INQUIRY OFFICER REPORT INTO CIVILIAN CASUALTY INCIDENT INVOLVING SOTG ON 27 MARCH 2011 IN THE VICINITY OF AFGHANISTAN

References:

A. CJOPS Instrument of Appointment of Inquiry Officer, dated 12 Apr 11
B. ADFP 06.1.4 - *Administrative Inquiries Manual*
C. QA Into SOTG CIVCAS Incident – 27 Mar 2011, dated 28 Mar 11
D. Decision Brief for CDF
E. DSOM 25 MAR 11
F. E-mail DSOM extension to to 27 Mar 11
G. Op SLIPPER CDF *Rules of Engagemen*
H. CJOPS Directive
I. Defence Instruction (General) ADMIN 45-2-*Reporting and Investigation of Alleged Offences within the Australian Defence Organisation*
J. Inquiry Officer Report,
K. Map 1:25 000 DEH RAFSHAW 25K NAV MGRS – 41S QS

Time Zone used throughout this Report: Local Afghanistan Time (unless noted otherwise)

Introduction

1. I, COL Goodyer, having been appointed to inquire into a matter concerning Joint Operations Command, namely an incident that occurred on 27 March 2011 involving members of the Special Operations Task Group XV (SOTG XV) which, amongst other aspects, involved a small child sustaining a very serious gunshot wound (GSW) from which he later died (the 'Incident'), and to collect evidence and submit a written report upon the matters included below herein submit my report.

2. During the Inquiry I was ably assisted by Legal Officer, COL Mc Lachlan and Inquiry Assistant, WO2 Matheson.

3. My Instrument of Appointment (IOA) and Terms of Reference (TOR) are at Enclosure 1. A matrix of my Findings and Recommendations is at Annex A.

Background

4. On 27 Mar 11 Elements of SOTG XV partnered by Afghanistan National Security Forces (collectively referred to as the 'Partnered Force') were conducting operations in the vicinity of Chora in Afghanistan. During the conduct of assigned tasks the Partnered Force was engaged by small arms fire from the far side of a stream approximately 350 to 400 metres to their west. The Partnered Force a local

child was identified as having sustained a GSW to the abdomen and it was discovered an adult male had also died from GSWs. The child was evacuated to Multi National Base – Tarin Kowt (MNB-TK), arriving [redacted] later and was admitted to the Role 2 Hospital at MNB-TK. The child was stabilised at the Role 2 Hospital and later transferred to the Role 3 Hospital at Kandahar (KAF) due to the serious nature of his injuries. The child had a poor diagnosis and was removed from active care by his family. In turn he succumbed to his injuries and died on 2 Apr 11.

5. A Quick Assessment (QA) was conducted into the incident and is attached to this report as enclosure 2.

Inquiry Methodology

6. The methodology adopted for this Inquiry was consistent with the IOA and TOR. The Inquiry was conducted as closely as practicable to the procedural guidance as contained in chapter six to the Australian Defence Force Publication (ADFP) 06.1.4 – *Administrative Inquires Manual*, 2nd Edition, Amendment List 1 dated 07 Aug 07 (reference B) – 'Inquiry Officer Inquires' and CDF Directive 04/2010 *Interim Arrangements – Quick Assessments and Administrative Inquiries* dated 23 Apr 10.

7. The inquiry methodology adopted was also consistent with the need to complete the Inquiry in a timely manner and as far as practicable, minimise any adverse impacts on the conduct of Australian Defence Force (ADF) operations in the Middle East Area of Operations (MEAO).

8. All witness interviews were conducted IAW the requirements of reference B. Prior to the conduct of any ADF witness interview each witness was shown a copy of the Inquiry Officer's IOA, the Inquiry Team's signed 'Statements of Impartiality and Independence' (Annex B) and the TOR. Each ADF witness was also provided a copy of their 'Rights and Obligations as Witnesses before an Inquiry Officer or Inquiry Assistant' and was required to sign a 'Privacy Notice'.

9. ADF witnesses were also asked by the Inquiry Officer at the commencement of each interview if they had read these documents, had understood the content of these documents and if they had any questions arising from the content of these documents. Witnesses were also informed by the Inquiry Officer at the commencement of each interview that no guarantee of confidentiality could be given in respect to the information provided in the course of the Inquiry.

10. At the conclusion of each interview and IAW reference B, ADF witnesses were reminded that it is an offence to disclose information or records of an inquiry without authority.

11. Prior to the conduct of interviews with civilian witnesses, it was explained to each witness that they were not obliged to answer questions. Their permission was also sought to record the interview. The Inquiry Officer explained these matters to the witness [redacted] before the recording of his evidence and did not make subsequent reference to this advice when the recorder was operating. This approach was adopted by the Inquiry Officer out of respect for the witness as he was a [redacted] and to ensure any cultural sensitivities were accommodated.

12. All interviews were conducted in the presence of all members of the Inquiry Team. At no time during the conduct of any of the witness interviews was evidence taken under oath or affirmation.

