LOCKE INQUIRY/OUT/2008/

INQUIRY OFFICER'S REPORT INTO THE DEATH OF 8229246 SGT MR LOCKE IN AFGHANISTAN ON 25 OCT 07

References:

A. CDF Instrument of Appointment dated 29 Oct 07
B. CDF Terms of Reference dated 29 Oct 07
C. Quick Assessment by – *Death of Australian During Incident* dated 25 Oct 07
D. Map Central and Western Uruzghan Province Planning Map - Afghanistan, 1:100,000
E. CDF ROEAUTH - ROE Serial 5 dated 12 Oct 07
F. DI(G) ADMIN 45-2 *Reporting and Investigation of Alleged Offences within the Australian Defence Organisation* dated 30 Oct 01
G. DI(G) PERS 11-2 *Notification of Service and Non-Australian Defence Force casualties* dated 18 Dec 01
H. ADFP 1.1.1 *Mortuary Affairs* dated Jan 07
I. DI(G) PERS 20-6 *Deaths within and outside Australia of Australian Defence personnel* dated 18 Sep 06
J. CDF Directive 12-2006 *Interim Arrangements for CDF Commissions of Inquiry into ADF Suicides and Deaths in Service* dated 30 May 06
K. Defence (Inquiry) Regulations, 1985, Part 8, *CDF Commissions of Inquiry* dated 26 Jun 07
L. ADFP 202 *Administrative Inquiries Manual*

Appointment and Terms of Reference

1. I, 8264599 LTCOL SG Durward, SC, having been duly appointed by Air Chief Marshal Allan Grant Houston, AO, AFC, Chief of the Defence Force, to inquire into the circumstances and facts surrounding the death of 8229246 Sergeant Matthew Raymond Locke in accordance with the Terms of Reference attached to the Instrument of Appointment (**Annex A**) herein submit my report.

Inquiry Officer Team

2. The Inquiry Team consisted of myself and two Assistant Inquiry Officers;

   a. 8223745 COL Gary Bruce Hevey, RFD; and

   b. 8223830 COL Peter John Short, DSC.

Introduction

3. On the morning of 25 Oct 07, , were involved in an operation in support of other coalition forces in Uruzgan Province, Afghanistan.

was conducting an interdiction task when their patrol commander SGT MR Locke was fatally wounded (the incident). SGT Locke was treated at the incident scene and aero-medically evacuated to Camp Russell medical facilities where he was pronounced life extinct. A Quick Assessment was conducted by the and is attached at **Annex B**.

Narrative[2]

4. was the code name for their role in supporting Region Command South's (RC(S)) ongoing operations against the Taliban, code named It was during Phase Two of that the incident occurred.

had cause to halt and discuss the sighting of an unarmed fighting age male[4].

At 0749 h and as the lead scout crossed a 15 to 20 metre wide exposed[5] gap in the vegetation, a heavy burst of machine gun[6] fire emanated from the WSW in the direction of the patrol. Members of the patrol immediately returned fire. In the earliest stages of the contact, the lead scout's pack was struck by a projectile, knocking him down and SGT Locke was fatally shot. Members of the patrol including a patrol medic provided immediate first aid to SGT Locke. SGT Locke was moved rearward under fire where he was attended to by the medical officer[7]. Throughout this time the patrol, along with reinforcing elements of were in contact with the enemy who were also attempting to outflank them to cut off their withdrawal. At 0858 h SGT Locke was aero-medically evacuated (AME) to Camp Holland. The AME occurred in very hazardous circumstances with the AME helicopter and other supporting rotary wing (RW) assets taking heavy fire from the enemy. force elements successfully broke contact in conjunction with force elements at 0929 h. The RW AME was damaged by fire and grounded upon reaching Camp Holland, Tarin Kowt. Upon arrival at Camp Holland, SGT Locke was eventually pronounced as being extinct of life at 0749 h.

5. An image of the incident site is included at **Annex C**. It depicts the location of the members of and the direction of enemy fire at the time of the incident.

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[1] Also referred to

[2] All times local (DE), 5.5 h behind AEST at time of incident.

[3]

[4] Upon sighting the Australian patrol, the FAM local national moved away and out of sight. The location where this occurred was a small cornfield approximately 100m x 100m in size. It provided excellent fire lanes and was assessed as a good ambush location for a waiting, unseen enemy force. These two factors created the suspicion.

