

[REDACTED]

**INQUIRY OFFICER'S REPORT INTO THE DEATH OF [REDACTED] PRIVATE
NATHAN JOHN BEWES IN AFGHANISTAN ON 9 JULY 2010**

References:

- A. CDF Instrument of Appointment and Terms of Reference dated 16 July 2010
- B. MTF-1 QA into [REDACTED] IED Strike – 09 Jul 10 dated 10 Jul 10
- C. 6 RAR BG (MTF-1) OPLAN – Operation [REDACTED] (Operation in URUZGAN Province 2010) dated [REDACTED]
- D. ISAF HQ CTED SOP [REDACTED] Report dated [REDACTED]
- E. CO MTF-1 Directive [REDACTED] – Force Protection [REDACTED] dated [REDACTED]
- F. DI(G) ADMIN 45-2 – *Administrative Reporting and Investigation of Alleged Offences within the Australian Defence Organisation* dated 26 Mar 10
- G. DI(G) PERS 20-6 – *Death of Australian Defence Force Personnel* dated 20 May 08
- H. DI(G) PERS 11-2 – *Notification of Australian Defence force and non-Australian Defence Force Casualties* dated 20 May 08
- I. HQ JTF633 SI(PERS) 04-06 – *MEAO Mortuary Affairs Management* dated 29 Apr 10
- J. CDF Directive 04/2010 – *Interim Arrangements – Quick Assessments and Administrative Inquiries* dated 23 Apr 10
- K. ADFP 06.1.4 – *Administrative Inquiries Manual*

Appointment and Terms of Reference

1. I, [REDACTED] Colonel (COL) [REDACTED] Cox, CSC, having been duly appointed by Air Chief Marshal (ACM) Allan Grant Houston, AC, AFC, Chief of the Defence Force (CDF), to inquire into the death of [REDACTED] Private (PTE) Nathan John Bewes in accordance with (IAW) the Terms of Reference attached to the Instrument of Appointment (Annex A), herein submit my Report.

Inquiry Officer Team

2. The Inquiry Officer (IO) Team consisted of me, as the IO, and the following Inquiry Assistants (IA):

- a. [REDACTED] Lieutenant Colonel (LTCOL) [REDACTED]
 - b. [REDACTED] Major (MAJ) [REDACTED]; and
 - c. [REDACTED] Corporal (CPL) [REDACTED]
- [REDACTED]

Methodology

3. The IO Team moved from Australia on [REDACTED] July 2010, arriving in the United Arab Emirates (UAE) on [REDACTED] July 2010. Following reception training, the IO Team moved forward to Multi-National Base – Tarin Kowt (MNB-TK), TARIN KOWT, URUZGAN Province, AFGHANISTAN (AFG) on [REDACTED] July 2010.

4. I consulted the Quick Assessment (QA) (Annex B) conducted by the Operations Officer (OPSO) of Mentoring Team – Charlie (MT-C), [REDACTED] **Soldier 16** dated 10 July 2010.

5. The IO Team was unable to visit the site of the incident due to the security situation, but this is not considered to be an impediment to the conduct of the Inquiry. Two members of the IO Team were able to visit and conduct interviews of key witnesses at Forward Operating Base (FOB) MIRWAIS and Combat Out Post (COP) MASHAL. Interviews with key Mentoring Task Force One (MTF-1) Headquarters staff were also conducted at TARIN KOWT. These interviews, together with the examination of key documents, maps, patrol imagery and the Weapons Intelligence Technical (WIT) reporting, has enabled the IO Team to conduct a satisfactory appraisal of the incident site.

6. The IO team evaluated all information and evidence provided on return to Australia. Additional interviews with key staff were subsequently conducted to clarify events and/or procedures prior to finalising the report.

Introduction

7. On the afternoon/evening of 9 July 2010, MT-C Call Sign (C/S) [REDACTED] and C/S [REDACTED] were returning from conducting an Australian (AS) only fighting patrol, IVO [REDACTED], North BALUCHI VALLEY, URUZGAN Province, AFG. Approximately [REDACTED] metres from COP MASHAL, whilst an element of the patrol were moving beside a dry aqueduct, an Improvised Explosive Device (IED) detonated on a foot pad that paralleled the aqueduct, at Grid Reference [REDACTED] killing the [REDACTED] PTE N.J. Bewes, and wounding the [REDACTED] [REDACTED]

Background

8. The Mission of the Sixth Battalion, Royal Australian Regiment (6 RAR) Battle Group (BG), MTF-1, is to mentor assigned Afghan National Army (ANA) units and contribute to capacity building in URUZGAN Province, from February 2010, in order to (IOT) support the International Security Assistance Force (ISAF) security and reconstruction/development lines of operations.

9. This Mission Statement reflects recent changes in the operational tasking of the MTF-1, away from that of their predecessors – the Mentoring and Reconstruction Task Forces One and Two (MRTF-1 and MRTF-2). The primary role of the MTF-1 is to mentor the 4th Afghan National Army (ANA) Brigade (Bde). This is reflected in their Command and Control (C2) structure at Annex C.

10. The generic structure of a MTF-1 Mentoring Team, totalling approximately personnel, is as follows:

- a. Company Headquarters (CHQ) of personnel;
- b. [REDACTED]
- c. Infantry Operational Mentoring and Liaison Team [REDACTED];
- d. Rifle Platoons of personnel each;
- e. ASLAV [REDACTED]
- i. Combat Engineer [REDACTED]
- g. [REDACTED]
- h. [REDACTED]
- i. Explosive Ordnance Detection [REDACTED] and
- j. [REDACTED]

Date, Time and Place of the Incident

11. The incident took place on 9 July 2010, at approximately 1820h local (L) AFG time (2350h Australian Eastern Standard Daylight Time (AESDT)) in the vicinity of (IVO) COP MASHAL, North BALUCHI VALLEY, URUZGAN Province, AFG.