13. The recorder malfunctioned during the interview with call sign [redacted] The remainder of the unrecorded evidence was not materially different from or contrary to the remaining evidence.

14. The Inquiry Team recorded all witness interviews. A transcript of each interview was prepared and presented to ADF witnesses for checking and to acknowledge that it was a true and correct transcript of their interview. Witness corrections were marked on the transcript. There was no opportunity due to operational restrictions to provide transcript to [redacted] and US military personnel who were interviewed by the Inquiry Team.

15. Two witnesses had prepared statements prior to their interviews and provided them to the Inquiry Team after they had been briefed on their rights and obligations and at the conclusion of their interviews.

16. All information relevant to the Inquiry that was practicable to obtain has been obtained and considered in the preparation of the Inquiry Report. It is also noted that:

a. although the collection of evidence does not need to be IAW the 'rules of evidence', in order to reach the Inquiry Officer's findings and subsequent recommendations, these rules were applied in the analysis of the evidence collected;

b. the Inquiry was conducted in accordance with the rules of natural justice and procedural fairness;

c. no witness refused or failed to answer any question of the Inquiry Team;

d. no person refused or failed to produce documents or articles to the Inquiry Team;

e. there was no requirement to pay witness expenses;

f. there were no guarantees of immunity or confidentiality given to any witness;

g. no notices of adverse findings were issued by the Inquiry Team; and

h. the Inquiry was not conducted in public.

17. One witness requested the presence of the [redacted] during their interview. The Inquiry Officer consented to the request.

18. The Inquiry Team spoke to a representative of Copenhagen Contractors who manage the mortuary affairs at the Role 3 Hospital KAF. They informed the team that deceased civilians were handed back to family members IAW set procedures which take into account cultural sensitivities. They did not consent to a formal interview.

19. At the Role 2 Hospital MNB-TK the Australian Regimental Medical Officer (RMO) was interviewed together with a US surgeon. This approach was adopted as they had worked in unison to stabilise the child. They also both had limited time available to conduct the interview because of urgent operational requirements.

20. There was no formal correspondence between the Inquiry Officer and the Appointing Authority. The Inquiry Team were in regular telephone contact with the Legal Global Operations' staff at HQJOC. During these conversations the Inquiry Team provided status reports on the progress of the Inquiry.

21. The Terms of Reference and Inquiry plan were reviewed IAW CDF Directive 4/2010 dated 23 APR 10.

Parties interviewed

22. Annex C provides details of the witnesses interviewed. The witnesses interviewed by the Inquiry Team provided all the relevant evidence which was practicable to obtain. Annex D contains the transcripts of the witnesses interviewed.

23. All witnesses interviewed were found to be honest, reliable and informative. I found no evidence of collusion between any witnesses or any attempt to reconstruct their version of events. There were some minor variations between witness accounts in relation to certain matters. These are expected taking having regard to the different perspectives of the witnesses and the impact of the events on the day.

24. As explained subsequently in this report, I was unable to interview the father of the child or members of the family of the deceased male.

Date, Time and Place of the Incident

25. The Incident occurred on 27 Mar 11 at approximately [redacted] at [redacted]

Geography

26. The Incident occurred along the banks of a wide slow flowing shallow stream. The stream consists of a main channel with the remainder of the stream width containing gravel deposits. The stream flows north to south and the area where the contact took place was at a bend where the stream flowed west for some 200 metres before turning and flowing in a south easterly direction for some 300 metres and then resuming its southerly course.

27. The location of the adult males that engaged the Partnered Force was on the western bank of the stream on some terraced ground adjacent to the apex of the bend in the stream. The terraces, with lower, mid and upper levels were bisected by a narrow track suitable for people or motorbikes, visible through gaps in the scrub. The terraces were delineated by rows of small trees and scrubs, dense in parts but with noticeable gaps. On the terraces themselves crops and small trees were growing; however due to the season did not have full foliage.

28. [redacted]

Compounds were located on both sides of the stream some several hundred metres from the stream bank with most activity seen occurring in and around compounds on the western bank of the stream.

29. The Inquiry Officer, could not visit the site; however, a The Inquiry Team was able to view imagery from the area in real time and select the most applicable imagery for inclusion with the report. A series of annotated images is at Annex E together with a map of the area marked with the relevant locations.

