

**INQUIRY OFFICERS REPORT INTO THE DEATH OF
PRIVATE B.J. RANAUDO
IN AFGHANISTAN ON 18 JULY 2009**

Reference:

A. ADFP 06.1.4—*Administrative Inquiries Manual*

INTRODUCTION

Preamble

1. At approximately 0647 hours local time on the 18 July 2009 (180215Z Jul 09), while conducting a cordon and search as part of OPERATION _____ in the BALUCHI VALLEY, an Improvised Explosive Device (IED) initiated by an anti-personnel mine, was struck at _____. It resulted in two Australian military and three local national civilian casualties. PTE Ranaudo was evacuated via aero-medical evacuation (AME) to Camp HOLLAND near TARIN KOWT where he was pronounced dead by a medical officer.

Appointment and Terms of Reference

2. I, COL Mark Graham Frendin, AM having been duly appointed by ACM Allan Grant Houston, AC, AFC, Chief of the Defence Force (CDF), to inquire into the death of Private Benjamin James Ranaudo in accordance with the Terms of Reference attached to the Instrument of Appointment (enclosure 1) herein submit my report.

Inquiry team

3. The inquiry team consisted of myself as the Inquiry Officer and the following Inquiry Assistants:
- a. WGCdr Christopher Michael Taylor, and
 - b. CPL Matthew John Clow.

Inquiry methodology

4. The methodology adopted for this inquiry was consistent with the Instrument of Appointment and terms of reference (enclosure 1) which specified, amongst other things, that:
- a. the inquiry be conducted in a timely manner as a matter of urgency;
 - b. the Inquiry Officer follow as closely as practicable procedural guidance contained in reference A;
 - c. the inquiry is not intended to be a substitute for a Commission of Inquiry and has a more limited scope and purpose;
 - d. the inquiry be conducted so as to minimise adverse impacts on the conduct of ADF operations in the Middle East Area of Operations.

5. Annex A contains details of the procedure and methodology adopted by this inquiry. Enclosure 2 contains statements and records of conversation of witnesses interviewed by me. Enclosures 3-13 contain documentary evidence considered by this inquiry.

NARRATIVE OF EVENTS

Training and deployment of MRTF

6. MRTF completed Mission Rehearsal Exercises and force preparation in 2009 and deployed into the MEAO in 09. It conducted prior to deploying into Afghanistan and replacing MRTF on 09 .

MRTF Role in URUZGAN PROVINCE

7. MRTF is under Commander Task Force URUZGAN (CTF-U) . MRTF primary task is to conduct tasks that contribute to TF-U efforts to enhance the security of the URUZGAN PROVINCE, increase the capability of the provincial government and enable sustained social-economic development in a stable environment.

8. MRTF tasks include the following

- a. Conduct construction and engineer project management.
- b. Conduct indigenous capacity-building with regard to engineering skills and trades.
- c. Train, mentor and operate in intimate support of the supported KANDAK (local unit),

in order to develop an effective Afghan National Security Force (ANSF) and improve the security and long-term development of Afghanistan (AFG).

d.

OP

9. TF-U issued the CONOPS for OP on Jun 09 . It was a three phase op designed to

a. Phase 1:

i. Main effort:

b. Phase 2:

i. Main effort:

c. Phase 3

i. Main effort:

MRTF Orders reflect this requirement. The mission was: '1 RAR
is to INS in BALUCHI VALLEY
IOT

Threat situation

10. FRAGO – OPERATION to OPLAN assessed that the INS
in the BALUCHI was approximately . The main modus operandi of the INS
is in order to through the area in order to
maintain their own freedom of action. The INS

indicated that the INS in the BALUCHI
providing the INS

11. assessments and products assessed the threat from IEDs as , The CO MRTF brief to CJTF 633 indicated that the response to counter this IED risk was through the allocation of and by

Forces involved

12. **Australian.** For Phase of OP , Combat Team – (CT), led by consisted of (which included PTE Ranaudo), an and KANDAK ,

13. **Afghan.** reported that an ANA from KANDAK was conducting searches of with at the time of the incident

14. **Coalition.** The following CF were involved:

- a. One CF AME helicopter which provided AME support
- b. The Dutch Role 2 Medical Facility at Camp HOLLAND, TARIN KOWT, where the injured were treated, PTE Ranaudo's body was initially received and from where his repatriation commenced .