Forces Involved

12. **Australian.** The AS Forces involved in the incident were:

- a. 16 personnel from MT-C consisting of:
 - (1) personnel:

- i. [REDACTED] Soldier 1 [REDACTED];

[REDACTED]

- [REDACTED]
- ii. [REDACTED] **Soldier 2** [REDACTED]
 - iii. [REDACTED] **Soldier 3** [REDACTED]
 - iv. [REDACTED] **Soldier 4** [REDACTED]
 - v. [REDACTED] **Soldier 5** [REDACTED]
 - vi. [REDACTED] PTE N.J. Bewes;
 - vii. [REDACTED] **Soldier 6** [REDACTED]
 - viii. [REDACTED] **Soldier 7** [REDACTED]
 - ix. [REDACTED] **Soldier 8** [REDACTED]
 - x. [REDACTED] **Soldier 9** [REDACTED]
 - xi. [REDACTED] **Soldier 10** [REDACTED] and
 - xii. [REDACTED] **Soldier 11** [REDACTED]

(2) [REDACTED] personnel:

- i. [REDACTED] **Soldier 12** [REDACTED]
- ii. [REDACTED] **Soldier 13** [REDACTED]
- iii. [REDACTED] **Soldier 14** [REDACTED]
- iv. [REDACTED] **Soldier 15** [REDACTED]

13. **Afghan.** There was no Afghan National Security Forces (ANSF) involved in the incident.

14. **Coalition.** The Coalition Forces (CF) involved in the incident were:

- a. The crew of the Task Force [REDACTED] (TF [REDACTED]) US Blackhawk Aero-Medical Evacuation (AME) helicopter;
 - b. Personnel at the [REDACTED] Role 2 Medical Facility at MNB-TK; and
 - c. Personnel at the Theatre Mortuary Affairs Evacuation Point for mortuary support in the [REDACTED]
- [REDACTED]

1) and combat casualty care was provided. Soldier 6 was initially assessed as having concussion and he was reported as ISAF Category (AS Priority 2) in the initial casualty evacuation (CASEVAC), but was soon revised as ISAF Category (AS Priority 3)

20. At approximately 1822h L, C/S was informed by C/S (the HQ element of) of an IED strike with casualties. At approximately 1832h L, C/S transmitted a North Atlantic Treaty Organisation (NATO) 9 Liner (with the on PTE Bewes) to C/S informed the appropriate personnel to stand up the AME helicopter. At approximately C/S received the on the second casualty, Soldier 6. At approximately the AME helicopter 'wheels up' from MNB-TK and 'wheels down' at the incident site at approximately. After loading PTE Bewes only, the AME helicopter subsequently 'wheels up' from the incident site at approximately and 'wheels down' at MNB-TK at approximately 1902h L. Soldier 6 was not placed on the AME helicopter due to his minor injuries and the negative effect that it would have on him travelling with his deceased mate, PTE Bewes. As a result of the detonation, PTE Bewes was Killed-In-Action (KIA) and Soldier 6 was Wounded-In-Action (WIA) –

21. On completion of the CASEVAC, C/S together with the PUC, returned to COP MASHAL at approximately 1854h L. Upon their return, C/S was tasked by C/S to physically re-secure the incident site. This was achieved through a combined AS and ANA patrol at approximately. The integrity of the incident site was maintained between. At approximately. Between the return of C/S and the arrival of, Soldier 6 was re-examined and evacuated back to the Role 2 Medical Facility at MNB-TK, together with at approximately.

Witnesses

22. Statements and/or interviews were obtained from/conducted with the following witnesses or others involved with the incident in AFG (Annex D):

- a. LTCOL M.R. Jennings



- b. **Soldier 17** [Redacted]
- c. **Soldier 18** [Redacted]
- d. **Soldier 19** [Redacted]
- e. **Soldier 20** [Redacted]
- f. **Soldier 21** [Redacted]
- g. **Soldier 22** [Redacted]
- h. **Soldier 23** [Redacted]
- i. **Soldier 1** [Redacted]
- j. **Soldier 24** [Redacted]
- k. **Soldier 25** [Redacted]
- l. **Soldier 26** [Redacted]
- m. **Soldier 27** [Redacted]
- n. **Soldier 2** [Redacted]
- o. **Soldier 28** [Redacted]
- p. **Soldier 16** [Redacted]
- q. **Soldier 29** [Redacted]
- r. **Soldier 30** [Redacted]
- s. **Soldier 46** [Redacted]
- t. **Soldier 3** [Redacted]
- u. **Soldier 31** [Redacted]
- v. **Soldier 32** [Redacted]
- w. **Soldier 33** [Redacted]
- x. **Soldier 34** [Redacted]





- y. **Soldier 35** [redacted]
- z. **Soldier 36** [redacted]
- aa. **Soldier 37** [redacted]
- bb. **Soldier 4** [redacted]
- cc. **Soldier 12** [redacted]
- dd. **Soldier 5** [redacted]
- ee. **Soldier 14** [redacted]
- ff. **Soldier 13** [redacted]
- gg. **Soldier 8** [redacted]
- hh. **Soldier 15** [redacted]
- ii. **Soldier 9** [redacted]
- jj. **Soldier 10** [redacted] and
- kk. **Soldier 11** [redacted]

23. Statements and/or interviews were obtained from/conducted with the following witnesses or others involved with the incident in Al Minhad Air Base (AMAB):

- a. **Soldier 38** [redacted] HQ Joint Task Force (JTF) 633 [redacted]
- b. **Soldier 39** [redacted] HQ JTF633 [redacted]
- c. **Navy Mbr 1** [redacted] HQ JTF633 (Tab 40);
- d. **Air Force Mbr 1** [redacted] HQ JTF633 [redacted]
- e. **Air Force Mbr 2** [redacted] Force Support Unit (FSU) [redacted]



- f. **Soldier 40** [REDACTED] – Australian Defence Force Investigative Service (ADFIS) (Tab 43); and
- g. **Soldier 41** [REDACTED] – RSM HQ JTF633 (Tab 44).