30. **Timeline of Incident**

a.	The Partnered Force commence foot infiltration	27 Mar 11
b.	Troops In Contact (TIC) declared	27 Mar 11
c.	Capture of initial position; 1 x KIA declared	27 Mar 11
d.	Aero Medical Evacuation (AME) requested via	27 Mar 11
e.	AME wheels up at Incident site	27 Mar 11
f.	Mission aborted, return to vehicles with child's father	27 Mar 11
g.	AME wheels down at MNB-TK	27 Mar 11
h.	Child admitted to Role 3 Hospital MNB-TK	271351DE Mar 11
i.	Deceased adult male	27 Mar 11
j.	Partnered Force complete in MNB-TK	271617DE Mar 11
k.	Father re-untied with child at Role 2 Hospital MNB-TK	271700DE Mar 11
l.	Child conveyed to Role 3 Hospital KAF	271730DE Mar 11
m.	Child removed from life support	312200DE Mar 11
n.	Child is pronounced dead	020053DE Apr 11

Mission of the Partnered Force

31. In accordance with reference E and F; the Partnered Force were conducting a Operation at on 27 Mar 11. During this operation they

32. Following the completion of this task, the Partnered Force were ordered to hold their position at the and stand by for a potential task to

33. The orders applicable to [redacted] are at Annex F.

Details and disposition of the Partnered Force personnel and units involved

34. [redacted]

35. [redacted]

36. **Coalition.** The Coalition Forces involved in the Incident were:

a. two AME helicopters;

b. [redacted]

c. the US Role 2 Hospital MNB-TK; and

d. the US Role 3 Hospital KAF.

Circumstances of the Incident

37. After being given approval to proceed with [redacted]

38. [redacted] Witnesses recalled the atmospherics changed during the approach march with local nationals not making any contact with the patrol, which would be normal in a more permissive area.

39. During [redacted] they were engaged with small arms fire (SAF) from the far side of a creek bed [redacted] The Partnered Force [redacted] Several adult males were identified with weapons. The partnered force [redacted] and discovered one dead male and one wounded child.

40. On discovery, the child was provided immediate treatment and stabilised by the medic, call sign The child was assessed as a Priority 1 casualty. AME was requested. Call sign ttempted to move all non essential personnel away from the child and t this time the ecame agitated, believing they were being kept from seeing the child and that there had been no weapon discovered on the dead male. They said they could not be blamed as they ha nd the fter treatment by callsign ssisted by the child was then evacuated to MNB-TK. On arrival at MNB-TK approx ater, the child was admitted to the Role 2 Hospital MNB-TK.

41. Two possible insurgents were observed withdrawing to the north by the nd members of the nd later reported entering into a compound. Call sign made the decision not to follow them due to the 'instability' of the Call sign did not observe any suspected insurgents leaving the contact site. They did; however, report seeing two males in the vicinity of a compound in which at least two weapons ould be seen leaning against a wall approximately 200 metres from ocation. hen captured images of the Incident site, destroyed medical paraphernalia used when treating the child. They then moved

Status of any Afghan local nationals (LNs) involved in the Incident

42. As nd were preparing to move number of LNs arrived at the Incident site, some who were in a distressed state. Through questioning of the LNs it was established the dead adult male was the child's uncle. was informed by a LN that he was the father of the child and the brother of the dead male. The father of the wounded boy said his son had fallen off a wall one or two days previously and had sustained a cut on his forehead. He also stated his brother had taken the boy to a local clinic or medic close by and had been travelling home on a motorcycle. The interpreter was also informed the father of the child was a local farmer. Once the identity of the father was established he was encouraged to o be with his son at MNB-TK. The father was initially reluctant to accompany because he wished to remain to bury his brother before sunse The father was reunited with his son at the Role 2 Hospital MNB-TK at approx 1730DE.

43. It would appear from the evidence a very quick assessment was made by some members of t the scene that the dead male was an 'insurgent'. For example, in his evidence, call sign sked prior to any "Would you like us to deal with the enemy KIA". The assessment of mmediately following the contact and in subsequent reporting states the dead male was an insurgent.

44. However having regard to all the available evidence, the assessment that the dead male was an insurgent is questionable. No spent cartridges were found on or in the vicinity of the dead male or in the immediate search area. No material found on the dead male indicated that he was an insurgent. The area surrounding the body was mainly cultivated soil with some small plants.

45. With the exception of the SOTG and t the site, SOTG personnel were adamant if a person hey had definitely fired a weapon. This is reflected in the evidence of the QA officer who stated that if a person or as he expressed it, hat person must have fired a weapon and this formed the basis for his conclusion in the QA report. CO SOTG was also of this opinion and reiterated this belief in his evidence to the Inquiry Team. Both the QA officer and the CO exhibited an incomplete understanding of

46. Advice provided to the Inquiry Officer by the s that the The tester must also take into account the context in which it is conducted. It cannot be used to determine if s present and is prone to false positives. re present in the environment in Uruzgan, including commonly used The ndicates the types of he dead male tested positive against. The does not indicate s a possible result.

47. To further satisfy the veracity of the information provided to the Inquiry Team, was conducted with two firers by th s a highly experienced member of th with qualifications and operational experience usin Before the test commenced, both firers were Jsing a A was then taken of the firer's hand, forearm and sleeves

48. I also consulted a scientific expert at Defence Science Technology Organisation (DSTO) on this matter. In an e-mail response to a question about interpretin for this particular Incident, the DSTO scientist replied that th on the body of the dead male are unlikely to be the result of the shooting itself. Importantly, the scientist advised that a is really only the initial screening and should not

be relied upon on its own and alternative should be used to confirm (or not) initial findings.

