



JUDGE ADVOCATE GENERAL

Australian Defence Force

MINUTE

SOCAUST

REVIEW OF VADM RITCHIE INQUIRY REPORT

References:

- A. VADM Ritchie (Retd) Inquiry Officer's Report dated 23 Jul 09
- B. SOHQ Minute AM 176258 dated 8 Oct 09
- C. Defence (Inquiry) Regulations 1985

1. Reference A is the Report of an Inquiry Officer into the death of LTM. K. H. Fussell.

2. LT Fussell died while on duty in Afghanistan. He was killed when his unit, Force Element (FE) was engaged in a night mission. The company was required to move along a trail. There were concerns that improvised explosive devices (IEDs) might have been laid on or near the trail. As a result

Each member of FE, including LT Fussell, had been trained to

The Inquiry Officer found that LT Fussell had been trained in this technique both in Australia and in the course of further training in Afghanistan. He died when he stepped off the trail and stood on an IED.

3. After receiving an initial report on the cause of LT Fussell's death CDF appointed an Inquiry Officer to undertake a wider examination of the circumstances surrounding the incident. Relevantly, the terms of reference for the inquiry required the Inquiry Officer to provide CDF "with a report detailing, with reasons, the findings of the Inquiry Officer on the following matters:

- a. the adequacy of the selection, preparation and certification of force readiness of LT Fussell's force element;
- b. the extent to which the assertions in relation to the inadequacy of the leadership of LT Fussell's force element were known and what, if any, actions were taken in response to those assertions;
- c. the sufficiency of training of Tactics, Techniques and Procedures (TTP) relating to the movement being conducted by LT Fussell's force element at the time of his death, including procedures for stopping any unsafe practice; and
- d. whether or not any of the matters in paragraphs (a) to (c) materially contributed to LT Fussell's death."

4. The Inquiry Officer made a number of adverse findings relating to the training, assessment, certification and leadership of FE

5. The findings in relation to assessment are summarised in Reference A at paras 64-71 as follows:

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64. The dates for the MRE were not ideal for the FE training continuum.

65. The MRE attended by FE was planned and focused on SOTG and FE.

66. Too much responsibility for the planning and conduct of the MRE, particularly the two FMP, was left with the FE command team. This is in stark contrast to the oversight given to FE.

67. Because the FE command team was so involved in conducting the MRE, it is reasonable to consider that the time and effort available for the training of the key staff themselves was less than appropriate.

68. The lack of a higher HQ exercise, directing and commanding FE resulted in the key staff of FE being fully aware of what activities were to be conducted, under what conditions those tasks would be conducted and what, when and how any threat to their task would eventuate.

69. The lack of any higher HQ or senior officer injecting the unexpected into the training resulted in a lack of pressure being placed on the FE command team, particularly Major 1

70. This lack of pressure resulted in an inability to assess the ability of the FE command team, particularly Major 1, to respond to unexpected pressure.

71. The method of assessment was not consistent. No one officer was present throughout the MRE to provide a consistent oversight to the assessment of FE. Moreover, there was no agreed format for the report to ensure that all necessary areas requiring assessment were covered."

6. The findings in relation to certification appear at paras 98-104. They read:

98. There was recognition at senior levels that the normal certification process was not comprehensive enough to cater for the unique circumstances of FE

99. Despite some differences in recollection, the certification process went roughly as intended by Brigadier . The individual training aspects were identified and other SF resources were able to contribute through their input to the Acting CO 1 CDO Regt.

100. Input to the certification process was not particularly coherent. Inputs were obtained in varying degrees of formality from interested parties but there was no obvious means of ensuring that identified deficiencies were rectified or that information was shared with each party so as to form a complete picture of FE

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101. The certification process was deficient in that the documentation chain failed to recognise the limitations and reservations expressed by either Lieutenant Colonel 1 or Lieutenant Colonel 2 whose reports were used as the main supporting documentation to certify readiness. Subsequent reports on FE capabilities were thus misleading.

102. The certification process was incapable of providing a true picture of FE capability because it lacked coherence in the collation of observations and because the collective training process had not subjected FE to unexpected, externally driven, testing.

103. There was a general understanding that FE would be assessed and if necessary, given further training, in theatre before being employed on operational tasks. This knowledge probably acted as a safety net for the certification process in Australia and thus detracted from the importance of that process.