24. Statements and/or interviews were obtained from/conducted with the following witnesses or others involved with the incident on return to AS:

- a. **Civilian 1** [REDACTED] Defence Community Organisation (DCO) (Tab 45);
- b. **Soldier 42** [REDACTED] Commander Land Combat Readiness Centre (COMD LCRC), (Tab 46);
- c. **Air Force Mbr 3** [REDACTED] Senior Health Officer (J07) at Headquarters Joint Operations Command (HQJOC), (Tab 47);
- d. **Soldier 43** [REDACTED] HQ JTF633, (Tab 48);
- e. **Soldier 44** [REDACTED] (Tab 49); and
- f. **Soldier 45** [REDACTED]

Authority to Conduct the Operation

25. The incident occurred during the conduct of normal framework operations. These activities were appropriately approved IAW Australian National requirements by Commanding Officer (CO) MTF-1 through the issue of Operations Order (OPORD) [REDACTED]

26. The specific mission conducted on 9 July 2010 was assigned to **Soldier 3** by A/OC, **Soldier 16** [REDACTED]. The patrol was also sanctioned by [REDACTED]

Finding – The operation on 9 July 2010 was appropriately authorised.

Involvement by Civil and Service Authorities

27. The local ADFIS representative opened ADFIS Investigation [REDACTED] [REDACTED] into the incident in accordance with (IAW) reference F. There has been no other known AS, local or CF investigations or inquiries into this incident.

[REDACTED]

[REDACTED]

28. The Queensland Coroner conducted an autopsy on PTE Bewes' human remains (HR) on 12 July 2010. The Coroner's Report is yet to be received.

Deaths and Injuries

31. **Deaths – Australian.** PTE Bewes was KIA as a result of the IED detonation. PTE Bewes

As a result of the initial triage, he was assessed as being CAT A NVS. However, he was still treated for his wounds by combat medical staff. PTE Bewes was involved in a combat related activity at the time of his death.

32. A statement from the J07 at HQJOC, who attended his autopsy, concludes that 'PTE Bewes died from multiple injuries as a result of an IED Blast. His injuries were not survivable and he died instantly.

33. **Injuries – Australian.** Soldier 6 was WIA as a result of the IED detonation. Soldier 6 sustained concussion and as a result of the detonation. He was involved in a combat related activity at the time of his injuries.

34. **Injuries – Other.** There were no known injuries to CF, ANSF or LN personnel.

Finding – PTE Bewes was KIA as a result of an IED detonation and died instantly.

[REDACTED]

Loss and Damage of Service Property

35. All PTE Bewes' Service property has been accounted for. His [REDACTED] [REDACTED] were returned to AS and are currently in the custody of ADFIS. It is likely that this equipment will be written off [REDACTED] [REDACTED] If deemed necessary, this will occur through normal unit procedures, as required.

Finding – All PTE Bewes' Service property has been accounted for.

Environmental Conditions

36. **Terrain.** The IED was emplaced on foot pad which ran adjacent to the edge of aqueduct that ran East to West. The aqueduct was lined with trees to a height of approximately six metres with some small shrubs in the immediate vicinity. It was reported by AS FE that the aqueduct had been dry for at least three weeks. There was a

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

37. **Incident Site.** The CP was on the edge of a significant change in terrain between the green zone and the dasht (desert), located approximately [redacted] metres South of COP MASHAL. [redacted]



Figure One – Incident Site.

38. **Weather.** The weather on the day of the incident was fine with clear skies and no impediment to visibility.

39. **Human Activity.** There were only a few LN in the vicinity. Due to the incident earlier that morning, LN were possibly wary of further incidents after the mornings contact and therefore remained distant. When the IED exploded, the remaining LN left the area. [redacted]

Finding – The environmental conditions did not contribute to the incident.



Operational Conditions and Factors

40. **Pre-Patrol Intelligence** -- The pre-patrol intelligence was as follows:

- a. **Previous Patrolling Activities.** Numerous patrols had previously been undertaken in the area by C/S [REDACTED]. There were two patrols of note in the [REDACTED] prior to the death of PTE Bewes:

[REDACTED]

- (2) **ANA Patrol – 9 July 2010.** The next patrol of note is the ANA patrol that was conducted on the morning of 9 July 2010. The ANA patrol was contacted by INS within the same general area. During this patrol it was noted that the INS were more aggressive than usual and

[REDACTED]

It was against this background that the AS fighting patrol was ordered by the A/OC, **Soldier 16**

- b. **Passage of Intelligence.** It was known to the Patrol Commander and staff at COP MASHAL [REDACTED]. The threat of IED [REDACTED] was also known [REDACTED] at the time of the incident [REDACTED]. The [REDACTED] threat was not well known by the patrol personnel. Most personnel [REDACTED] the primary threat was from [REDACTED]. These devices, commonly referred to as [REDACTED] devices, influenced the positioning and employment of [REDACTED].
- c. **Understanding of the Intelligence.** Although [REDACTED] IED threats were known to the patrol, it was the greater threat of [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]
that [REDACTED] This was a realistic assessment supported by recent events [REDACTED]
[REDACTED] The Patrol Commander had accurately assessed the risk and deployed his assigned assets in an appropriate manner. [REDACTED]

Finding – The local IED threat was [REDACTED]
[REDACTED]

41. **Pre-Patrol Planning** – The pre-patrol planning was as follows:

- a. **General.** The patrol was ordered by **Soldier 16** [REDACTED] in response to the INS attack on an ANA patrol that morning. **Soldier 16** [REDACTED] insisted that the patrol investigate the area of interest as [REDACTED]
[REDACTED]
- b. **Intent for Normal Framework Operations.** The patrol was intended as a fighting patrol to [REDACTED]
[REDACTED]
- c. **Planning.** There was limited time for detailed planning to be conducted. **Soldier 3** [REDACTED] had requested **Soldier 16** [REDACTED] reconsider the patrol on the basis that:

- (1) [REDACTED]
[REDACTED]
- (2) [REDACTED]
[REDACTED]
- (3) [REDACTED]
[REDACTED]

42. After some discussion between **Soldier 16** [REDACTED] and **Soldier 3** [REDACTED] **Soldier 16** [REDACTED] ordered the patrol to proceed. [REDACTED]

43. **Orders.** Orders were received from **Soldier 16** [REDACTED] at approximately [REDACTED] to conduct an non-partnered fighting patrol IVO [REDACTED] IOT [REDACTED]
[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

44. **Command and Control.** The A/OC was **Soldier 16** and the Patrol Commander was **Soldier 3**. Although the chain of command was clear, [REDACTED]

[REDACTED] **Soldier 16** [REDACTED]

Communications between the two locations is enabled by [REDACTED]. Movement between the two locations is very restricted [REDACTED]

[REDACTED] generally requires [REDACTED] to support safe passage.