[5] Devoid of cover or concealment.

[6] Anecdotal evidence from witness statements which describes the initial fire as heavy and automatic small arms fire.

[7] force elements fought forward to bring the MO to SGT Locke.

Date, Time and Place of Incident

6. The incident occurred approximately 23km of Tarin Kowt, Afghanistan.

Units Involved

7. was conducting in support of the directed Australian forces comprised No other Afghanistan based Australian forces participated directly in Australian forces operated in conjunction with other coalition military forces however consisted of only Australian ground forces. As part of a coalition operation, force elements had coalition air assets at their disposal.

Authority to Conduct the Operation

8. The operation during which the incident occurred was code named was the supporting contribution to conducted The aim of was to disrupt Taliban forces within a key Taliban line of communication. It is notable that the directed operation emanated from provided intelligence. The Australian participation had been approved by CJTF633, SOCAUST and COMISAF (**Annex E** refers). All Australian personnel involved in were considered to be on duty at the time of the incident.

Involvement by Civil and Service Authorities

9. A theatre based Australian Defence Force Investigation Service team took initial statements from witnesses and commenced gathering evidence prior to the arrival of the Inquiry Team. The ADFIS personnel continued to support the Inquiry Team throughout the gathering of evidence. There has been no ADF service investigation into the incident. An ADFIS report, based upon analysis of the initial statements taken and early evidence collected is included as **Annex D**.

10. Due to the high security risk, the Inquiry Team was not able to visit the actual site of the incident. This was not considered to be a significant shortfall given the availability of imagery. The Team was able to conduct the Inquiry without any impact upon deployed forces.

11. The death of SGT Locke has not been investigated by any other military or civil agency.

Death and Injuries

12. **Deaths.** 8229246 SGT Matthew Raymond Locke, posted to the Special Air Service Regiment, was killed in action as a result of this combat related incident. His next-of-kin is was informed on 25 Oct 07 at approximately 1858 h (AEST).

13. SGT Locke sustained a single gunshot wound to his chest. The entry wound was located in the upper left chest just below the left clavicle. From witness statements, it is likely that the projectile was a 7.62mm high velocity projectile fired from a machine gun, likely to be a

PKM heavy machine gun[8] but this weapon system can only be speculative. The projectile appears to have entered SGT Locke's chest from an elevated angle striking in a downward, angled direction.[9]

I note that the attending doctor at Tarin Kowt made the assessment that there was no exit wound. This statement is made at **Annex E**, the AD604 Certification of Death.

The description of SGT Locke's posture (kneeling within a shallow irrigation ditch), the absence of life signs (all provided by 'on the ground' witnesses) and the location of the entry wound supports the downward trajectory of the projectile theory and this in turn, supports the supposition that the projectile may have disintegrated within SGT Locke's upper torso with some fragments exiting at the lower left back region.

14. The formally recorded time of death was originally stated on the Certification of Death (see encl 3 to **Annex B**) by as 0900 h. This was amended to 'at scene' and therefore equating to 0749 h (local). Whilst an autopsy would provide definitive proof, I am satisfied that sufficient evidence exists to conclude that SGT Locke died almost immediately from a single gun shot wound to the upper left chest as a result of a 7.62 mm high velocity round fired from a machine gun, probably a PKM heavy machine gun. I am satisfied that SGT Locke's time of death is 0749 h (local or 1319 h AEST).

15. The matter of why an autopsy was not conducted is dealt with later in this report (paras 40 to 42.

16. At all times following his death, SGT Locke was treated with dignity and respect by his comrades. His repatriation to Australia and the military funeral was indicative of a man who died in the service of his country.

17. **Injuries.** There were no injuries to Australian service personnel as a result of this incident.

Damage to Property

18. SGT Locke's service related equipment and clothing was destroyed as a result of first aid treatment at the scene and blood contamination. Whilst the availability of SGT Locke's clothing would have been useful for assisting the determination of whether an exit wound existed or not, I note the difficulties and extremeness of the circumstances the soldiers were confronted with as they attended to SGT Locke under fire.