104. Deficiencies in the certification process arising from the conduct and supervision of MREs appear to have been rectified.”

7. The findings relating to leadership appear at paras 137-142. They read:

“137. Captain 1 Captain 2 Warrant Officers 1 and 3's evidence supports a long history of concern over Major 1 command ability within 1 CDO Coy.

138. None of the force preparation or certification process was able to identify weaknesses in the command of FE.

139. When he finally became fully aware of doubts about Major 1 Lieutenant Colonel 1 informed Lieutenant Colonel 3 CO SOTG before FE deployed.

140. Higher command in Australia was not informed of any doubts about Major 1 prior to deployment.

141. Lieutenant Colonel 3 does not acknowledge that he was informed of doubts about Major 1 but he does appear to have taken extra care in assessing FE as fit for operations.

142. Conversations between CO SOTG, SOCAUST and CJTF 633 in mid December, were the first identifiable notification of concerns to higher authority about the leadership of FE.

8. When the Inquiry Officer came to consider whether any of these matters materially contributed to LT Fussell's death he directed himself that:

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"163. In making this determination the relevant legal principles applicable to causation have been applied. A circumstance may be caused by a single cause, or it may be the result of a combination of causes. Where there are multiple causes it is only those which materially contribute to the result that are considered relevant. Thus, if conduct, be it omission or commission, operates to increase the risk of injury or death to a person that circumstance materially contributed to any subsequent injury or death. The expression "materially contributed" is used extensively in civil law."

9. The Inquiry Officer then made the following critical finding:

"170. The initial Inquiry Officer's Report into the death of Lieutenant Fussell by Colonel McCullough identified that the immediate and direct cause of Lieutenant Fussell's death was his contact with the pressure plate of an IED causing it to detonate thereby killing him. That however was not the sole cause of death. Deficient training, assessment, certification and consequently leadership of the FE operated to increase the risk that such a casualty might occur. Therefore, those deficiencies materially contributed to the death of Lieutenant Fussell."

10. By reference B I have been asked to provide SOCAUST with legal advice as to efficacy of this finding.

11. The issue to which the Inquiry Officer's attention was directed by sub-para (d) of the Terms of Reference required him to determine whether any of the matters referred to in the preceding sub-paragraphs had "materially contributed to LT Fussell's death." In seeking to deal with this term the Inquiry Officer drew on jurisprudence which had developed in the context of personal injuries litigation and in particular, litigation in which a defendant was alleged to have acted negligently. The legal position was summarised by McHugh J in *Chappel v Hart* (1998) 195 CLR 232 at 244-5 as follows:

"Before the defendant will be held responsible for the plaintiff's injury, the plaintiff must prove that the defendant's conduct *materially contributed* to the plaintiff suffering that injury. In the absence of a statute or undertaking to the contrary, therefore, it would seem logical to hold a person causally liable for a wrongful act or omission only when it increases the risk of injury to another person. If a wrongful act or omission results in an increased risk of injury to the plaintiff and that risk eventuates, the defendant's conduct has *materially contributed* to the injury that the plaintiff suffers whether or not other factors also contributed to that injury occurring. If, however, the defendant's conduct does not increase the risk of injury to the plaintiff, the defendant cannot be said to have *materially contributed* to the injury suffered by the plaintiff. That being so, whether the claim is in contract or tort, the fact that the risk eventuated at a particular time or place by reason of the conduct of the defendant does not itself *materially contribute* to the plaintiff's injury unless the fact of that particular time or place increased the risk of the injury occurring". (Emphasis added).

See also *March v Stramare (E&MH) Pty Ltd* (1991) 171 CLR 506 at 514 (per Mason CJ) and 532 (per McHugh J).

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12. In many cases the causal issue can be resolved by an analysis which asks whether the injury or death would have occurred "but for" the act or omission of the defendant. In *March* the High Court accepted that the "but for" test could not be applied as an exclusive test of factual causation. It referred to its earlier decision in *Fitzgerald v Penn* (1954) 91 CLR 268 at 276 where the Court had propounded the test of "whether a particular act or omission can fairly and properly be considered a cause of the accident": see at 276 (emphasis added). What is fair and proper is to be judged as a matter of common sense: *Chappel* at 268 (per Kirby J). It was thought necessary to temper the operation of the "but for" test to deal with cases in which its application might lead to untoward results. In *Faulkner v Keffalinos* (1971) 45 ALJR 80 at 86, for example, Windeyer J rejected reasoning along the lines that, had it not been for an accident, the plaintiff might have still been employed by the defendants and not been where he was when a second accident, for which the plaintiff sought to hold the defendant responsible in damages, happened.