SYNOPSIS OF THE INCIDENT

15. **Date, time and place of the incident.** The incident took place on the 18 Jul 09 at approximately 0647h local Afghanistan time. The site was from Combat outpost (COP) MASHAL at in an area known as the BALUCHI VALLEY . This location is approximately 27 km North of the at Camp HOLLAND near TARIN KOWT.

16. **OP Phase Jul 09.** On receipt of intelligence regarding CO MRTF () directed OC CT to prepare a cordon and search operation on Jul 09 After a back brief, CO MRTF approved the plan and to reinforce CT . Preparations were undertaken at . On Jul 09, CO MRTF directed OC CT to proceed with the operation . OC CT delivered orders to

elements in location and CT . First moves commenced at on Jul 09.

17. **Movement of PTE Ranaudo's group.** PTE Ranaudo was a member of , This element was known as Call Sign The was tasked to in the vicinity of . It was to site and provide Orders were delivered by Commander , on Jul 09 and the group moved into position by Jul 09 without incident .

18. **Establishment of the cordon.** The cordon were in location by . Minor adjustments occurred on and in response to in the area. The search of the primary was underway by this time.

19. **Events prior to the incident and local atmospherics.** At approximately was approaching a Local National . reported that civilians were in the vicinity . PTEs and Ranaudo were collocated near the position. PTE was and PTE Ranaudo was civilians . PTE had been in this area for at least hours . It was reported by OC CT that civilians had been in the area at the time of the incident. The Quick Assessment reported that approximately 30 civilians had moved through the general vicinity of the incident and that atmospherics were normal (that is, they showed no concerns) .

20. **The incident** . At 0647h an explosion occurred . Some members in the vicinity indicated they initially thought it was a suicide bomber or a rocket propelled grenade. The group while moved to assist PTEs and Ranaudo. Among several nearby, and went to PTE Ranaudo's assistance. They both reported that it was clear to them from his head injuries that PTE Ranaudo was killed outright and after confirming there were no signs of life they moved to assist PTE the IED The mine which injured him was also IED charge which caused the death of PTE Ranaudo. The location of the two victims was within metres of the craters .

21. **Immediate actions** . First aid was provided for the surviving casualties and PTE Ranaudo was covered with a ground sheet and moved into low ground near the incident site.

AME was requested by CT . The casualties and the three civilians were evacuated in two flights. The first AME Black Hawk arrived at 0725h and delivered PTE to the Role 2 Medical Facility, CAMP HOLLAND at 0745h. The second AME delivered PTE Ranaudo to the same facility at approximately 0815h .

22. **Subsequent actions.** The cordon and search task continued and CT subsequently provided the incident site . CT withdrew from the area at .

Authority to conduct the operation

23. OP was planned and conducted within the scope of CDF EXECUTE ORDER OP SLIPPER and FRAGO TO CJOPS OPORD - OP SLIPPER

This document provides guidance on authority to . In this case, CO MRTF was authorised to conduct OP was required only to provide a CO MRTF sent a brief concerning OP to CJTF 633 on Jul 09 and CJTF 633 subsequently noted that brief

24. TF-U orders for the conduct of Op were provided in FRAGO OPERATION to OPLAN

Involvement by civil and Service authorities

25. The local Australian Defence Force Investigative Service (ADFIS) representative () opened an ADFIS investigation () into the incident IAW DI(G) ADMIN 45-2—*Reporting and Investigation of Alleged Offences within the Australian Defence Organisation*. I am not aware of any other Australian, Afghan or Coalition police investigations into this incident.

26. The Victorian State Coroner has jurisdiction regarding PTE Ranaudo's death. An external medical examination of PTE Ranaudo's remains was conducted on 27 Jul 09 at the Victorian Institute of Forensic Medicine in Melbourne .

Deaths and injuries

27. PTE Ranaudo was killed as a result of this incident. The explosion resulted in catastrophic injuries that would have caused death instantly. Given the circumstances of the explosion and the injuries sustained, I am satisfied that PTE Ranaudo's death occurred as a result of a IED that had been laid by INS.

28. Official confirmation of death was declared by the RMO MRTF () at CAMP HOLLAND at 0845h, 18 Jul 09 . Notwithstanding this, the available evidence supports PTE Ranaudo's time of death as being at approximately 0647h, 18 Jul 09.

29. An external medical examination was conducted at the Victorian Institute of Forensic Medicine on 27 Jul 09 and this was attended by Joint Operations Command. observations of this examination are at enclosure 10(a). A report from the Victorian Institute of Forensic Medicine () is at enclosure 10(b). The opinion of , and is that PTE Ranaudo died immediately from his wounds.