49. Upon checking other available within SOTG it was noted that a report was received indicating the dead male was not an insurgent (Annex G) and was reported to be the village clergyman. This report was available at the time during which the QA was being prepared. Having checked reporting it is reasonable to expect that the QA officer would have also checked other available within SOTG to confirm or otherwise confirm the identity of the dead male. It appears that this did not occur.

50. In my opinion the QA officer did not take in to account the relationship between the child and the dead male. It is unclear why, having regard to the circumstances, the dead male has been labelled an insurgent and not a civilian accompanying a small child.

51.

52. I have no reason to dispute the account given by the father of the child immediately after the Incident; that is, his brother was returning home from taking the child and his teenage son to a clinic on the red motorbike found at the scene. The personal effects of the dead male collected at the scene included in a variety of small ziplock bags containing tablets with markings consistent with paracetamol tablets and antibiotics. One container was labelled antibiotics. Chemical analysis of the tablets confirmed the presence of a variety of antibiotics and paracetamol tablets. As stated in evidence by the medical staff at the Role 2 Hospital MNB-TK, the child had a prominent head wound that had occurred some 24 hours prior to the Incident and it is reasonable to conclude the tablets and medicines were to be used to treat the head wound the child had suffered.

53. I also question whether it is realistic to expect that the dead male (who was the child's uncle) could or would have used a weapon to engage the Partnered Force given the child was found tucked or huddled next to him and had not been noticed during of the site. In the circumstances it is reasonable to conclude the dead male was in fact trying to protect the child during the engagement. I also note no one had sighted the dead male or child during the assault phase.

54.

55. **Findings.** I find that:

a. Based on the evidence available to me the deceased male who died at the scene of the engagement was not actively taking part in hostilities and in my opinion was not associated with the insurgents who engaged the Partnered Force.

b. The lack of rigour given to the analysis to establish the identity of the alleged insurgent by within SOTG is poor. Processes and

procedures must be improved within SOTG to check all available sources of information in order to properly identify alleged insurgents.

c. The understanding and interpretation of [redacted] results by the senior members of SOTG is inadequate and based on false assumptions concerning test results.

d. The QA did not indicate that appropriate weight had been given to all of the evidence in making a determination as to the identity of the dead male.

56. **Recommendations.** I recommend that:

a. [redacted] processes and procedures be reviewed within SOTG to ensure adequate mechanisms are in place to check the identity of alleged insurgents.

b. Remedial training to be conducted for all ranks of SOTG Rotation XV to ensure an adequate understanding of the interpretation of [redacted] conducted in the field. This training should be extended to cover Mission Specific Training (MST) and Mission Rehearsal Exercises (MRE) in Australia for follow on rotations.

Command and Control (C2) arrangements within and between the Partnered Force

57. The Partnered Force consists of [redacted]

58. [redacted]

59. Having regard to the above C2 arrangements it is difficult to imagine how call sign [redacted] and the SOTG mentors would have been able to influence [redacted] the [redacted] and dissuade [redacted] from abandoning cooperation following the discovery of the wounded child. The CO noted if the [redacted] Call sign [redacted] noted that after this Incident the [redacted] remained nearby and discussed what had taken place and returned to base with the [redacted] elements. According to call sign [redacted] within 24 hours the [redacted] were working normally as part of the Partnered Force without any residual issues emerging.

60. Notwithstanding the [redacted] behaviour during the [redacted] of this Incident the command and control arrangements for the Partnered Force throughout the engagement appear

to be sound taking into account that SOTG is working alongside and mentoring a

61. There is no evidence of any specific weakness in the command and control arrangements within SOTG or

Partnered force's knowledge and visibility of the hostile elements and civilians in the vicinity of on 27 Mar 11

62. The Partnered Force was aware the The eported the Partnered Force was made aware of nd the possibly there would be an insurgent presence in the vicinity of the nd possibly urther north t is possible that the presence of ould account for the engagement with the Partnered Force.

Orders

63.

64. On the morning of 27 Mar 11 During that time it was tasked to standby for a potential task to nd derived a scheme of manoeuvre All members interviewed had a good understanding of the mission.

65. Civilians not taking part in the hostilities were not targeted.

66. CO SOTG commented in his evidence that he was confident that the members o They had received clear direction during their training. He had not seen or heard of any incident where civilians had been targeted. The message had been very strongly provided to all members of SOTG that civilians were not to be targeted.

67. After conducting over 40 interviews into this Incident I am confiden

Authority to Conduct the Operation

68. CO SOTG in his evidence stated provided approval for operation which is the norm for these types of operations. This operation included the As per standing arrangements Planning and preparation was then undertaken by the Partnered Force prior to the conduct of the operations in the vicinity of on 27 Mar 11.