Contribution of Operational Conditions and Factors to the Incident.

45. **Understanding the Mission.** It is important to understand the extant guidelines governing MTF activities. Under the MTF mission, the role states that the 'ANA should take the lead in most operations [REDACTED]

[REDACTED] There will be times when ANA will not be directly involved in an operation, however the purpose of such operations must be linked to [REDACTED]

[REDACTED]

[REDACTED] Under the Commander's Intent, it also states that 'All operational patrols and activities are to have a clear mission/task that [REDACTED]

[REDACTED] With the exception of [REDACTED] in particular, no operation or patrol is to be conducted unless it is [REDACTED] or has a clear [REDACTED]

[REDACTED] mission/task to achieve. In principle security operations are to be partnered. Procedures are to be developed for the conduct of [REDACTED] patrols'.³¹

46. Implied in these guidelines is the requirement to [REDACTED] which would include [REDACTED]. However, such

patrols have the requirement to be appropriately planned and considered prior to being implemented. It appears from the evidence that **Soldier 16** directed the patrol occur IOT [REDACTED], to [REDACTED] in the area, and to [REDACTED]

[REDACTED] This intent is echoed in the [REDACTED] however the purpose stated in the [REDACTED] is to [REDACTED]

[REDACTED] Noting the similarities between **Soldier 16** direction and the documented [REDACTED] I conclude the conduct of the patrol was IAW the MTF-1 Mission guidelines.

[REDACTED]

[REDACTED]

47. Although the unpartnered fighting patrol was at short notice, it appears from the evidence that **Soldier 16** conducted deliberate planning to task the patrol. However, the following criticisms were directed at **Soldier 16** in directing the patrol from the perspective of some of the Patrol members:

- a. Ordering the conduct of an AS only fighting patrol ³³
- b. Failing to _____ or immediately request _____ for example, _____ ³⁴
- c. Insisting the patrol continue despite the concerns being raised _____ that supported **Soldier 3** concerns _____ ³⁵

Finding – The AS only fighting patrol was appropriately planned, authorised and conducted.

48. **Relief Out of Country Leave (ROCL)/Relief Out of Country Fare Assistance (ROCFA) Period.** The new role for MTF-1 was well understood by key MTF-1 command/staff incumbents, however, at the time of the incident two key command positions (the OC MT-C and the Platoon Commander of COP MASHAL) were being manned by junior members due to ROCL/ROCFA absences. The A/OC was **Soldier 16** and the Acting Platoon Commander was **Soldier 3**. Both members had limited command experience and were operating in an isolated environment without additional control measures in place. While additional control measures may not have

³³ **Comment:** The aspect of ANA partnering the AS patrol has already been discussed in paragraphs 45 and 46. I consider the ordering of the unpartnered AS only fighting patrol to be appropriate IOT support LN confidence building in the capacity of the ANSF/CF IAW the Mission.

³⁴ **Comment:** The aspect of failing to _____ is argued by **Soldier 16** _____ as the responsibility of the Commander of C/S **Soldier 3**. This criticism stems primarily from the soldiers participating in the patrol, who may not have been fully aware of the fact that _____ was on call. Noting the task was to _____ I support **Soldier 16**'s conclusion that 'the patrol strength was sufficient for the task and IAW the common practices of all MTF-1 operations at the time.'³⁴

³⁵ **Comment:** **Soldier 16** _____ states that _____ throughout our deployment to Afghanistan. It was _____ and only effected decision making when _____. At no stage during both the planning and conduct of the patrol was _____. Further, at no stage during the patrol do I recall **Soldier 3** concerns relating to _____. In any event, as the ground commander **Soldier 3** had full authority to _____. If **Soldier 3** deemed that the information _____ presented such an increase in threat as to require the mission be abandoned, then he had the authority to make this decision. As it happened, and as I have stated to the CDF COI Inquiry Officer on 20 Oct 10, **Soldier 3** did _____, and I supported him as the ground commander to make this decision.* I conclude that **Soldier 3** was supported by **Soldier 16** during the conduct of the patrol.

[REDACTED]

been deemed necessary, a risk assessment should have been conducted on the impacts of leave periods on the operational manning of key command positions.

Finding – The synchronisation of the ROCL/ROCFAs Program had potential implications on command decision making surrounding this patrol.

Recommendations. It is recommended that all temporary replacements for key command positions are carefully vetted and that comprehensive handover/takeovers are conducted prior to the incumbent proceeding on leave periods.

49. [REDACTED] There was [REDACTED] at the time of the patrol that [REDACTED]. An intelligence review of the information reveals [REDACTED]. The evidence also suggests that [REDACTED]. The information provided by [REDACTED] was accurate and timely.

50. [REDACTED] **Analysis and Fusion of Information.** Personnel at COP MASHAL had [REDACTED] to inform them of [REDACTED] however, it appears that due to the [REDACTED].

a. [REDACTED]

b. [REDACTED]

51. **Information Clarity.** Personnel at COP MASHAL, [REDACTED] believed that [REDACTED]. When in fact, [REDACTED].

