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Australian Government

Department of Defence

**INQUIRY OFFICER'S REPORT INTO MATTERS RELATING TO THE
FORCE PREPARATION, TRAINING, CERTIFICATION AND
LEADERSHIP ASSOCIATED WITH THE FORCE ELEMENT
IDENTIFIED IN THE INQUIRY OFFICER'S REPORT INTO THE
DEATH OF LIEUTENANT M.K.H. FUSSELL**

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INTRODUCTION

Background

1. On the night of 26-27 November 2008, Force Element – (FE) of the Special Operations Task Group (SOTG) were conducting an activity within Phase One of OP in the north-east of Tarin Kowt, Afghanistan. In the process of a to the target, Lieutenant Michael Kenneth Fussell was killed by an improvised explosive device (IED).
2. The Inquiry Officer's report into Lieutenant Fussell's death found that:
 - a. Lieutenant Fussell inadvertently activated a pressure plate IED; and
 - b. Lieutenant Fussell was killed instantly by the resulting explosion on 27 November 2008.
3. The Inquiry Officer's report also identified a number of issues which fell outside the Inquiry Terms of Reference which were recommended for further examination.
4. On 20th April 2009, the Chief of Defence Force, Air Chief Marshall A.G. Houston appointed Vice Admiral Christopher Angus Ritchie, an Inquiry Officer, pursuant to Defence (Inquiry) Regulations 1985, to inquire into those issues identified by the initial inquiry into Lieutenant Fussell's death, being:
 - a. the adequacy of the selection, preparation and certification of force readiness of Lieutenant Fussell's force element;
 - b. the extent to which the assertions in relation to the inadequacy of the leadership of Lieutenant 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 Lieutenant 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 Lieutenant Fussell's death.
5. Inquiry Assistants for the purpose of assisting the Inquiry Officer were:
 - a. Commodore Tim Deneys Wood, RANR; and
 - b. Brigadier Damian Stanley Maliphant Roche.

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6. A copy of the Instrument of Appointment and Terms of Reference is at Annex A.

Approach

7. The broad approach adopted by the Inquiry Officer was:
- a. a thorough review of the Inquiry Officer's Report into the death of Lieutenant Fussell;
 - b. the identification and a thorough review of the relevant documents relating to the issues under inquiry; and
 - c. the identification and interview of personnel considered relevant to the Inquiry.
8. Responses to requests for information and relevant documentation were obtained from:
- a. Army Headquarters,
 - b. Headquarters Joint Operations Command,
 - c. Headquarters Special Operations Command (SOHQ),
 - d. 4 RAR (Commando) Regiment (4 RAR(CDO)),
 - e. 1st Commando Regiment (1 CDO Regt),
 - f. Special Forces Training Centre (SFTC), and
 - g. Incident Response Regiment (IRR).

Interviews

9. A list of witnesses to this Inquiry and their statements or records of interview are at Annex B.

Site Visit

10. Inquiry Assistant, Brigadier Roche, visited Training Area to observe a Mission Rehearsal Exercise (MRE) conducted by SOHQ for a force element (FE) in its final pre- deployment preparatory training.

Reconciling Witness Statements

11. All witnesses presented as honest and open in their responses to the enquiries questions. Many had been interviewed by the initial Inquiry Officer and where that was the case, their evidence was generally consistent with what they had previously given. However, recollections of the directions and procedures established to prepare, train and certify FE and as to knowledge of any leadership concerns in the FE were not consistent and this presented the Inquiry with some difficulty in arriving at its findings. In such cases preference has been given to the weight of evidence on disputed issues.

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12. The Inquiry notes that some of the witnesses had previously been questioned about the activities of FE in relation to a separate incident, which while quite different in itself, might have had some bearing on the issues of training, preparation and certification of FE. The Inquiry was not aware of this at the time it conducted its interviews.

SOCOMD COMMITMENT TO AFGHANISTAN

13. Since SOCOMD has been committed to providing forces to the ISAF in Afghanistan in the form of a Special Operations Task Group (SOTG). The SOTG has been tasked with operations in Oruzgan province including the Australian Reconstruction Task Force (RTF). The SOTG forces had been drawn from Special Air Service Regiment (SASR) and 4 RAR (CDO).

14. By SOCOMD was experiencing a period of very high operational tempo. In addition, forces were required to be held in Australia. The outcome was

15. In Afghanistan, the winter months of December through to February had traditionally seen a lull in insurgent activity, largely because of the limitations imposed on movement by the severe weather conditions.