Assessment of Hostile Elements and Civilian Presence

69.

70. In his evidence the S2 advised that had reported atmospherics and interaction with the civilian population during the operation to was quite positive and local nationals were relatively polite. He reported that during the

71.

Rules of Engagement

72. The applicable Rules of Engagement (ROE) for OP SLIPPER were issued by Chief of Defence Force (CDF) (reference G) and

73. when they were engaged by SAF from approximately 350 to 400 metres. The members of A number of adult males were positively identified with AK-47s and one RPG at the point of origin of the firing moving tactically responded to

this hostile act by returning fire targeting the adult males.

74. During the attack the fire by was controlled and ceased when the threat was considered to have dissipated. The duration of the engagement was short and the minimum force necessary was used to neutralise the threat. Civilians who were not taking an active or direct part in hostilities were not targeted were engaged when they were moving to an authorised objective. The circumstances required them to neutralise the threat to allow for completion of their mission.

75.

76. The members of reasonably believed their conduct was necessary to defend their own lives and the lives of the members continued to act in self defence

77. It was reasonable and necessary for to respond to the hostile actions of the adult males. There was no opportunity to capture the adult males and they continued to keep their weapons with them as they exfiltrated from the contact site.

78. It not known whether the deceased male fired upon the patrol. The SAF from the adult males came from a location across a creek line and from highly vegetated terrain. In the event the deceased male did not actively participate in the engagement, his death and the wounding of the child were collateral to the lawful actions of

79. The members of the are subject to Afghan Law and are not bound by Australian ROE. Nevertheless the actions of the were consistent with Australian ROE.

80. **Finding.** I find that the actions of all the members comprising at the Incident site complied with the extant ROE. The death of the adult male and the wounding of the child were collateral to the lawful actions of the Partnered Force.

Means and methods used by the Partnered Force to identify any hostile forces involved in the Incident

81. The means and methods used by the Partnered Force to identify hostile forces involved in this Incident were straightforward. The Partnered Force was engaged by adult males, positively identified as carrying AK47's and an RPG

paraphrased by several witnesses as follows

Witnesses stated the engagement was short, punctuated by sporadic fire and lasting no more than a few minutes. As indicated elsewhere in

this report at no time did the Partnered Force sight or become aware of civilians located within the vicinity of the adult male's firing position.

Nature and cause of injury or death of any person involved in the Incident

82. responded to being engaged with small arms fire by the insurgents IAW the extant OP SLIPPER ROE. Whilst they could identify a firing position and the adult males engaging them, they did not identify a child in or around the position during the assault

83. The speed of the assault and the dense foliage that the adult males were firing through prevented any of the Partnered Force from identifying that there was a child co-located in the position. This was complicated by the wounded child being discovered by huddled and held close to the body of the deceased adult male as elements o

84. The cause of death of the deceased male was due to gunshots to th No further investigation was carried out as to the cause of death. The body was left at the scene. It was therefore not possible to identify the type of round(s) that caused the death of the adult male and no autopsy could be performed.

85. According to the trauma doctor who treated the child at the Role 2 Hospital MNB-TK the child was severely wounded by a single gunshot wound After receiving treatment at the Role 2 Hospital the child, due the serious nature of his injuries was evacuated to the Role 3 hospital KAF at approximately 1730DE on 27 Mar 11. Given the nature of his injuries his prognosis was assessed as poor. After initial surgery the child appeared to be doing well; however, his condition gradually deteriorated to the point where he was placed on life support. After consultation with medical authorities the child's father agreed to switch off the ventilator and comfort care was maintained until the child was declared deceased at 0053DE on 2 Apr 11. The cause of death was listed as respiratory failure (see death certificate at Annex I).

86. The wounding of the child was a tragic and unfortunate occurrence. The circumstances surrounding the wounding are straight forward. The Partnered Force was engaged, positively identified a number of insurgents with weapons and responded appropriately IAW OP SLIPPER ROE (reference I). The child was discovered huddled against the body of the deceased adult male by The child was not identified in or around the firing position during the assault and on discovery was immediately stabilised and evacuated to receive appropriate medical care.

87. The cause of death of the male found at the scene was due to gunshot wounds. Witnesses at the scene have stated in evidence to the Inquiry that they observed the dead male with

gunshot wounds to th This is supported by photographic evidence taken of the dead male at the scene (Annex E).

Level of involvement and/or responsibility of the Partnered Force in the cause of death or injury to any person involved in the Incident

88. It is impossible to say who, or what calibre weapon was responsible for firing the rounds that resulted in the death of the male or the child. No forensic examination was able to be carried out on the body of the male who died at the scene. The doctors that treated the child at Role 2 Hospital were unable to give an opinion as to the calibre of round that struck the child.

89. As stated in evidence, several witnesses said they took well aimed shots at a person who could have fitted the description of the dead male. There is no evidence to link any particular person firing their weapon to the death of the male and the injury to the child. I have reported elsewhere all members of the Partnered Force adhered to their ROE and any death or injury to persons other than identified insurgents was clearly not intentional.