[REDACTED]

[REDACTED]

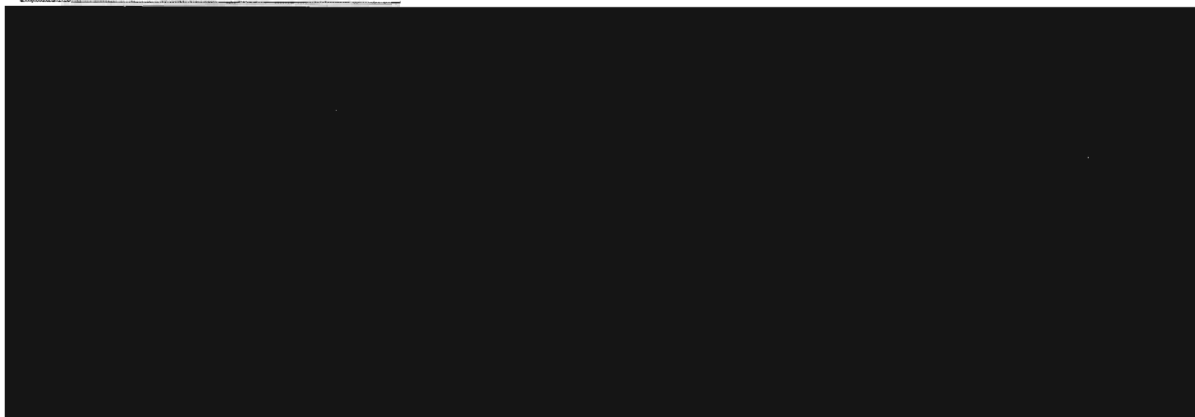
52. **Information Fusion.** There is a need to ensure [REDACTED]

[REDACTED] A synthesis of information dissemination at [REDACTED] level is required to support [REDACTED] decision making.

53. **PTE Bewes' Conduct and Professionalism.** PTE Bewes was known to volunteer for patrols and was [REDACTED] for approximately [REDACTED] of them. [REDACTED] Of particular note was the fact that he was involved in a near miss incident the [REDACTED] 2010, as the [REDACTED] PTE Bewes was 'in the [REDACTED] for about 5 minutes before [they] managed to get him back'. [REDACTED] On the morning of 9 July 2010, the ANA had been [REDACTED] from a determined INS contact. This concerned many of the AS personnel at COP MASHAL who were not overly happy with mounting another patrol that day. However, without hesitation, PTE Bewes again volunteered to be [REDACTED]

54. **Patrol Composition.** The patrol composition on 9 July 2010 included an [REDACTED] **Soldier 1** [REDACTED] conducting a [REDACTED] initiated by the CO MTF-1. [REDACTED] **Soldier 1** was carrying [REDACTED] and was the [REDACTED] person in the order of march on the return leg to COP MASHAL, just prior to the IED detonating. [REDACTED] There are a number of issues that arise from the member attending this patrol:

- a. **Authority to Patrol.** While the patrol on 9 July 2010 was appropriately authorised, the attendance of the **Soldier 1** [REDACTED] was not. The relevant [REDACTED] was authorised on 2 June 2010 by CO MTF-1 [REDACTED]. The [REDACTED] clearly indicates that **Soldier 1** had authorisation from 2 June 2010 to visit [REDACTED] [REDACTED] for the purpose of [REDACTED] not to conduct patrolling activities with the soldiers. The evidence clearly indicates



[REDACTED]

that **Soldier 1** travelled to the field on [REDACTED] and started patrolling on [REDACTED]. He had already completed [REDACTED] patrols and two [REDACTED] [REDACTED] prior to the submission and approval of the Proposal on 2 June 2010. Evidence clearly indicates that **Soldier 45** [REDACTED] at the time, was aware of **Soldier 1**'s patrol attendance. **Soldier 45** notes on **Soldier 1** Performance Appraisal Report on 10 June 2010 that he '...used his initiative to identify suitable [REDACTED] tasks, volunteered to participate in patrolling operations with [REDACTED] Force Elements...'.⁴⁷ However, both CO MTF-1, [REDACTED] are adamant that his [REDACTED] tasks were only to be conducted within the confines of [REDACTED]. **Soldier 1** acknowledges that he had no 'specific approval' to conduct such activities [REDACTED].

- b. **Training/Competency.** **Soldier 1** had not been certified, on the Headquarters 1st Division (HQ 1 Div) Mission Rehearsal Exercise (MRE), prior to conducting operations outside of the COP. His training was limited to attending the basic training required for individuals working from base environments within AFG. [REDACTED] **Soldier 1** attended the training like most other soldiers, but had limited understanding on the [REDACTED]. He was therefore reliant on being directed by the **Soldier 4** [REDACTED].
- c. **Chain of Command.** The chain of command for **Soldier 1** was unclear and did not contain appropriate control measures. [REDACTED] The current J8 HQ JTF633, **Soldier 43** identified concerns with [REDACTED] soon after taking over his appointment and following his discussion at VTC he submitted a formal Reach back Request [REDACTED] a review of [REDACTED].

55. Although the [REDACTED] chain of command for **Soldier 1** was unclear, his [REDACTED] tasks in [REDACTED] were clear. It appears **Soldier 1** invited himself on patrols without first applying for and receiving the appropriate authorisation from HQ MTF-1. [REDACTED] **Soldier 1** did not have the appropriate training or waiver to participate on patrols, although this appears to have been sanctioned by the **Soldier 45** [REDACTED].

⁴⁷ Statement of [REDACTED] **Soldier 1** states that **Soldier 43** was also aware of his patrolling activities. [REDACTED]

Individual attachments to [REDACTED] need to be clearly briefed and controlled to ensure individual safety is maintained and operational tasks are not compromised.

Action Taken – HQ JTF633 has since released a new Standing Instruction on [REDACTED]. This document now provides robust command and control arrangements for all [REDACTED] and guidance for the conduct of [REDACTED] in MEAO (Annex M). [REDACTED]

Findings – The following findings are made:

- a. The information provided by the [REDACTED] was accurate and timely.
- b. A synthesis of information dissemination at [REDACTED] level is required to support local tactical decision making.
- c. Evidence indicates that a member accompanied MTF-1 patrols without adequate training or authority; however more robust control measures are now in place to prevent future reoccurrences of this nature.

Recommendations. It is recommended that:

- a. The process of [REDACTED] be reviewed IOT [REDACTED]
- b. The authorisation process of members attending patrols is reviewed.

Device Construction and Method of Operation

56. Whilst the device was initially reported to have been [REDACTED] by the AS WIT that investigated the incident, [REDACTED] this was later amended to [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] The following is an assessment of the device: [REDACTED]

a.

[REDACTED]

b.

c.

d.

e.