13. It does not follow necessarily that because the terminology "materially contributed" is employed in a particular sense in one context that it will be applied in that same sense in another. In *Chappel* at 268 Kirby J observed that:

"The starting point is to remember the purpose for which causation is being explored. It is a legal purpose for the assignment of liability to one person to pay damages to another. It is not to engage in philosophical scientific debate, still less casuistry."

The observation of McHugh J in *March* (at 533) also bears noting: "Indeed, I suspect that what commonsense would not see as a cause in a non-litigious context will frequently be seen as a cause, according to commonsense notions, in a litigious context."

14. The advice of the Inquiry officer has not been sought by the CDF for the purpose of allocating blame or financial responsibility. It has been sought pursuant to the Defence (*Inquiry*) Regulations so that the relevant facts can be found in order to inform future command decisions. The Inquiry Officer was, in my view, required to apply a common sense approach when determining whether there was any causal nexus between the deficient training, assessment certification and leadership of the FE and LT Fussell's death. The "but for" approach was not appropriate. Had LT Fussell not been posted to FE or had FF not been deployed in Afghanistan by the ADF, he would not have been present in the place where he met his death. It would be strictly logical to say that, but for the posting and the deployment LT Fussell would not have died but these events cannot be said to have materially contributed to his death: cf *Faulker v Keffalinos*, above.

15. The factual findings of the Inquiry Officer as to the deficiencies in the training, assessment, certification and leadership of FE must be accepted for present purposes. The issue is whether these deficiencies materially contributed to LT Fussell's death. I have set out the findings of the Inquiry Officer in relation to these matters. None of them relate specifically to the issue of the maintenance of track discipline. It was not found that the training of the unit was deficient because it did not instruct members on

Nor did the Inquiry Officer find that such a failure had implications for the assessment, certification or leadership of the FE

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16. On the contrary, the Inquiry Officer found that the track discipline regime that was employed on the night on which LT Fussell died was appropriate (para 146). LT Fussell himself was appropriately trained in the track discipline regime (para 149). The training of FE in matters of track discipline was also judged to be "adequate" (para 152).

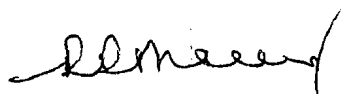
had had occasion, on the day prior to LT Fussell's death, to remind him of the need to adhere to track discipline (para 154).

17. Notwithstanding the importance attached to the maintenance of track discipline during training and the reminder given to LT Fussell, on the night in question he left the path with fatal consequences. The Inquiry Officer was unable to make a definite finding as to why LT Fussell deviated from the path. On the evidence, he was only able to record some speculative reasons which had been suggested by witnesses. In these circumstances there was not, nor could there have been, a finding that there was a direct nexus between the deficiencies identified by the Inquiry Officer and the taking by LT Fussell of the fatal step. Whatever deficiencies there were in the training, assessment certification and leadership of FE, they did not relate to the maintenance of track discipline.

18. There is one qualification. There is a suggestion (at para 161e) that MAJ 1 may have contributed to LT Fussell's death by a failure to enforce track discipline because

There was, however, no evidence that he was in a position to observe, even if he had been alert and minded to do so, whether LT Fussell was maintaining track discipline at the relevant time. I do not, therefore, consider that this alleged failure on the part of MAJ 1 (if it be one) can be said to have materially contributed to LT Fussell's death.

19. The Inquiry Officer's findings, in my view, entitled him to conclude, as he did, in a general sense, that the deficiencies which he identified in the training, assessment certification and leadership of FE operated to increase the risk that a casualty might occur on operations in Afghanistan. What his findings did not, in my opinion, entitle him, as a matter of law, to conclude was that these deficiencies led to the breach of track discipline on the part of LT Fussell on the night of his death.



RRS TRACEY RFD
MAJGEN
JAG

14 Oct 09