After Incident Medical Care

90. **Evaluation of first aid performed at the Incident site.** First aid provided to the wounded child at the scene by call sign and s timely, competent and conducted within constraints provided by the medical equipment available. According to the evidence given by the doctors at the Role 2 Hospital MNB-TK the standard of immediate trauma care was medically competent and call sig was complimented on his calm professional approach to treating a child, a situation he had not previously faced.

91. In his evidence call sig provided a detailed account of his treatment at the scene. The Inquiry Team was impressed by his evident competence and the way he used his initiative to provide a level of immediate care whilst lacking some basic paediatric equipment and at the same time providing direction to call sig who assisted him in treating the child. The child was able to be stabilised by call sig t the scene and upon arrival of the AME was carried to the helicopter by call sig for the flight to the Role 2 Hospital MNB-TK.

92.

93. According to call sign nd medical officers at the Role 2 Hospital MNB-TK some limited or basic equipment could be carried by medics that would assist in the treatment of small children. I note at the time of writing this report Australian medical staff at the Role 2 Hospital have made a request to be issued paediatric kits.

94. **Finding.** I find that some limited or basic equipment could be carried by medics that would assist in the treatment of small children.

95. **Recommendation.** I recommend that the carriage of limited supplies of medical equipment suitable for the immediate treatment of infants and young children, be considered for issue to ADF medical personnel operating in the Afghanistan theatre.

96. **Suitability and responsiveness of the method and means of casualty evacuation.** Given the condition of the According to the radio log AME was requested by call sign using a standard reports at regular intervals. Wheels up for the AME at the Incident site was reported by call sign at Wheels down at MNB-TK was at and the child was admitted to the Role 2 Hospital at As noted by CO SOTG this is well within the expected

97. **Finding**

98. **The in-patient hospital care at both MNB-TK and KAF**

a. **'End of life' decisions, time and cause of death.** The RMO at Camp Baker tracked the progress of the child through surgery and into post operative care at the Role 3 Hospital KAF. All documentation associated with the treatment of the child was provided by the Regimental Medical Officer (RMO) to the Inquiry Team. The medical documents and death certificate reveal the child died from respiratory failure. As reported to the Inquiry Officer and revealed in the medical documents the prognosis for the child was poor. In consultation with the child's father, the child was taken off the ventilator on the evening of 31 Mar 11, placed into comfort care and died within several hours at approximately 0053DE on 01 Apr 11.

b. **Whether appropriate ADF policy was adhered to WRT non-ADF casualty tracking.** The Inquiry Officer is not aware of any specific ADF policy regarding non-ADF casualty tracking. The RMO at Camp Baker provided regular updates on the child's condition to the HQJTF633 and Role 2 Hospital medical staff in TK. The Senior Medical Officer (SMO) at HQJTF633 reported to the Inquiry Officer that current guidelines, as opposed to policy, are contained within the Incident reporting requirements.

c. **How the child's remains were returned to his family for burial.** The child's body was returned to the family through established processes at the Role 3 Hospital KAF. Copenhagen Contractors have the responsibility for preparing the body for transport to a checkpoint within Kandahar Airfield and releasing the body to the family. The Inquiry Team visited Copenhagen Contractors and obtained a copy of the death certificate for the child and was informed of the process for returning remains to family members.

d. **Whether and how Afghan cultural traditions and religious beliefs were respected during the repatriation of the remains.** The Inquiry Team was advised by the RMO Camp Baker that cultural traditions and religious beliefs were respected during the repatriation of the child's remains.

99. **Finding.** I find that:

a. According to medical records obtained by the Inquiry Officer the child died at the Role 3 Hospital KAF from respiratory failure after been taken off life support and placed on comfort care.

b. The in-patient hospital care at the Role 2 Hospital MNB-TK and the hospital care at the Role 3 Hospital KAF were responsive and adequate and everything possible was done to save the life of the child.

Post Incident Events and Factors

100. **Reporting.** The CO SOTG confirmed that all the mandated incident reporting was undertaken. Reports were provided to [redacted] as well as to [redacted] In addition to mandated reporting, the CO briefed key personnel in theatre. The CO commented that a considerable amount of time was taken up preparing various reports at a time when SOTG was still focused on the completion of the task and the return of the patrol. He pointed out the inevitable tension between the chain of command's desire for immediate reporting with the time that is needed to provide more accurate reporting.

101. [redacted] in accordance with the directive from CJTF633. On the day of the Incident the CO, in accordance with his directive, made an initial report, verbally and via email. The first formal report provided was an Incident report required within 45 minutes of the event occurring; as the Incident was determined to be of a serious nature. In the case of a civilian casualty [redacted] referred to as a first impressions report and a civilian casualty report.

