INQUIRY OFFICER'S REPORT INTO THE DEATH OF 8298024 TPR DR PEARCE AND INJURY TO IN AFGHANISTAN ON 8 OCT 07

References:

A. CDF Instrument of Appointment dated 29 Oct 07
B. CDF Terms of Reference dated 29 Oct 07
C. RTF 3 Quick Assessment by – *Death and Injury of AS FE During IED Incident* dated 8 Oct 07
D. DI(G) ADMIN 45-2 *Reporting and Investigation of Alleged Offences within the Australian Defence Organisation* dated 30 Oct 01
E. DI(G) PERS 11-2 *Notification of Service and Non-Australian Defence Force casualties* dated 18 Dec 01
F. ADFP 1.1.1 *Mortuary Affairs* dated Jan 07
G. DI(G) PERS 20-6 *Deaths within and outside Australia of Australian Defence personnel* dated 18 Sep 06
H. CDF Directive 12-2006 *Interim Arrangements for CDF Commissions of Inquiry into ADF Suicides and Deaths in Service* dated 30 May 06
I. Defence (Inquiry) Regulations, 1985, Part 8, *CDF Commissions of Inquiry* dated 26 Jun 07
J. ADFP 202 *Administrative Inquiries Manual*

Appointment and Terms of Reference

1. I, 8264599 LTCOL SG Durward, SC, having been duly appointed by Air Chief Marshal Allan Grant Houston, AO, AFC, Chief of the Defence Force, to inquire into the circumstances and facts surrounding the death of 8298024 Trooper David Ronald Pearce and injury to 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 Officer Team consisted of myself as the Inquiry Officer and two Assistant Inquiry Officers;

a. 8223745 COL Gary Bruce Hevey, RFD; and

b. 8223830 COL Peter John Short, DSC.

Introduction

3. On 8 Oct 07, at approximately 0930 hours local (1500 hours AEST) Australian Light Armoured Vehicle (ASLAV) call sign V30E struck an improvised explosive

device (IED) resulting in the combat death of TPR DR Pearce and injury to The vehicle sustained major damage as a result of the incident. V30E was part of a larger Australian force element conducting a reconnaissance mission within the Tarin Kowt Area of Operations. The incident occurred approximately 6 km north east of the Australian – Dutch Forward Operating Base known as Camp Russell (FOB Russell). The IED was placed by hostile opposition forces (the Taliban) targeting coalition military forces including Australian Defence Forces. A Quick Assessment conducted by is at **Annex B**.

Synopsis of Incident

4. Over the period 6 to 8 Oct 07 Reconstruction Task Force Two (RTF 2) conducted a reconnaissance task into the Chora Valley, north of FOB Russell. The purpose of the task was to site a future Afghan National Security Forces FOB and provide operational familiarity to RTF 3 as part of their relief-in-place program (the 'task'). The task was commanded by the outgoing Officer Commanding and consisted of both RTF 2 and RTF 3 personnel. During the return phase of the task on 8 Oct 07, ASLAV call sign V30E, as an element of the force advance guard moving south, was tasked with clearing the route for follow on forces Responding to directions from the patrol commander, the crew commander of V30E (moved the vehicle forward It was during this move that V30E struck what was assessed to be a pressure plate activated IED based upon an anti-tank mine (the 'incident'). As a result of the ensuing explosion, the driver was killed instantly (TPR Pearce) and the crew commander sustained non-life threatening injuries. The vehicle was immobilised sustaining significant damage to its left front wheel system, external hull and forward interior. The immediate area was subsequently secured and immediate first aid provided to was aero-medical evacuated to FOB Russell for further treatment. V30E was recovered to FOB Russell along with the body of TPR Pearce and the remainder of the patrol.

5. The area surrounding the incident is considered highly vulnerable due to the history of Taliban laid IEDs. The Task Commander had identified this area for additional route clearance measures and included such planning in his orders. The victim operated IED was highly likely to have been placed by the Taliban. Local Taliban forces claimed responsibility for the incident shortly afterward (page 1 of **Annex C** refers).