19. There was no collateral damage that occurred as a result of this incident.

Witnesses

20. **Statements.** Statements were obtained from the following members:

[8] The PKM heavy machine gun is a common weapon used by Taliban forces and would more than likely be their preferred small arms weapon to initiate an ambush in the given circumstances of the incident.
[9] This remains conjecture since only an autopsy could determine the actual trajectory taken by the projectile.

a.

b.

c. (incl addendum statement);

d. (incl addendum statement);

e. (incl addendum statement);

f. (incl addendum statement);

g. (incl addendum statement);

h.) (incl addendum statement); and

i. (incl addendum statement).

21. These statements are contained at **Annexes F** to **N**.

22. The following witnesses provided notes or statements which are included as **Annexes O** to **P**:

a. , Medical Officer, Reconstruction Task Force Three (RTF 3); and

b. , ADFIS; and

23. I advise that I found each of the witnesses interviewed to be honest and forthcoming. They appeared to be capable, well trained soldiers who handled the difficult task with which they were confronted with professionalism. I found no evidence of collusion between them or any attempt to reconstruct their version of events. While there were some small variations in relation to unimportant matters those variations are such as one would expect having regard to the vagaries of individual memory, different perspectives from which observations were being made and the friction experienced in circumstances of combat.

Environmental Conditions

24. **Terrain.** The terrain is located within the Baluchi Valley and is predominately vegetated with crop fields centred along the Tiri Rud River. The Tiri Rud River is a major obstacle to all movement and provides a sporadic network of irrigation channels that are both a source of cover and obstacles for foot movement. The general area is dominated by surrounding mountain ranges running along the east and western sides of the Tiri Rud River. These mountain ranges accord positions of long distance observation furthering the difficulty of concealing movement by day. Access to the area is by roads which are observed and mined by Taliban forces or by air insertion. The area is sparsely populated with local nationals residing mainly in towns and along the irrigated crop fields. The local nationals reside in a system of small compounds within larger compounds. The compounds are constructed from mud brick surrounded by walls four to eight feet tall. There is little symmetry to the design of the compounds as many are added on to pre-existing structures over time. Life is centred upon the

Tiri Rud River which provides water for irrigation of crops, the main source of income. The irrigated areas are commonly referred to by coalition forces as the green belt (GB). A wide view of the incident site depicting the general terrain is included as **Annex Q**.

25. **Incident Site.** The incident occurred at a small cornfield (measuring 100m x 100m). The cornfield varied from one and a half to two metres in height and provided concealed movement except for gaps between fields. These gaps were straight, around 15 to 20m wide and upwards of 100m plus in length. They presented excellent fire lanes for would be ambushing forces and therefore, were considered obstacles to foot movement. The cornfield in question ran adjacent to an irrigation channel which provided cover from fire. This irrigation channel became too difficult to move along due to vegetation thickness and as a result, was moving between the cornfield and the irrigation channel at the time of the incident (approximately 2 to 5 metres in width). There were no populated areas or dwellings within the immediate area of the incident. **Annex C** depicts the actual incident site.

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

27. **Visibility.** The incident occurred in daylight and visibility was assessed as excellent. Visibility at ground level varied from ten metres when moving within high crop fields to limitless when moving across open fields.

28. **Human Activity.** The majority of the operation occurred throughout the night when local inhabitants were inside dwellings. The incident occurred early in the morning when the movement of local nationals was sporadic and few. It is notable that an unarmed local national fighting age male (FAM) was observed by the lead scout of upon their approach to the gap in the corn field. Whilst the individual could not be positively identified as an enemy combatant, he was observed to move away from the patrol toward the general direction of where the enemy fire eventually emanated from.

The local population were a mixture of pro-Afghan Government, pro-Coalition Forces, pro-Taliban forces (albeit some coerced) or ambivalent toward all forces.

Operational Conditions

29. **Adequacy of Intelligence.** has access to coalition intelligence sources and the incident area had been the subject of intelligence interest over a period of time. It was operations and intelligence that led to the conduct of the directed operation. force elements were aware of the presence of Taliban fighters and had been involved in contacts with the enemy within the area leading up to the morning of 25 Oct. force elements expected contact with the enemy during the conduct of (**Annex G** refers). There was no understatement of the threat at the time of the incident.

30. **Adequacy of Orders.** Detailed orders were issued by the Officer Commanding throughout the conduct of (an events based mission) and in turn all subordinate commanders issued orders as appropriate. Many members of the patrol were unequivocal in their belief that orders were adequate and pertinent to the task. There were no indications that orders issued were anything but clear and effective.