102. [redacted] made subsequent reports to [redacted] The CO made his initial reports, commencing at 1315DE, to all of those officers and then made a number of updated reports following his initial report that afternoon, including a number of emailed reports to those individuals. [redacted] Incident reports were compiled and completed in accordance with directives from JTF633 and ISAF SOF for that afternoon. After the first reports of the Incident were received, the CO also appointed a Major to commence the QA and to have the report to him within 24 hours.

103. **Personnel Management.** All relevant members of the [redacted] were interviewed by the Inquiry Team. There was no indication that any members of the [redacted] required support subsequent to the Incident. The [redacted] Commander advised that [redacted] men saw the death of the child as tragic but they had moved on. No other LNs appear to have been involved in the Incident.

104. **Review of Procedures.** After the Incident normal back briefs occurred and the conduct of the operation was reviewed. No corrective action was identified by SOTG other than the testing the child's father [redacted] when he came with [redacted]

105. **Compensation.** At the time of writing this report no compensation has been paid to the families for the loss of their child or for the deceased male. The CO SOTG has advised the

Inquiry Officer that he is seeking a Shu[redacted] with the family to discuss the circumstances of the death of the child only and compensation. The Inquiry Team had been advised by the International Committee of the Red Cross (ICRC) that the family did not wish to meet members of the Inquiry Team out of fear of reprisal from the Australian Army.

106. A meeting with the father of the child and brother of the dead mal[redacted] was arranged by the Inquiry Team throug[redacted] of the Afghanistan Independent Human Rights Commission. The meeting was to be held a[redacted] After initial face to face discussions, confirmatory e-mails and telephone calls wit[redacted] all indications were that the meeting would go ahead. The day prior I was informed by Operations Officer at MTF 2 that the meeting could not be held at the Human Rights Commission building due t[redacted] I met wit[redacted] at th[redacted] and was informe[redacted] was unable to attend the meeting due to his concerns about possible reprisals from the Taliban on return to his village. A telephone call t[redacted] confirmed this was indeed the case. Based on this information it appeared no opportunity would present itself for meeting wit[redacted] or members of the family at a neutral venue. Information as to the identity and contact details for th[redacted] were taken, as were confirmatory details of the deceased male. These details were passed to CO SOTG to enable any outstanding issues with regard to compensation to be pursued.

107. The Inquiry Team was unable to meet wit[redacted] and hear his account of the Incident in question[redacted] informed the Inquiry Officer of the circumstances of the Incident by referring to the notes he had taken during a telephone conversation wit[redacted] He stated [redacted] brother, [redacted] had taken [redacted] on to a local clinic for treatment for a gash to his forehead. Upon returning home on his motorbike he had been accidentally caught up in the engagement between coalition forces and some insurgents. When he tried to take cover with the child he was shot. This account is similar to that provided to th[redacted] by[redacted] on the day of the Incident.

108.[redacted] The family of the deceased male have not made any claim for compensation as at the date of this report. Apart from my meeting wit[redacted] where compensation was discussed, it is my understanding that the family has not been contacted and advised by the ADF or any other official of any eligibility and rights to submit claims for compensation. An Australian Broadcasting Corporation (ABC) television news story aired on 5 May 11 and showed an interview with the uncle of the deceased male[redacted] He stated the family did not want compensation. As SOTG has formed the view that the deceased male had engaged in hostilities and/or was a member of the insurgency no consideration has been given by SOTG to providing his family compensation.

109. The family of the deceased male and child has a prima facie case to claim compensation. However, it is impossible to determine whether the deceased male and child were shot either by the members o[redacted] The injuries [redacted]

[6] [redacted]

documented by the Role 2 and Role 3 Hospitals. Based on the information I have received in regard to the identity of the deceased male and the child there is no reason why compensation should not be considered for each.

110. **Finding.** I find the family of the deceased male and child has a prima facie case to claim compensation.

111. **Recommendation.** It is recommended that the families of the deceased male and the child be contacted formally by SOTG and be advised of their rights to make a claim for compensation.

Other Events and Factors

112. **Human Factors.** There is no evidence any human factors, (such as, fatigue or medical issues) contributed to the Incident nor where there any identified deficiencies in the post incident treatment of the child. The child was provided the best possible care by a specialist paediatric surgeon at the Role 3 Hospital KAF.

113. **ADF Performance.** The Partnered Force reacted in accordance with their training and applied their ROE as the situation dictated. The performance of the soldiers reflected their extensive training and experience undertaken during Specific to Theatre (STT) training, MRE and past operations. As reported in the evidence soldiers and the exhibited disciplined fire control during the engagement. The mentors reported being satisfied with the battle drills and fire discipline of the The medical treatment of the child at the scene was competent and professional given the circumstances and all reporting was conducted efficiently and effectively. It was not until after the engagement was completed that the indicated they had reservations about continuing the operation. The commander, call sign wisely decided to conclude that phase of the operation and return to base.