[REDACTED]

[REDACTED]

[REDACTED]

Finding – The IED that killed PTE Bewes was most likely [REDACTED]
[REDACTED]

Training and Procedures

57. **Training - General.** PTE Bewes was enlisted into the Australian Regular Army (ARA) on 9 May 2005 and was posted to the 6 RAR on 22 February 2006. He had previously done one tour of AFG over the period [REDACTED]. PTE Bewes commenced his [REDACTED] Training for MTF-1 on [REDACTED] completing the [REDACTED] Course (which included Explosive Hazards Awareness Training (EHAT) conducted by the [REDACTED]) over the period [REDACTED]. He attended the MTF-1 MRE conducted by the [REDACTED] at the [REDACTED] Field Training Area [REDACTED] over the period [REDACTED]. PTE Bewes deployed to AFG on 26 January 2010 (Annex K). [REDACTED]

58. PTE Bewes was outside of the [REDACTED] period for redeployment to the MEAO and had undertaken all mandatory training prior to his deployment with MTF-1. Taking into account PTE Bewes' experience from his previous tour of AFG, including pre-deployment training, the member was well prepared and certified for deployment to the MEAO.

59. **Training - General.** There was [REDACTED] training conducted by the [REDACTED] as part of the mandatory EHAT for MTF-1. [REDACTED]

60. At the time of MTF-1 deployment, there was no [REDACTED]
[REDACTED]

61. The Officers and Soldiers at COP MASHAL had [REDACTED] within the limitations of their training and understanding of both [REDACTED] and the [REDACTED]. The patrol personnel believed that [REDACTED] and had [REDACTED] appropriately. [REDACTED]

[REDACTED]

[REDACTED]

62. **Specialist Training.** [REDACTED] were provided with a comprehensive theoretical and practical [REDACTED] package during the conduct of their specialist Specific to Theatre training. Teams were assessed during their Certification Exercise (CERTX).

63. **Training versus Issuing of [REDACTED]** training for MTF-1 was limited due to the fact that [REDACTED]. The priority was to issue [REDACTED] with minimal training as opposed to not issuing [REDACTED] until the development of a more comprehensive training package. The later decision would have left soldiers without [REDACTED].

64. There is no evidence to suggest that a better [REDACTED] regime could have been incorporated for MTF-1 [REDACTED] within the short training window available prior to deployment. There were also steps being taken to address the shortfalls known about the training at the time. [REDACTED] However, a more robust [REDACTED] package has now been developed and being utilised in Force Preparation training by HQ 1 Div. [REDACTED]

Finding – Although [REDACTED] was limited at the time, it was the best training available in the interests of disseminating essential [REDACTED] in a timely manner. Current [REDACTED] is now well advanced and has addressed all issues identified. All other training and procedures were seen to be effective and efficient and did not contribute to the incident.

Post Incident Events and Factors

65. **Medical Treatment.** Immediately after the IED detonation, when casualties were identified, first aid was promptly provided by the Patrol Medic, **Soldier 9**, and Combat First Aiders, **Soldiers 5 and 8**. PTE Bewes was assessed as having [REDACTED] (NVS). PTE Bewes' reported injuries included: an [REDACTED]. The other casualty, **Soldier 6** was initially assessed as having [REDACTED] his category was [REDACTED]

[REDACTED]

⁶³ Transcript of [REDACTED] The training to support this has been redesigned and... includes a new system where the Combat Training Centre is engaged in a series of exercises that lead up to the mission rehearsal exercise that provides opportunities to be exposed to the challenges associated with the [REDACTED] threats and the employment of [REDACTED]

[REDACTED]

reported as ISAF CAT [REDACTED] in the initial CASEVAC. However, the Patrol Medic, in his evidence, recalls assessing Soldier 6 as ISAF CAT [REDACTED]

66. **CASEVAC.** Two separate CASEVAC occurred in relation to this incident. The initial CASEVAC involved the use of a TF [REDACTED] US Blackhawk AME helicopter from MNB-TK. At approximately 1822h L (two minutes after the IED detonation), C/S [REDACTED] (the MTF-1 CP [REDACTED] were informed by C/S [REDACTED] (the HQ element of MT [REDACTED] [REDACTED] of an IED detonation with casualties. At approximately 1832h L, C/S [REDACTED] transmitted a NATO 9 Liner (with [REDACTED] on PTE Bewes) to C/S [REDACTED]. Between [REDACTED] and [REDACTED] the C/S [REDACTED] informed the appropriate personnel to stand up the AME helicopter. At approximately [REDACTED], C/S [REDACTED] received the [REDACTED] on the second casualty, Soldier 6. At approximately [REDACTED] the AME helicopter wheels up from MNB-TK and wheels down at the incident site at approximately [REDACTED]. After loading PTE Bewes, the AME helicopter subsequently wheels up from the incident site at approximately [REDACTED] and wheels down at MNB-TK at approximately 1902h L. From initial reporting to AME response was 19 minutes.

67. Soldier 6 was not placed on the initial CASEVAC helicopter due to the concern for his mental well being. It was assessed by Soldier 5 and others close to PTE Bewes that it was not in Soldier 6's best interests to travel back in the same helicopter as PTE Bewes' HR. Soldier 6 returned to COP MASHAL with the remainder of C/S [REDACTED] and was reassessed by the Patrol Medic. Soldier 6 was assessed as ISAF CAT [REDACTED]. As a precautionary measure, Soldier 6 was later CASEVAC from COP MASHAL to MNB-TK at [REDACTED] that day. Overall, the medical treatment and evacuation process in support of PTE Bewes was professionally and promptly facilitated by all involved.

68. **Casualty Notification.** The appropriate notifications were completed IAW current guidelines and procedures in a timely and efficient manner (Annex M). [REDACTED]

69. **Repatriation.** At all times following his death, PTE Bewes' HR were treated with dignity and respect by his comrades. Following his return to MNB-TK, MTF-1 placed a vigil at the [REDACTED] Role 2 Medical Facility Morgue until the ramp ceremony and subsequent departure of his HR by AS C130. Prior to the ramp ceremony, a memorial service was conducted by MTF-1 and attended by CF allies. Subsequent ramp ceremonies were conducted in [REDACTED] and AS. [REDACTED]

70. There were no issues with the repatriation of PTE Bewes' HR back to AS. The various ramp ceremonies and the subsequent burial occurred in an appropriate manner,



[REDACTED]

showing due respect for a fallen soldier. There were even accepted changes to protocol to allow members to show their respects in an individual manner. As noted by the RSM HQ JTF633 during PTE Bewes' memorial service in TARIN KOWT '...his section jumped up on the stand at the memorial service and stood behind the young man who spoke on behalf and remembered Nathan. Which hadn't happened before...Very moving'.