6. The forces structure of the force elements involved in the incident is detailed in **Annex D**. A detailed sequence of events is included at **Annex E**. The sequence of events has been reconstructed from witness statements and thus provides and explanation of how the incident occurred.

Persons and Vehicles Involved

7. **General.** The total force deployed consisted of both RTF 2 and RTF 3

8. **V30E (Struck Vehicle).** TPR Pearce was the driver of V30E and was the vehicle commander. statement is included as **Annex H**. The vehicle call sign was designated V30E. Its Army Registered Number was 16458. The vehicle was a subordinate element within a larger force element (see para 6 and **Annex D**). It was the only vehicle damaged as a result of the incident.

9. **Passengers.** A number of passengers were travelling inside V30E when it was struck.

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10. Their statements are included in **Annexes I** to **Q**.

11. **Other Witnesses.** A number of other personnel who participated in the task, and were significant to the incident, have provided statements at **Annexes R** to **JJ**.

12. I advise that I found each of the witnesses interviewed to be honest and forthcoming. They appeared to be capable, well trained soldiers who handled the

difficult task with which they were confronted with professionalism. I found no evidence of collusion between them or any attempt to reconstruct their version of events. While there were some small variations in relation to unimportant matters those variations are such as one would expect having regard to the vagaries of individual memory, different perspectives from which observations were being made and the friction experienced in circumstances of combat.

Involvement by Civil and Service Authorities

13. An Australian Defence Force Investigation Service member conducted interviews and collected statements from all significantly involved personnel shortly following the incident. was replaced in-theatre by another ADFIS investigator, , who completed a Service Police Report which is included as **Annex KK**. statement and copies of both investigators' notes are appendices to **Annex KK**. A service investigation was not conducted. To date, there has been no involvement of civil authorities.

14. Due to security concerns, no investigative authority has returned to the incident site. This is not regarded as an impediment to the investigation or findings of this Inquiry. It is noteworthy that of the incident was available to the Inquiry Team which aided the reconstruction of events leading up to the incident .

Involvement of Other Military Forces in this Incident

15. Up until the time of the incident, no other military forces were involved in the conduct of this task or the actual incident. Post-incident, the Afghan National Police (ANP) attended the scene and provided an escort vehicle during the recovery to FOB Russell.

16. There has been no evidence to suggest the involvement of local Afghani Security Forces involved in this incident.

17. No other military force has conducted an investigation into this incident.

Involvement of Civilian Personnel in this Incident

18. There was no evidence to suggest any local civilian personnel were involved in this incident.

19. There was no collateral damage as a result of the incident.

Death and Injuries

20. **Deaths.** 8298024 Trooper David Ronald Pearce (posted to 2/14 was killed as a result of this incident. TPR Pearce had suffered massive head and lower limb injuries and there can be no doubt his death immediately followed the explosion. A copy of the Medical Certification of Death is included as **Annex MM**. An Identification Photographic Supplement is at included as **Annex NN** (this should be accessed with care noting it contains body images).

21. TPR Pearce's next-of-kin is was informed by COMD 7 BDE at approximately 2230 h (AEST) on 8 Oct 07. TPR Pearce's body was returned to Australia and he was buried with full military honours.

22. At all times following his death, PTE Pearce was treated with dignity and respect by his comrades. His repatriation to Australia and the military funeral was indicative of a man who died in the service of his country. The RTF Recreation hut at Camp Russell has been named 'Poppy's Place' in honour of TPR Pearce.

23. **Injuries.** (posted to 2/14 was injured as a result of this incident. sustained a superficial injury to his face. He was treated at the scene of the incident and taken to FOB Russell by aero-medical evacuation for final treatment which included suturing of a wound and some minor dental treatment. He has since returned to full duties and has no visible permanent injuries as a consequence of the incident. A copy of the clinical notes relating tc injury and treatment are at **Annex OO**.

24. at approximately 1800 h (AEST) on 8 Oct 07.