Deficiencies or weaknesses

114. The circumstances of the Incident and its aftermath do not indicate any deficiencies or weaknesses in the following:

a. the structure, composition and/or disposition of any force elements;

b. the C2 arrangements;

c. the planning and preparation undertaken by the Partnered Force (and, where relevant, its chain of command) prior to the conduct of the clearance operations in the vicinity o on 27 Mar 11;

d. the Partnered Force' on 27 Mar 11;

e. the applicable orders, directions instructions, operating procedures, policies, documents, briefings and/or practices;

f. the application during the Incident of the orders, directions instructions, operating procedures, policies, documents, briefings and/or practices as referred to elsewhere in this report;

g. the means and methods used by the Partnered Force to identify any hostile persons/elements involved in the Incident; and

h. the medical response to the Incident, including advising next of kin of the wounding and subsequent death of the child and repatriation of his remains.

115. **Finding.** With the exception of the matters I have raised elsewhere in my report concerning the identification of the dead male, I did not identify any deficiencies in the wider post-incident response.

Conclusion

116. partnered by was conducting clearance operations in the vicinity of Chora in Afghanistan. When the Partnered Force was engaged by small arms fire it acted IAW the extant ROE. An adult male was killed and a child sustained a serious gunshot wound as a result of the engagement. It is impossible to ascertain whether the rounds were from ADF members or Afghan that killed the man and injured the child. The child received care at Coalition medical facilities but subsequently succumbed to his wounds and died.

117. The dead male tested positive for Despite the fact that this test is not conclusive, the dead male was categorised as an insurgent by SOTG and this view was reflected in the QA. Inadequate consideration was given to the dead male's proximity to the child during the engagement or to the fact that no weapon or empty casings were located near his body. No subsequent investigations were undertaken to determine the dead male's identity or his relationship to the child and the child's family. No post incident review of the available was undertaken to confirm whether he was an insurgent. This flawed process has the potential to frustrate legitimate claims for compensation and undermine Counterinsurgency (COIN) Initiatives.

Findings

118. I find that:

a. Based on the evidence available to me the deceased male who died at the scene of the engagement was not actively taking part in hostilities and in my opinion was not associated with the insurgents who engaged the Partnered Force.

b. The lack of rigour given to the analysis to establish the identity of the alleged insurgent by within SOTG is poor. Processes and procedures must be improved within SOTG to check all available sources of information in order to properly identify alleged insurgents.

c. The understanding of and interpretation of the results of an by the senior members of SOTG is inadequate and based on false assumptions concerning test results.

d. The QA did not indicate appropriate weight was given to all evidence in making a determination as to the identity of the dead male.

e. All the members comprising [redacted] complied with the extant ROE. The death of the adult male and the wounding of the child were collateral to the lawful actions of the Partnered Force.

f. Some limited or basic equipment could be carried by medics that would assist in the treatment of small children.

g. [redacted]

h. According to medical records obtained by the Inquiry Officer the child died at the Role 3 Hospital KAF from respiratory failure after being taken off life support and placed on comfort care.

i. The in-patient hospital care at the Role 2 Hospital TK and the hospital care at the Role 3 Hospital KAF was responsive and adequate and everything possible was done to save the life of the child.

j. The family of the deceased male and child has a prima facie case to claim compensation.

k. With the exception of the matters I have raised elsewhere in my report concerning the identification of the dead male, I did not identify any deficiencies in the wider post incident response.

Recommendations

119. I recommend the following:

a. [redacted] processes and procedures be reviewed within SOTG to ensure adequate mechanisms are in place to check the identity of alleged insurgents.

b. Remedial training to be conducted for all ranks of SOTG Rotation XV to ensure an adequate understanding of the interpretation of [redacted] conducted in the field. This training should be extended to cover MST and MRE in Australia for follow on rotations.

c. The carriage of some limited supplies of medical equipment, suitable for the immediate treatment of infants and young children, is considered for issue to ADF medical personnel operating in the Afghanistan theatre.

d. The families of the deceased male and the child are contacted by CO SOTG and that they are advised of their rights to make a claim for compensation.

[redacted] Goodyer

[redacted] GOODYER
Colonel
Inquiry Officer

7th June 2011

Annexes:

A. Findings and Recommendations Matrix
B. Signed Inquiry Officer and Inquiry Assistants 'Statements of Impartiality and Independence'
C. Witness List
D. Witness interview transcripts, privacy statements and two witness statements
E. Photographic Imagery of Incident site and deceased male; topographic map
F. Orders
G.
H.
I. Death Certificate of child
J. Unclassified executive summary of findings and recommendations

Enclosures:

1. Defence (Inquiry) Regulations Inquiry Officer Instrument of Appointment – COL Goodyer dated 12 Apr 11 and Terms of Reference dated 12 Apr 11
2. QA into SOTG CIVCAS Incident – 27 Mar 2011, dated 28 Mar 2011
3. Map 1:25 000 DEH RAFSHAW 25K NAV MGRS – 41S QS
4. Supporting Documents