Findings – The following findings are made:

- a. The medical treatment and evacuation process in support of PTE Bewes was professionally and promptly facilitated by all involved.
- b. The repatriation of PTE Bewes HR was carried out professionally and efficiently while maintaining due dignity and respect.

Other Factors – Equipment

[REDACTED]

72. The disposition of these assets in relation to the [REDACTED] along with the names of the personnel carrying them, is detailed in [REDACTED]. The following Table details [REDACTED].

[REDACTED]

[REDACTED]

Table One

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] The following comments are drawn from an analysis of the above table and the positioning of [REDACTED] at the time of the incident:

[REDACTED]

74. **Doctrine and Training.** The doctrine and training extant at the time of the incident, indicates that [REDACTED]

[REDACTED]

[REDACTED] **Tactics.** [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]



Figure Three – Recreation of Position of [REDACTED]
 (Note: The geographical features [REDACTED])

77. [REDACTED] Deployment. Given the likelihood of contact with the INS, the Patrol Commander chose to use a [REDACTED] formation that [REDACTED]. This offered the best [REDACTED]. Given all of the factors and evidence on that day, the decision to adopt a [REDACTED] formation and to use [REDACTED] was sound.¹² However, [REDACTED] formation has limitations on [REDACTED].

78. The [REDACTED] was a contributing factor in PTE Bewes' death. However, [REDACTED] deployed based on the main threat being [REDACTED]. The Patrol Commander also correctly orientated his [REDACTED] against the imminent threat of INS contact, which was [REDACTED]. This formation, however, limited [REDACTED].

¹² This also supported by the [REDACTED] assessment 'Overall, the decision to utilise the [REDACTED] to [REDACTED] is considered reasonable considering the [REDACTED] threat that existed, and the heavy [REDACTED]'. [REDACTED]

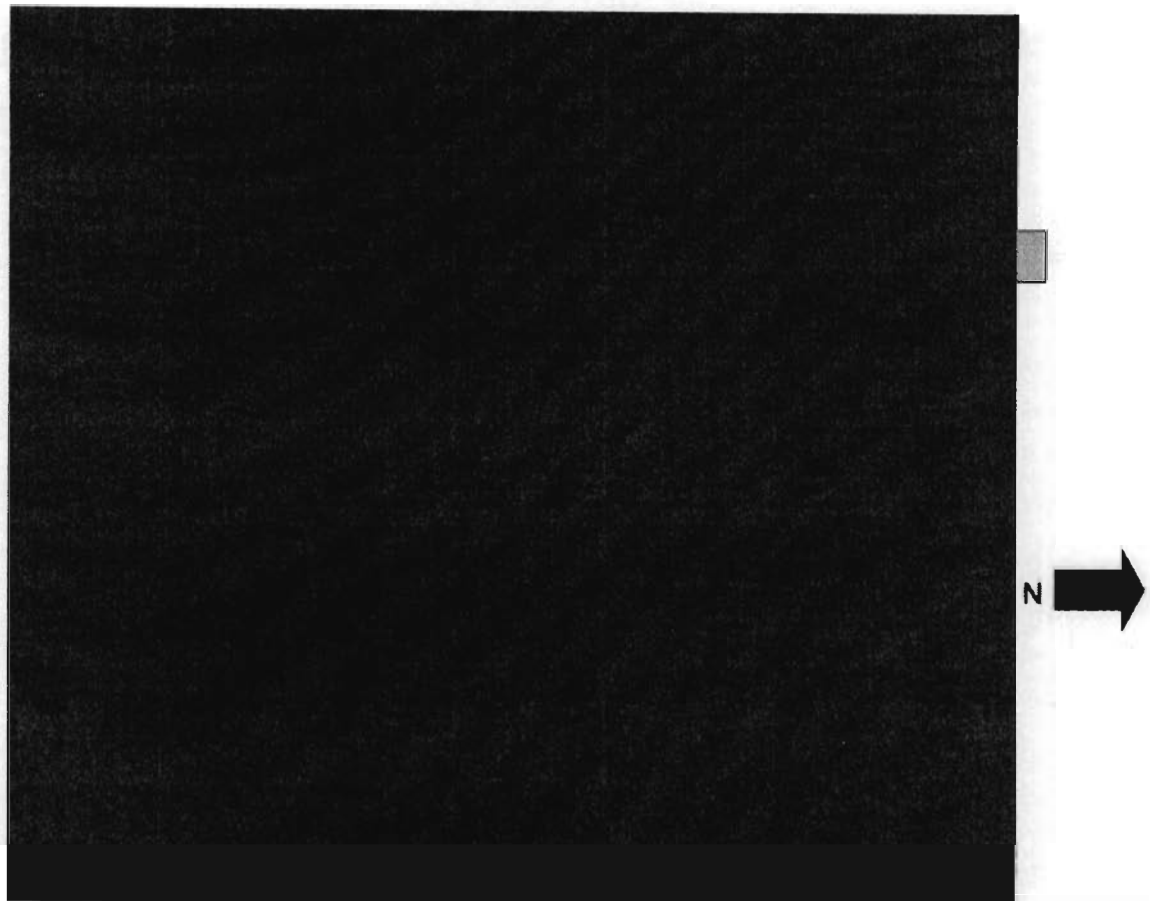


Figure Four – Approximate Position of [redacted] prior to IED Detonation.
 (Note: The [redacted])

79. [redacted] Equipment. The patrol was [redacted]. There is currently a program underway to purchase and provide [redacted] to [redacted] personnel [redacted]. These [redacted] will provide a [redacted] where [redacted] are not available or where [redacted].