25. Despite the presence of other personnel travelling inside the vehicle at the time of the incident (listed at para 9), no other apparent injuries were reported as a result of this incident. The injury radius was confined to the driver and crew commander areas.

Damage to Vehicles and Property

26. **Vehicles.** Vehicle call sign V30E (ARN 16458) sustained major damage as a result of the incident. The vehicle was located at Camp Russell and approval was given for its release for subsequent repair. A Vehicle Technical Inspection Report is included as **Annex PP**. Photographic images of the damage sustained by the vehicle are at **Annex QQ**. No other vehicles were damaged as a result of this incident.

27. **Property.** TPR Pearce's issued combat equipment and clothing were destroyed either as a direct result of the incident or subsequently as a result of blood contamination. No other property, military or civilian was damaged as a result of this incident.

28. **The IED.** An assessment of the IED was made by the RTF 3 OED Team from sustained by the vehicle and known Taliban IED techniques. The Hasty IED Report and the Pre-Technical Report (IED Report) are included as **Annexes RR** and **C** respectively. The IED was assessed to be a victim operated pressure plate improvised explosive device (VO PP IED). The device was initiated by the pressure of ASLAV call sign V30E's left front wheel as it passed over the pressure plate. This action completed the electrical circuit which fired the main charge. The IED was concealed by dirt and was laid just below ground surface. The location of the IED was positioned in terrain which only military class vehicles could negotiate. The timing of

emplacement or whether the explosion was observed by hostile forces can not be established. , it is unlikely that the IED was placed just prior to the arrival of the Australian force element. Noting the location of the IED, I am satisfied that the IED was placed to target any coalition military vehicle on an opportunity basis.

29. The IED Report at **Annex C** states "this device is

The technical analysis of vehicle armour protection is beyond the expertise of the Inquiry Team. Notwithstanding this and noting the advantages of the ASLAV as referred to in para 38 of this report, there is no suggestion that the ASLAV variant is not suited to the operational environment currently confronting RTF 3.

Environmental Conditions

30. **Terrain.** The terrain traversed during the conduct of the task is largely open, undulating, dry and dusty. There are large fields of view however dust plumes from moving vehicles restrict the visibility of following vehicles. Vehicle dust plumes can be observed for significant distances. There is scant vegetation except for localised scrub and domestic crops centred on irrigated areas. The numbers of routes available to traffic is limited and are generally in poor condition. The general area is sparsely populated other than in towns/villages where much of the population is concentrated. The local nationals reside in a system of small compounds, sometimes within larger compounds. The compounds are constructed from mud brick surrounded by walls two to eight feet tall. The compounds and walls are generally referred to as quala (pronounced as 'koala') compounds and quala walls. There is little symmetry to the design of the compounds as many are added on to pre-existing structures over time. Life is centred upon the Tirin Rud River which provides water for irrigation of crops, the main source of income. The irrigated areas are commonly referred to by coalition forces as the green belt (GB).

31. **Incident Site.**

It is a large, open and undulating feature. is an obstacle to vehicle movement. The north-south route (which the force was travelling on consisted of a compacted single dirt lane. The west-east route ( ) which was the next route to be traversed was a hard compacted single dirt lane. Despite mapping indications, this route is not a substantial carriageway by way of size or condition. Notwithstanding this, both routes are regarded as relatively high use routes. The immediate area was populated by locals who were largely concentrated along the irrigated channels and a modest number of Afghani's (presumably local and non-local) located at The irrigation channels and local dwellings provided further obstacles to vehicle movement.

32. **Weather.** The weather conditions at the time of incident were reported as cool but fine with no inclement conditions prevailing. The weather is assessed as having no impact on the outcome of the incident.

33. **Visibility.** The incident occurred early in the day and general visibility was excellent. Dust plumes from moving vehicles significantly restricted the view of following vehicles.

34. **Cultural Environment.** The local population were considered to be a mixture of pro and anti Government of Afghanistan and most displayed ambivalence toward the presence of coalition forces.