16. The indicative operational tasks that any interim force would be expected to undertake were described in the relevant direction as

SELECTION OF FORCE ELEMENT

17. In , ministerial agreement was given to the concept of manned SOTG rotations each year with a during the winter months. Evidence was given that as early as the latter part of 2007, discussions had been taking place within Army and in particular SOHQ, about the potential to use a company from 1 CDO Regt, a general reserve unit, in Afghanistan over the winter period or "winterization" as it was known. In the winter of 2007/2008, a from

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had performed the task and as a result of that experience, it was generally accepted that,

18. Lieutenant Colonel 1 was Commanding Officer (CO) SOTG in Afghanistan over that winter period of 2007/2008 and as part of his lessons learnt he reported that a was an appropriately sized FE for the winter period. He suggested that 1 CDO Regt could fulfill the commitment. On his return to Australia in 2008 he discussed the issue with Special Operations Commander Australia (SOCAUST), Major General Timothy McOwan, and in early 2008 he gave a briefing as CO 1 CDO Regt to SOCAUST on 1 CDO Regt's capacity to provide the winter FE. He received confirmation from SOCAUST that planning for the deployment should continue. SOCAUST has said that he was conscious of the difficulties imposed by the selection of a company from 1CDO, but he thought those difficulties were offset and his intention for a rigorous and thorough program of training and preparation.

19. On 2008 a noting brief was sent to Chief of Army (CA) and Commander Joint Operations (CJOPS) from SOCAUST informing them that 1 CDO Regt would provide the Winterization FE deploying from early 2008 until 2009 and that a detailed and comprehensive program had been developed to ensure the FE was prepared for deployment. This preparation was to be supported by 4RAR (CDO) and SFTC. The brief also advised that the SOTG force command element (FCE) would remain unchanged during the Winterisation period and that 1 CDO Regt would be supported by elements units, the resulting sub unit to be known as FE. 1 CDO Regt's successful provision of the basis of a company minus on Operation Astute in was noted. Whilst not specifically noted in that brief, it was generally known that there were high levels of individual experience available within 1 CDO Regt. (The later certification minute to CA noted that substantial numbers were former members.)

20. Formal direction was given to 1 CDO Regt by SOHQ on 2008.

21. Within 1 CDO Regt, the commitment to Afghanistan was regarded as an obligation on the unit as a whole and 1 CDO Company (Coy) was supplemented by personnel from who already had the task of supplying a number of personnel to the Camp Russell team. These additional personnel were also seen as a source of supplementation in theatre for FE should that be required, thus the of FE as opposed to its predecessor FE was, taken in conjunction with not seen as an issue.

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22. 1 CDO Coy was selected over [redacted] because of the latter's existing tasking for the [redacted] team and because the OC of 1 CDO Coy had been in place longer than [redacted] who in turn, had had a busy operational program in other units before joining 1 CDO Regt.

23. It follows from the selection of 1 CDO Regt, that there was an obligation on SOCOM to ensure that, as it was a reserve unit, particular care be taken to ensure the adequacy of all aspects of its force preparation. This was acknowledged by SOCAUST. Much of this is dealt with in the following parts of this report, but the following aspects are relevant to consideration of the selection process.

24. The historical role of 1 CDO Regt had been to [redacted] SOCOMD units. The regiment had previously provided members to the Camp Russell [redacted] in Afghanistan and to [redacted] in East Timor but they had not formally deployed operationally as a sub unit.

25. The staffing of the regimental HQ at 1 CDO Regt was not of the same order [redacted] and its capacity to support the preparation of a deploying sub unit was thus limited. This was recognized by SOHQ.

26. Within 1 CDO Regt's sub units, the leadership came from the pool of officers remaining after selections had been made for sub unit command in [redacted]

It is reasonable to suspect that this leadership was not selected with a view to them exercising command on operations because this had not previously been a role for companies in 1 CDO Regt. There is evidence that this might have been recognized by the CO 1 CDO Regt and that he took action to give the nominated OC some command experience. This is further dealt with in the section of this report covering leadership.

27. Resources in 1 CDO Regt were known to be limited. Evidence was given that [redacted] cross leveling or sharing of equipment was common. This process was normally directed by SOHQ in order to ensure compliance with operational priorities but 1 CDO Regt was invariably at the end of the chain. The noting brief to CA and CJOPS specifically said that SOHQ would coordinate the allocation of personal equipment and Mission Essential Items (MEI) to ensure 1 CDO Regt was adequately equipped for the deployment.

28. As already noted, no 1 CDO Regt sub unit had been operationally deployed in its own name but by early 2008 1 CDO Regt was supplying a large part of [redacted] in East Timor, [redacted] This contribution included in the latter months of 2008 the Officer Commanding (OC) the group, Major 1 [redacted] who was OC of 1 CDO Coy. The East Timor commitment had started off as a [redacted] task, supplemented over time by 1CDO Regt personnel [redacted]. Whilst the situation in East Timor was different to that in Afghanistan, the supplementation by [redacted]

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1 CDO Regt was regarded as successful and thus, there was some confidence in taking the next step and deploying a complete sub unit.