Findings – The following findings are made:

- a. The [redacted] was a contributing factor in PTE Bewes' death. However [redacted] was deployed based on the main threat being perceived as [redacted]. The Patrol Commander also correctly orientated his Platoon against the imminent threat of INS contact. While this action maximised [redacted] it also limited [redacted].

- b. The employment of [REDACTED] may provide a limited [REDACTED] for [REDACTED] patrols where [REDACTED] are not available or where [REDACTED]

80. **Personal Protective Equipment (PPE).** PTE Bewes was wearing an In-Service combat helmet and [REDACTED] body armour at the time of the incident. Owing to PTE Bewes' position in relation to the blast [REDACTED] and the estimated [REDACTED] of the device, the protective effects of the PPE were negated.

81. **Patrol Routes – Pattern Setting.** There is no evidence to suggest that MT-C had been complacent in their drills. [REDACTED] MT-C had carried out in excess of [REDACTED] patrols from the COP, both day and night. Due to the [REDACTED]

There is no evidence to suggest that the patrol was pattern setting.

82. **Drugs and Alcohol.** There is no evidence that drugs or alcohol were involved or contributed to the death of PTE Bewes or the injuries sustained by [REDACTED] Soldier 6

Findings – The following findings are made:

- a. There is no evidence to suggest that the patrol was pattern setting.
- b. There is no evidence to suggest that drugs or alcohol were involved in the incident.

Performance of Duty

83. After assessing the available evidence, there is evidence to suggest that [REDACTED] Soldier 1's performance of duty is questionable. He knowingly attended patrols without proper training or authority. His actions had the potential to place himself and others at risk. The evidence from which this conclusion is drawn was discussed at paragraphs 52 to 53.⁷⁴

⁷⁴ IAW procedural fairness, [REDACTED] was offered the opportunity to respond to the extracts of the report pertaining to his conduct. [REDACTED] response states that [REDACTED] was also aware of his patrol participation [REDACTED]

84. The available evidence suggests that the actions and behaviour of **Soldier 3**, **Soldier 5** and **Soldier 8** were both commendable and noteworthy of recognition.

Findings – The following findings are made:

- a. **Soldier 1**'s performance of duty was questionable.
- b. The actions and behaviour of **Soldier 3**, **Soldier 5** and **Soldier 8** were both commendable and noteworthy of recognition.

Conclusion

85. PTE Bewes was KIA as a result of the injuries he sustained from an IED detonation on 9 July 2010. Medical evidence suggests that PTE Bewes died instantly and no amount of medical intervention would have saved his life.

86. PTE Bewes was a professional and dedicated soldier. He was very well regarded within his Platoon and despite being involved in a near miss incident, the [REDACTED] willingly volunteered to act as the [REDACTED] on 9 July 2010.

87. The personnel involved in this incident performed creditably in dangerous and chaotic circumstances. The ability of the patrol to perform their tasks to the level they did and maintain cohesion is a testament to their training and professional conduct.

88. While there were some shortfalls in [REDACTED] training at the time, the necessity to [REDACTED] to deployed personnel was seen as a sound decision. IED threat intelligence, planning and orders were all sufficient prior to the incident and there were no shortfalls identified in these areas that contributed to the death of PTE Bewes. A CDF Commission of Inquiry (COI) is unlikely to discover any further relevant material, information or evidence in the context of this incident.

Finding – A CDF COI into the death of PTE Bewes is not warranted.

Recommendation – The appointment of a CDF COI into this matter is not warranted.

Findings

89. I find the following:

- a. The operation on 9 July 2010 was appropriately authorised.
- b. PTE Bewes was KIA as a result of an IED detonation and died instantly.

- [REDACTED]
- c. All PTE Bewes' Service property has been accounted for.
 - d. The environmental conditions did not contribute to the incident.
 - e. The local IED threat [REDACTED]
[REDACTED]
 - f. The AS only fighting patrol was appropriately planned, authorised and conducted.
 - g. The synchronisation of the ROCL/ROCA Program had potential implications on command decision making surrounding this patrol.
 - h. The information provided by the [REDACTED] was accurate and timely.
 - i. A synthesis of information dissemination at [REDACTED] level is required to support local tactical decision making.
 - j. Evidence indicates that a member accompanied MTF-I patrols without adequate training or authority; however more robust control measures are now in place to prevent future reoccurrences of this nature.
 - k. The IED that killed PTE Bewes was most likely [REDACTED]
[REDACTED]
 - l. Although [REDACTED] was limited at the time, it was the best training available in the interests of disseminating essential [REDACTED] in a timely manner. Current [REDACTED] is now well advanced and has addressed all issues identified. All other training and procedures were seen to be effective and efficient and did not contribute to the incident.
 - m. The medical treatment and evacuation process in support of PTE Bewes was professionally and promptly facilitated by all involved.
 - n. The repatriation of PTE Bewes HR was carried out professionally and efficiently while maintaining due dignity and respect.
 - o. The [REDACTED] was a contributing factor in PTE Bewes' death. However, [REDACTED] was deployed based on the main threat being perceived as [REDACTED]. The Patrol Commander also correctly orientated his Platoon against the imminent threat of INS contact. While this action maximised [REDACTED] it also limited [REDACTED]
 - p. The employment of [REDACTED] may provide a limited [REDACTED] for [REDACTED] patrols where
- [REDACTED]

[REDACTED] are not available or where [REDACTED]

- q. There is no evidence to suggest that the patrol was pattern setting.
- r. There is no evidence to suggest that drugs or alcohol were involved in the incident.
- s. Soldier 1 performance of duty was questionable.
- t. The actions and behaviour of Soldier 3, Soldier 5 and Soldier 8 were both commendable and noteworthy of recognition.
- u. A CDF COI into the death of PTE Bewes is not warranted

Recommendations

90. I recommend the following:

- a. All temporary replacements for key command positions are carefully vetted and that comprehensive handover/takeovers are conducted prior to the incumbent proceeding on leave periods.
- b. The process of [REDACTED] reviewed IOT [REDACTED] be [REDACTED]
- c. The authorisation process of members attending patrols is reviewed.
- d. The appointment of a CDF COI into this matter is not warranted.


[REDACTED] COX, CSC
Colonel
Inquiry Officer

23 February 2011

[REDACTED]