Operational Conditions

35. **Adequacy of Intelligence.** The local area was assessed as high threat. There had been a significant history of IED attacks and IEDs located along the routes within this area. The area itself had been dubbed 'IED Alley' by coalition forces. The area was assessed to include a number of locals who were either Taliban or supportive of Taliban anti-coalition operations. There was no understatement of the threat at the time of the incident.

36. **Adequacy of Orders.** Detailed orders were issued by the Officer Commanding on 5 Oct prior to the force departing FOB Russell on 6 Oct issued further orders throughout the conduct of the task as appropriate. (ASLAV Troop Commander) attended all orders groups and issued orders to his assigned force elements as required. Orders for the return movement to FOB Russell occurred on the evening of 7 Oct.

orders for the return task have been reviewed by the Inquiry Team. I also note that CO RTF 3 was in attendance at the 5 Oct orders and described them as "...well delivered and clear..." (**Annex JJ** refers). The detail of the written orders and the statements made by witnesses lead me to the conclusion that all orders were adequate, timely and effective.

37. **Adequacy of Task Preparation.** There was a belief expressed by some witnesses that time made available for task rehearsal was less than desirable. It is well understood that forces that have been operating for protracted periods of time are capable of condensing task preparation. Alternately, recently deployed forces require comparatively greater time for task preparation. Since the task was led by the outgoing and experienced deployed force (RTF 2 force elements), the preparatory time made available was based around their requirements. Notwithstanding, the specific actions that took place leading up to the incident could not have been mitigated by the provision of additional task preparation time. The incident occurred as a result of the actions of hostile forces and was influenced by specific decisions made, not techniques or tactics. It is notable that this task preparation shortfall was acknowledged by CO RTF 3 and has been captured in the RTF 3 After Action Review (**Annex SS**). Whilst task preparation was less than desirable noting the relative inexperience of the recently deployed RTF 3 elements who participated in the task, I am satisfied that it was not a contributing factor in the actual incident.

38. **Adequacy of Equipment**

39. **Adequacy of Equipment – Individual Combat Issue.** All personnel wore issued combat ballistic vests in addition to standard combat clothing and enhanced combat helmets. Additionally, ASLAV vehicle crews wore neck collars on ballistic vests and crew commanders wore blast proof eye protection. Notwithstanding, the force of the explosion was of such magnitude that no clothing or equipment could have prevented the death of TPR Pearce. Further, the wearing of the ballistic collar by more than likely reduced potential further injury by deflecting blast away from his neck and face.

40. **Adequacy of Equipment –**

[1] Note: Asst IO COL Short has worked with armoured vehicles since 1985 and commanded the ASLAV/IMV based Al Muthanna Task Group Two, Iraq in 2005/06.

The IED that struck call sign V30E was a victim operated IED

41. **Adequacy of Equipment – ASLAV Recovery Capability.** After the incident a recovery operation was necessary to retrieve the severely damaged ASLAV. This task was complicated by the non-availability of a suitable platform that could recover the vehicle quickly and return it over a distance. An ASLAV-Fitters vehicle was required to recover the vehicle.

The availability of a purpose designed recovery vehicle would have allowed for a timely and more efficient recovery operation. I understand that the deployment of a suitable recovery vehicle has been approved. However, this capability had not arrived in theatre with effect late Dec 07.

42. **Adequacy of Techniques, Tactics and Procedures (TTPs). Annex SS** documents a number of TTPs that were identified by RTF 3 force elements as requiring improvement as a result of the conduct of the task and the incident. Whilst some of the TTPs identified relate to TTPs leading up to the incident, they are inconsequential to the incident and not considered to be causal factors.

43. **Adequacy of Command and Control.** As discussed in para 36, the orders throughout the task were effective. Notwithstanding this, there were some differing views expressed about the adequacy of effective command and control. I considered these views and found that whilst they related to the conduct of the task, they were not causal factors in the incident. I note that the location of the respective commanders were such that control could be effected in so far as the circumstances allowed. For the reasons outlined in para 40, the level of control available to was significantly diminished and as such, he had to rely upon the training, experience and intuition of his subordinate commanders.