Findings

29. There was broad discussion and understanding of the need for a Winterisation FE and that the FE would come from 1 CDO Regt. Moreover, there was an understanding at the higher command levels that the selection of a part time reserve unit to provide the Winterisation FE required an increased level of force preparation and training to ensure that the selected FE was capable of achieving the standards both individually and collectively necessary to deploy.

30. Selection of 1 CDO Regt was a reasonable response of SOCOMD given the the winter period.

PREPARATION AND TRAINING OF FORCE ELEMENT

SOCOMD Overview

31. Within SOCOMD, the responsibility for preparing forces for deployment on operations rests largely at unit command level. HQ SOCOMD provides direction and oversight and determines resource priorities to ensure appropriate levels of support are provided to units preparing to deploy. The day to day and routine preparation is the responsibility of the unit and its CO providing the FE. This approach was used for previous FE deployments and remains current. A modified version of this approach which recognized the need for additional external support was intended for the preparation of FE from 1 CDO Regt.

32. An FE identified for deployment moves through a unit developed training program designed to cover administrative preparation, individual training and collective training for the tasks and other contingencies expected to be performed while deployed. The culmination of this program is the MRE which is intended to confirm the FE's readiness for deployment and is the conclusive determiner of certification of the FE.

33. For SOCOMD FE deploying on operations in Afghanistan, this preparation is designed to confirm competence for deployment to Afghanistan. Final confirmation of an FE's readiness in Afghanistan is the responsibility of the CO SOTG

1 CDO Regt Preparation and Training Overview

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34. While some preparatory work had been conducted, 1 CDO Regt commenced its main effort for pre deployment training after a briefing provided to SOCAUST by CO 1 CDO Regt, Lieutenant Colonel 1 , on 2008 . The outcome of this briefing was SOCAUST direction for 1 CDO Regt to 'crack on and make it happen'. This direction was confirmed by the receipt of the Warning Order for deployment from SOHQ on 2008 . The training program and standards to be achieved for FE were developed during a conference conducted by CO 1 CDO Regt, Lieutenant Colonel 1 . The training program covered the period up to the expected deployment period of 2008 and staged through individual training and preparation to a series of collective activities.

Finding

35. The initial planning and direction given for the training and preparation of FE was appropriate.

Individual Training

36. Individual training was primarily conducted during the period 2008. During this period the Reserve members of FE were brought onto full time service and qualified in the necessary Commando individual competencies. From the evidence presented this period of individual training was satisfactorily supported and conducted.

Finding

37. From the evidence presented the period of individual training up to late 2008 was satisfactorily supported and conducted.

Collective Training

38. The responsibility for the planning and conduct of the collective training program leading up to the MRE is the responsibility of the unit CO providing the FE for deployment. As CO 1 CDO Regt, Lieutenant Colonel 1 developed the broad collective training program for FE and directed that the training for FE was to be the same as for a FE preparing to deploy. The details of this training program were developed by the FE command team. This process is normal and is not a cause for concern by the Inquiry Officer.

39. The collective training period for FE commenced in late 2008 and included four main collective activities:

- a. FE company level training activity at
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- b. Main collective training activity at The exercise included company level collective training leading up to the MRE
 - c. Live firing ranges and practices at
 - d. Final collective activity at
40. A copy of the training program for FE is at Attachment 4.
41. While the model employed to prepare FE within the regular SOCOMD units appears to work well, it is based on the capacity of these regular units to develop and conduct the appropriate level of training and the internal regular manning to ensure direction and oversight to unit FE preparation. 1 CDO Regt did not have a similar capacity as its regular counterpart units because it was not manned and resourced to the same levels.
42. In addition, consistent unit command oversight was disrupted by the posting of Lieutenant Colonel 1 in mid 2008. While the reasons for this posting are not at issue, the posting of Lieutenant Colonel 1 at this stage of the preparation of FE certainly reduced the capacity and the command oversight of 1 CDO Regt to effectively prepare FE for deployment, more so because the Acting/CO, Major 2 , was preparing and training for his own deployment at the same time.
43. Similarly concerns about the level of oversight at sub unit level have been raised in a number of statements made by members of FE , most notably Captain 1 who stated that Major 1 was not present at all the collective training activities. While he attended the MRE at , he did not attend the collective training activity at (due to a private need to be elsewhere and acknowledged by Major 2) and he attended only parts of the training conducted at
44. As previously stated in this report, there was a general understanding within SOHQ and by senior SF staff and commanders that the decision to deploy an FE from 1 CDO Regt necessitated an increased level of support to the preparation of that FE than would be the case with an FE from . However, from the statements provided by the members of FE (Major 1 , Captain 1 , Captain 2 , Warrant Officers 1 and 2) and others, including Lieutenant Colonel 2 and MAJ 2 , the expected increased level of support did not eventuate. Major 1 expressed a wide felt concern of many that "We (FE) were just playing second fiddle to as far as the equipment or the block scale of the issue of equipment and also as far as the MRE activity itself was also concerned."
45. The sequencing of the collective training program for FE was influenced by the need to comply with the MRE activity planned for . To ensure FE had access to the necessary support and resources, it was decided that FE would attend the MRE scheduled for . While this decision is reasonable and understandable, it did reinforce the perception within the FE command team that FE was considered of lower priority to FE from . The outcome of this scheduling was that