31. **Adequacy of Techniques, Tactics and Procedures (TTPs).** Many members of the patrol commented that they considered the execution of the task as effective and in accordance with established TTPs. Commanders insisted they were satisfied with the execution of the task and the performance of their subordinates. It is noteworthy that SGT Locke's assessment proved to be sound.

and may well have limited the number of friendly force casualties as a result.

32. **Actions On Contact** and in so doing, limited the momentum of the enemy ambush. They quickly attended to SGT Locke and, under fire, effected both first aid on SGT Locke , despite a prepared and committed enemy attempting to outflank them. Other patrols within quickly responded to difficult situation and supported their rearward movement. The rapid and effective execution of 'action on contact' is a major contributing factor why other friendly force casualties were not sustained.

33. **Adequacy of Command and Control.** Despite the immediate loss of the patrol commander (SGT Locke) during the initial burst of enemy machine gun fire, the patrol was able to effectively return fire, secure their immediate environment, provide first aid to SGT Locke all under fire. There is evidence of calm and effective support toward the ground forces by commanders at all levels. The effective command and control was another contributing factor for the avoidance of additional casualties.

34. **Adequacy of Equipment.** At the time of the incident, SGT Locke was equipped with the 'Marine Eagle' fighting harness that was fitted for, but not with the issued ballistic armour plates. The command policy of whether ballistic armour plates should have been worn or not is dealt with in **Annex H.** It is standard procedure for commanders to determine whether ballistic armour plates are worn and this is dependant upon a combination of the task and the individual's discretion. I note that task was one requiring stealthy foot movement and avoidance of contact with an enemy in close quarter or unfavourable circumstances. I therefore unequivocally accept the operating procedure of task basing the wearing of ballistic armour plates. In a task such as this, the weight of the armour would have degraded the soldier's ability to move quietly and with freedom over any distance. I further note that the wearing of a ballistic armour plate would not have accorded any protection to SGT Locke from the fatal projectile since the entry wound was located above the area accorded protection by the chest plate. I find that the equipment worn by SGT Locke was appropriate to the task he was conducting and was not a contributing factor toward his death.

35. **Adequacy of Rules of Engagement.** Rules of Engagement (ROE) are covered in reference E. had been operating with these ROE since arrival in theatre and were familiar with their content and application. From witness statements, there would appear to be no issues concerning rules of engagement.

I find that there is no reason to believe tha ROE are inadequate for their tasking as a result of this incident.

36. **Adequacy of Training.** Numerous members believed their training and preparation for this operation was sufficient. It is noteworthy that most members have substantial operational experience having previously deployed on multiple operations.

Alcohol and Drugs

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

Other Factors

38. **The Enemy.** The significant contributing factor in the incident is the deliberate action carried out by a prepared, equipped and determined enemy. There is little doubt that the enemy who engaged had decided to engage the Australian patrol with the intention to inflict casualties. Through witness statements and imagery of the incident site, I am satisfied that the enemy had planned and prepared for their actions on the morning of 25 Oct 07 and therefore, such actions were deliberate.

Post-Incident Procedures

39. **Notification Procedures.** The incident was reported in accordance with references F and G. The notification of the NOK occurred in accordance with reference G.

40. **Post-Mortem Procedures.** SGT Locke was evacuated from the battlefield to Tarin Kowt by RW AME. He was originally taken to the US Field Surgical Team located at Camp Holland. Upon advice that SGT Locke had deceased, (RTF 3 MO) arranged for an ambulance to convey SGT Locke to the Dutch Role 2 hospital, also located at Camp Holland. Upon arrival at the Dutch Role 2 Hospital, took custody of SGT Locke's body arranging his transportation to the Tarin Kowt morgue facility. At the morgue facility, positively identified SGT Locke[10] and arranged for his body's cleaning and preparation for repatriation to Australia. Despite the presence of an ADFIS investigator, and the Investigator's requests, SGT Locke's body was not subject to formal identification procedures in accordance with the references (**Annex P** refers). Further, SGT Locke's body was cleaned and prepared for repatriation prior to any authorised decision that further post-mortem inquiry was not required. At this point in the process, the ADFIS Investigator (was accorded access to SGT Locke's body where he completed the identification process as far as it could be achieved. The photographic images are contained as **Annex S** (electronic copy only). The unit's actions in taking custody of SGT Locke's body then making preparations for repatriation was not in accordance with post-mortem procedures. My limited inquires into this matter reveals that sought guidance from his chain of command in the further management of SGT Locke's body. Without further intrusive inquiry, it is not clear who made the decision that there would be no investigation. Whilst I am satisfied that all personnel were acting in good faith, nonetheless the correct post-mortem procedures were not followed. I also note that the correct post-mortem procedures were carried out by the same individuals as a result of a subsequent fatal casualty shortly afterward. I am therefore satisfied those post-mortem procedures are adequate and that currently deployed personnel are sufficiently versed in their prescribed requirements.