30. At all times following his death, PTE Ranaudo's remains were reported as being treated with dignity and respect by his comrades. Following his return to CAMP HOLLAND, MRTF placed a guard at the Dutch Role 2 Medical Facility until the ramp ceremony and the departure of PTE Ranaudo's remains for . A service was conducted by the MRTF Chaplain, , and supported by the Theatre and SOTG Chaplains and attended by Coalition allies .

31. PTE was seriously injured and evacuated to the Role 2 Hospital at Camp HOLLAND . After stabilisation he was evacuated to Germany and subsequently to Australia . There were three civilians injured as a result of the IED detonation which killed PTE Ranaudo and severely injured PTE . All were evacuated by helicopter and treated at the Role 2 Hospital in Camp HOLLAND . Two local nationals including a child were evacuated with PTE on the first helicopter and another local national with less serious injuries was evacuated on a second helicopter soon after . Subsequent reporting indicated their injuries were not life threatening and that they were treated and released .

ANALYSIS OF THE INCIDENT

Environmental conditions

32. reporting contains of the terrain at the incident site . The evidence does not indicate that environmental conditions contributed adversely to the outcome of the incident in any direct way.

Operational conditions and factors

33. **Pre-operation intelligence.** The for OP describes the nature of the likely threat, including IEDs .

A [redacted] was issued by [redacted] MRTF [redacted] to OC CT [redacted] on Jul 09. OC CT [redacted] confirmed receipt of the [redacted] and reflects [redacted] threat in his orders. In summary, MRTF [redacted] elements were aware of IED [redacted]. The [redacted] process provided timely information [redacted] for the overall operation and specifically for the conduct of [redacted] of OP [redacted]. There were no significant weaknesses identified.

34. **Pre-operation planning.** Planning for the operation was a [redacted] process undertaken at various levels by [redacted] MRTF [redacted] and CT [redacted]. The planning process appears to have been sound and time was available to undertake [redacted] in detail. There were no significant weaknesses identified.

35. **Orders.** Orders for OP [redacted] from [redacted] to MRTF [redacted], and subsequently to CT [redacted], were provided in writing. The [redacted] of the operation were relatively uneventful for CT [redacted] and the [redacted] (which included PTE Ranaudo). Following the possible location of [redacted] CO MRTF [redacted] gave verbal direction for OC CT [redacted] to develop a concept for the cordon and search of [redacted]. OC CT [redacted] gained approval from CO MRTF [redacted] for his concept and CO MRTF [redacted] added [redacted]. Later, CO MRFT [redacted] directed OC CT [redacted] to proceed with this operation. OC CT [redacted] orders were delivered [redacted] to CT [redacted] elements. [redacted] statement reflects a sound understanding of these orders. Orders are assessed as suitable for the conduct of this operation.

36. **Command and Control.** Command and control throughout the cordon and search activity appears to be sound. There is no evidence of any weakness in the command and control of the operation.

IED placement

37. The INS employs IEDs to attack the CF. Key factors relevant to this incident are as follows:

a.

- b. It was assessed by CF that _____ I regard this assessment as having been reasonable based on the information available.
 - c. The choice of the IED emplacement location (next to an aqueduct) provided INS a _____
 - d. _____
 - e. The exact position of the IED strike had been occupied by PTE _____ for the entire time the patrol had been in location (_____ hours). Previous interaction between _____ and civilians had occurred in this general area
 - f. The _____ task as part of the cordon required members to be prepared to control _____. The tactical imperative was to place _____ members in locations which _____

 - g. _____ analysis indicated :
 - (1) _____ Both _____ had been moving in this area extensively prior to the strike. It is likely the device was initiated when the _____ shifted position placing pressure on the initiator.
 - (2) It would have been very difficult for a _____ patrol, _____ this device prior to detonation.
 - (3) It is unknown who this device was specifically targeting but it is likely to have been intended to be triggered by _____
 - (4) _____
-

Tactics, Techniques and Procedures - IEDs

38. MRTF had inherited MRTF TTP and had undertaken training in their application during

39. A key procedure for dealing with a threat of IED is the drill

40. reported that the drill was carried out but the task due to reported the drill was conducted. He also indicated that the fact civilians were in that particular area. It appears that the IED which killed PTE Ranaudo was well hidden, given the had been in location for several hours before the IED was initiated.