It is a common theme throughout the incident.

44. **Adequacy of Training.** A number of members believed their training and preparation for this operation was sufficient. Whist the task was planned and lead by an RTF 2 commander, the route clearance component was conducted by the relatively inexperienced RTF 3 cavalry troop. The experienced RTF 2 Cavalry Troop Sergeant accompanied . Notwithstanding this, most witnesses believed they were sufficiently trained and prepared to conduct the task. Some would have preferred greater force preparation time as discussed in para 37. Many members have a substantial amount of operational experience having previously deployed on multiple operations. It was noted by the

Inquiry Team that RTF 3 had not trained against a recently identified Taliban tactic This training shortfall was briefed to RTF 3 by RTF 2 and it has been established by the Inquiry Team that the Combat Training Centre and RTF 4 are informed. I am satisfied that the training required to conduct this type of task was satisfactory prior to the deployment of the force.

45. Prior to the commencement of the Inquiry, (the brother-in-law of TPR Pearce) questioned why an 'inexperienced driver such as TPR Pearce was being employed in a high threat area'. Experience is a relative concept and in the profession of arms, can only be gained by on-the-job exposure. I have already stated the level of training conducted by RTF 3 leading up to deployment was satisfactory and I note from witness statements that TPR Pearce was regarded as a 'capable' and 'experienced' driver. I also note that the TTPs employed by the deployed forces do not change from a high to a low threat area. It is the level of risk adopted that changes and this is a command decision in judgement. ASLAV vehicle drivers are not called upon to make such decisions and therefore, their individual actions reflect decisions made by vehicle crew commanders and force element commanders. I also note from the current operational conditions that no location can be denied to the anti-Coalition forces and therefore no 'relatively safe' areas exist to provide a graduated level of exposure to 'inexperienced' personnel. I am satisfied that TPR Pearce was sufficiently force prepared by way of training and skills to be deployed as part of RTF 3.

Alcohol and Drugs

46. There is no evidence identifying alcohol or drugs as factors in this incident.

Other Factors

47. The significant factor that contributed to this incident was the deliberate emplacement of the IED by anti-coalition forces (the Taliban) for the purposes of killing or injuring coalition military forces including ADF personnel. The area is a well known location favoured by anti-coalition forces for emplacing IEDs. The area has a well recorded history of IED attacks and incidents. There were no other factors of significance that contributed to the incident.

Duty Status and Authorisation

48. The force elements involved in the incident were conducting a tactical level reconnaissance task that had been duly authorised by the appropriate authority, Commander Joint Task Force 633 (CJTF 633) and Task Force Uruzgan Commander. This was reinforced during a meeting between CJTF 633 and the Inquiry Team on 28 Nov 07. All ADF personnel involved in the incident were on authorised duty at the time the incident occurred.

Performance of Duty

49. The task was conducted in accordance with issued orders and established tactics, techniques and operating procedures. There was no evidence of personnel failing in their performance of duty.

Post-Incident Procedures

50. **Notification Procedures.** A possible breach in notification procedures was communicated to the Inquiry Team by believed other personnel within Australia (namely neighbours) knew the identity of the deceased member before the next of kin was formally informed. From the Inquiry Team's observations, it would appear that the reporting and notification procedures carried out were in accordance with references D and E. The only potential areas of breach detected were:

a. the identification of the friendly force KIA by actual name over the radio shortly after the incident occurred; and

b. phone call to NOK.

51. The time lapse between the incident occurring and the order to lockdown communications may have provided an unknown member time to make contact with someone in Australia. The Inquiry Team could see no reason why the KIA member should have been identified over the radio in this circumstance. This matter needs to be addressed by the enforcement of radio operating procedures that preclude the identification of individuals under such circumstances.

52. It was noted that advised his NOK by phone at 1800 h (AEST) on 8 Oct 07. TPE Pearce's NOK were informed later that evening at approximately 2230 h (AEST). Whilst there is no suggestion that was the source of the breach, and it is emphasised the source of the possible breach is not known to the Inquiry Team, the identity of all personnel involved was known well prior to the NOK being advised. Whilst this is not considered remarkable in itself, it would require a unit local inquiry to confirm if and how a notification breach occurred.

53. **Post-Mortem Procedures.** The post-mortem procedures, namely the identification, handling and repatriation of TPR Pearce, were carried out in accordance with references F and G. An autopsy was not conducted by the Queensland coroner on TPR Pearce's body. Whilst I consider an autopsy to not be necessary in this case, I am unaware why such a decision was made.

Media Reports

54. At **Annex TT** is a media report filed by Mark Dodd of ABC News which speculates about the role of Afghanistan National Police (ANP) in the death of TPR Pearce. As previously stated in para 16 there is no evidence to suggest the involvement of local Afghanistan Security Forces involved in this incident.

Weaknesses in the System and Method of Control

55. The identification of the member KIA by actual name, over the radio, was a weakness in the method of controlling notifiable information. The matter needs to be reviewed in order to avoid a repeat and possible breach of NOK notification procedures.

Conclusions

56. TPR Pearce was killed and injured on 8 Oct 07 by the emplacement of an IED by anti-coalition forces in order to kill or injure coalition forces. TPR Pearce's death occurred in circumstances of combat.

57. The equipment that TPR Pearce and wore, particularly personal protective equipment was appropriate to the task and the level of threat and was not a contributing factor to either death or injury. Further, the vehicle platforms available to the RTF are appropriate to the task. No vehicle exists which protects against every hostile circumstance.

58. Training, intelligence and orders were all sufficient prior to the conduct of the task. Further, TTPs conducted and control exercised during the contact was sufficient. There were no other contributing factors to this incident.

59. A Commission of Inquiry (COI) is unlikely to discover any further relevant material, information or evidence in the context of the Terms of Reference.

Recommendations

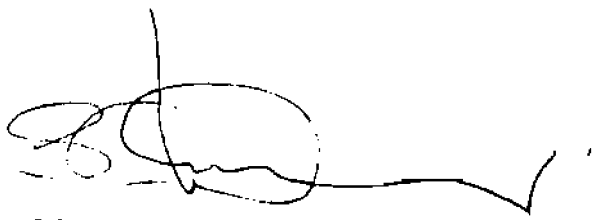
60. It is recommended that;

a. the appointment of a Commission of Inquiry into this incident is not warranted,

b. JTF633 review policy and RTF 3 review radio operating procedures to reinforce the minimisation of reference to actual names for notifiable incidents,

c.

d. AHQ facilitate the timely deployment of an appropriate recovery vehicle to the RTF.



SG DURWARD, SC
Lieutenant Colonel
Inquiry Officer

22 Jan 08

Annexes:

A. Instrument of Appointment and Terms of Reference

B. Quick Assessment by dated 8 Oct 07
C. Pre-Technical Report 07/017 (IED Report) dated 8 Oct 07
D. Task Force Structure
E. Sequence of Events
F. Statement by
G. Statement by
H. Statement by
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. Statement by
T. Statement by
U. Statement by
V. Statement by
W. Statement by
X. Statement by
Y. Statement by
Z. Statement by
AA. Statement by
BB. Statement by
CC. Statement by
DD. Statement by
EE. Statement by
FF. Statement by
GG. Statement by
HH. Statement by
II. Statement by
JJ. Statement by
KK. ADFIS Report by dated 21 Nov 07
LL.
MM. Medical Certification of Death – 8298024 TPR DR Pearce
NN. Identification Photographic Supplement – 8298024 TPR DR Pearce
OO. Clinical Treatment Notes
PP. Vehicle Technical Inspection Report
QQ. Photographic images of the damage sustained by the vehicle (electronic copy only)
RR. Hasty IED Report dated 8 Oct 07
SS. RTF 3 After Action Review dated 17 Oct 07
TT. Media Report by Mark Dodd, ABC News dated 14 Dec 07