41. I have seen email correspondence between (MO RTF 3) and (J07 HQ JTF633) and it is my understanding that no post-mortem inquiry was

[10] Identification occurred through facial recognition, body markings and the presence of an identification card and passport (**Annex R** refers).

conducted on the body of SGT Locke (**Annex T** refers). I am not aware of the decision rationale for not conducting such an inquiry, other than information that he was told by the WA Coroner's Office Forensic Pathologist that the Coroner had declined to take the case

42. It is clearly desirable that a post-mortem be conducted in combat death incidents. The decision of the WA Coroner in this case is an issue beyond the Terms of Reference of the Inquiry.

Performance of Duty

43. The task was conducted in accordance with issued orders and established tactics, techniques and operating procedures. There was no evidence of personnel failing in their performance of duty in respect to the conduct of the task leading up to the incident occurring. I have discussed the matter of post-mortem procedures and whilst the correct procedures were not followed, I maintain there is evidence that all key personnel within the process are now versed in what the correct requirements are.

Weaknesses in the System and Method of Control

44. The breach in post-mortem procedures would indicate a weakness in the knowledge levels of deployed personnel and possibly others preparing to deploy. It would appear to be a procedure that is not well understood until such a time that key individuals within the process have been subjected to it. It is conceivable that such a knowledge weakness could lead to a catastrophic loss of evidence in the event a criminal act is apparent. It remains a matter that warrants clarification to ensure force preparation and ongoing deployed force awareness[11] of post-mortem procedures is sufficiently adequate.

45. There were no other identified weaknesses in the system or method of control.

Conclusions

46. SGT Locke was killed in action on 25 Oct 07 from a single gun shot wound that penetrated his upper left chest. SGT Locke's death occurred in circumstances of combat.

47. The equipment that SGT Locke wore, particularly personal protective equipment was appropriate to the task and the level of threat and was not a contributing factor to his death.

48. Training, intelligence and orders were all sufficient prior to the conduct of the task. Further, ROE applied, TTPs conducted and control exercised during the contact was effective.

49. Other than the deliberate actions of a prepared enemy, there were no other contributing factors to this incident.

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

[11] Recognises the constant change of key personnel within the post-mortem procedure including the absence of such personnel during ROCTFA absences.

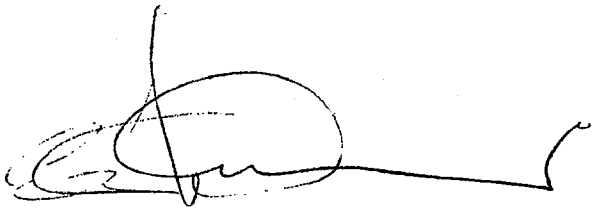
Recommendations

51. It is recommended that:

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

    b. post-mortem procedural awareness training for force preparation (by Mounting Authorities) and ongoing deployed force awareness (JTF633) is implemented; and

    c. State Coroners be informed of the need to conduct post-mortems following combat death incidents.



SG DURWARD, SC
Lieutenant Colonel
Inquiry Officer

22 Jan 08

Annexes:

A. Instrument of Appointment and Terms of Reference
B. Quick Assessment dated 25 Oct 07
C. Image of the Incident Site
D. ADFIS Report
E. AD604 Certification of Death
F. Statement by
G. Statement by
H. Statement by (incl addendum statement)
I. Statement by (incl addendum statement)
J. Statement by (incl addendum statement)
K. Statement by (incl addendum statement)
L. Statement by (incl addendum statement)
M. Statement by (incl addendum statement)
N. Statement by (incl addendum statement)
O. Notes by
P. Statement by
Q. General Terrain Image (Incident Site)
R. Series of Emails (Legal Offr and ADFIS Investigator)
S. Photographic Identification SGT Locke (elec copy only)
T. Series of Emails (MO RTF 3 and J07 HQ JTF633)