41. I am satisfied that the members involved were trained and practiced in identifying the majority of IED threats and that they were aware of the general threat in the area they were operating in. In this case the use of a

Individual training

42. PTE Ranaudo's role required the skills and training of an infantry rifleman. After reviewing the relevant PMKeyS entries, I am satisfied that PTE Ranaudo was fully qualified in this role. PTE Ranaudo completed the MRE and in-theatre training. Additionally, witness statements indicate a high degree of confidence in PTE Ranaudo's abilities within his and unit.

Protective equipment

43. The Defence Scientific and Technology Organisation (DSTO) examined PTE Ranaudo's helmet and body armour. DSTO analysis led to the conclusion that there was no evidence to suggest that the armour system behaved in a manner that was inconsistent with its protective specifications and standards.

Human factors

44. At the time of the incident the had been operating from early morning for nearly hours. indicated he was able to location. Available evidence does not indicate that fatigue was factor in this incident.

Operational factors - conclusion

45. Members of CT were aware of the threat and carried out drills in accordance with their training. The task required the members to occupy the aqueduct crossing point. It was reasonable that the the threat of IEDs in the area occupied by PTEs Ranaudo and as given the in the area. The method of IED attack was

46. As to why search was not employed to clear the area occupied by PTEs Ranaudo and , it was reasonable that the (as compared to other locations in the vicinity of being searched).

47. I assess this attack reflects the tactical sophistication of the INS and their ability to adapt and develop new methods of targeting the CF in response to operations in the BALUCHI VALLEY.

48. CT commenced this operation with an understanding of the threat, were provided with appropriate orders and had time to complete . There are no significant shortcomings identified in the operational conditions or factors in the context of the IED incident which killed PTE Ranaudo.

POST-INCIDENT EVENTS AND FACTORS

49. **Medical treatment.** It has been ascertained that PTE Ranaudo was killed instantly and that no medical intervention would have changed the outcome . However, it is considered that the actions taken by medical staff from the time of the incident to the arrival at the Dutch Role 2 Medical Facility, where PTE Ranaudo was formally pronounced dead, were appropriate. PTE said that the medical treatment he received was 'first class' .

50. **CASEVAC.** The MRTF Quick Assessment records timings for the AME for PTE , the civilian casualties and PTE Ranaudo . PTE Ranaudo was removed by helicopter from the incident site within 90 minutes of the IED blast. PTE and two of the injured civilians was evacuated to CAMP HOLLAND within 60 minutes. CO MRTF indicated he was impressed with the AME support . The evidence does not indicate any concerns with the CASEVAC process.

51. **Identification of PTE Ranaudo's remains.** PTE Ranaudo was positively identified from his passport photograph after he arrived at CAMP HOLLAND . The MRTF RMO, , pronounced him dead at 0845h .

52. **Casualty notification.** Available evidence from post activity reporting indicates that the casualty notification process worked in a timely manner .

53. **Repatriation.** Enclosures 2(a), 2(e), 2(g), 2(h), 9(l)-(n), 9(t) and 9(w) provide extensive information concerning the repatriation process for PTE Ranaudo. While these reports indicate areas for minor improvement, there were no significant problems with the repatriation of PTE Ranaudo. The various ramp ceremonies and his return to Australia were reported to have occurred in an appropriate manner.

Other Factors

54. **Drugs and alcohol.** The evidence does not indicate that drugs or alcohol were involved or contributed to PTE Ranaudo's death .

55. **Other.** There were no other factors contributing to the incident.

Performance of duty

56. The evidence does not indicate any substantial shortcomings by ADF personnel in the context of PTE Ranaudo's death.

Conclusion

57. PTE Ranaudo was killed in action as a result of an INS emplaced IED exploding in close proximity while he was manning a on a cordon. He suffered catastrophic wounds that were instantly fatal. His death was a direct result of INS actions to attack coalition forces in the BALUCHI VALLEY.

58. Training, intelligence, planning and orders were all sufficient prior to the incident and there were no associated shortcomings which contributed to PTE Ranaudo's death. The tactical decisions made by CT command elements all appear to have been soundly based and reasonable.

59. In the course of this inquiry, I have discovered no issues that would benefit from further consideration by a CDF Commission of Inquiry (COI). A COI is unlikely to discover any further relevant material, information or evidence in the context of this incident.

Findings

60. I find that the circumstances associated with the death of PTE Ranaudo do not warrant the appointment of a COI.

Recommendation

61. I recommend that a COI not be appointed into the circumstances surrounding PTE Ranaudo's death.

M.G. FRENDIN

Colonel
Inquiry Officer

Sep 09

Annex:

Enclosures:

