerprinting, collecting DNA samples and taking a series of photographs.

61. On 15 Aug 10, ADFIS Investigators obtained TPR Brown’s personal protective equipment (PPE) which was photographed together with a copy of his passport, Army ID and items for DNA comparison. TPR Brown’s PPE had by then arrived at TK with the remainder of FE- , which had a delayed extraction due to inclement weather. To assist the Coroner in any inquiry, ADFIS prepared an evidence trunk containing TPR Brown’s PPE, his personal effects (PE) and a separate ADFIS evidence file for transportation to Australia with TPR Brown’s remains. TPR Brown’s remains were transported to Australia to enable post mortem examination in Australia.
Repatriation

62. Members of 2 Cdo Regt and the Chaplain of the IRR attended on TPR Brown’s parents early on 14 Aug 10 to inform them of their son’s death.

63. TPR Brown’s remains were escorted from TK to Australia by MAJ and CPL  
   a. On 16 Aug 10, TPR Brown’s remains departed TK for aboard a RAAF C-130 after a memorial service and ramp ceremony conducted by JTF and ISAF forces.
   b. On 17 Aug 10, TPR Brown’s remains departed for Australia aboard a RAAF C-17 after a memorial service and ramp ceremony.
   c. On 18 Aug 10, TPR Brown’s remains arrived in Australia at RAAF Pearce and a ramp ceremony was conducted.

64. TPR Brown’s remains, his PPE and the ADFIS evidence brief were handed over to SGT of ADFIS on arrival in AS for delivery to the WA Coroner. An autopsy was conducted on Friday 20 Aug 10 in the presence of SGT and GPCAPT . Inquiries have revealed that TPR Brown’s personal effects were handed over to the SASR on arrival in Australia at RAAF Pearce for later delivery to his parents.

65. I am satisfied the repatriation was handled with due care and dignity and in accordance with reference I. To preserve the remains for a possible coronial autopsy, due care was taken by the escorting officers. Post incident procedures were conducted appropriately and records of all relevant documentation have been maintained by the TK.

66. Drugs and Alcohol. There is no evidence that drugs or alcohol were involved or contributed to TPR Brown’s death. A toxicology report provided to the WA Coroner, and sighted by the Inquiry team, confirms this fact.

Performance of Duty

67. From assessing the evidence and gathering witness statements there was no evidence of any person failing in the performance of his or her duties. The mission was well planned and well executed. All parties responded immediately and quickly to the contact and organised the AME efficiently. The post-mortem administration was performed well and in accordance with orders and the appropriate references.

Conclusion

68. TPR Brown was killed in action on 13 Aug 10 from multiple gunshot wounds. His death occurred in the straightforward circumstances of combat and as a direct result of INS action. TPR Brown was participating in a duly authorised mission conducted in accordance with the SOTG mission in Afghanistan.

69. Prior to the incident, individual and collective training, planning and orders were all thorough and used all available intelligence; and there were no shortfalls in these areas that contributed to TPR Brown’s death.
70. The members of the patrol reacted immediately in dangerous and chaotic circumstances and under heavy INS fire. The ability of the patrol to perform to the level they did and maintain cohesion is a testament to their training.

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

Findings

72. I find that the circumstances associated with the death of TPR Brown do not warrant the appointment of a COI.

Recommendations

73. I recommend against the appointment of a COI into this matter.

DOWNING
Colonel
Inquiry Officer

27 October 2010

Annexes:

A. Instrument of Appointment and Terms of Reference dated 24 Aug 10
B. Imagery
C. Quick Assessment
D. Addendum – Quick Assessment for CTG
E.
F.
G. Sketch of contact site by
H. SOTG Storyboard
I. Statement by
J. Statement by
K. Statement by
L. Statement by
M. Statement by
N. Statement by
O. Statement by
P. Statement by
Q. Statement by
R. Statement by
S. SOTG
T. SOTG
U. 
V. AD 604 Confirmation of Death TPR Jason Thomas Brown dated 131654Z Aug 10
W. Service Police Statement of
X. ADFIS MEAO
Y. AD 604 Confirmation of Death TPR Jason Thomas Brown dated 141050DE Aug 10