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FE had only the time to complete one collective training activity prior to deploying to for its MRE. This potential deficiency in collective training was addressed by an extended pre MRE training program at

Findings

46. While it was recognized that additional support was necessary to allow 1 CDO Regt to prepare FE for deployment, there was a strong and unified belief within FE that the level of support and direction provided by SOHQ was not as forthcoming as expected.

47. The posting of Lieutenant Colonel 1 from 1 CDO Regt to reduced the capacity and the command oversight of 1 CDO Regt to effectively prepare FE for deployment.

48. The non attendance by Major 1 at all of the FE collective training activities reduced the capacity and the command oversight of FE to effectively prepare FE for deployment.

49. There was a strong and unified perception within FE that they were not receiving similar levels of support to that provided to FE from

Mission Rehearsal Exercise

50. The MRE is intended to confirm the FE's readiness for deployment and is the conclusive determiner of certification of the FE. It includes a number of activities similar to those expected to be conducted by the FE during its operational deployment. The FE is assessed on its capability to perform those tasks under the physical, time and threat imposed pressures as like as possible to those encountered in the area of operations. The result is an assessment of the FE's readiness to deploy.

51. SOHQ is responsible for the general planning for the MRE and determines, in consultation with SOCOMD units, the time and place for the MRE as well as the provision of the necessary SOCOMD and external support to enable the conduct of the MRE.

52. The MRE attended by FE was an already scheduled MRE planned for SOTG and FE from Both SOTG and FE were to deploy into Afghanistan after FE. SOTG was planned to relieve SOTG and once deployed would command all the SF FE in Afghanistan. It would assume command of the already deployed FE from SOTG and command FE once FE had completed its deployment. SOTG was commanded by Lieutenant Colonel 2 and his XO was Major 2. In the briefing by the then CO 1 CDO Regt, Lieutenant Colonel 1, to SOCAUST on, SOCAUST acknowledged and noted that the

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dates for the MRE were not ideal for the FE training continuum but that another independent MRE for FE could not be replicated at a later and more appropriate time.

53. A review of the key documents relating to the MRE indicates that these documents were primarily written and focused on SOTG and FE . On 2008 SOCAUST released Mounting Directive – SOTG . In Annex D to this directive, released in 2008 and titled Pre Deployment Trg of SOTG ROT to Meet Operational Commitments in AFG , the responsibilities for the preparation and training of SOTG are clearly presented. Of note is that this document clearly requires units to conduct Middle East Area of Operations (MEAO) focused training in preparation for the MRE and during the MRE units are responsible for conducting two FMP in accordance with guidance from CO SOTG. In addition, this document directs that the incoming CO of the SOTG is responsible for conducting the MRE in accordance with readiness objectives.

54. The Initiating Directive – SOTG /Winterisation MRE (FMP and command post exercise (CPX) released in 2008 clearly refers to Winterisation, the role which FE was deploying to undertake. The Background paragraph states that build up training will be conducted at from 2008. The remainder of the document clearly focuses on SOTG and makes no further reference to Winterisation. The Conclusion paragraph states that ‘This directive provides units and SOHQ guidance for the tasks that need to be achieved in order to (IOT) ensure that the SOTG Rot and MRE are conducted in a manner that enhances the preparation of the SOTG.’

55. On 2008 SOHQ released SOCOMD OPORD SOTG ROT Mission Rehearsal Exercise – Training Area 2008. The Situation paragraph of this document clearly states that 1 CDO Regt will conduct winter relief training in the period leading up to the MRE; that winter relief training is a SOCOMD directed unit run exercise to build unit, individual and collective skills prior to a combined SOTG MRE; and that concurrently a CPX will be conducted at to provide the FCE for the SOCCE operating in . No further mention is made of winter relief training or 1 CDO Regt in this document. While the MRE for SOTG and FE appears to have been conducted in accordance with the direction given at Annex D to the Mounting Directive, the same cannot be said for FE . In fact, FE had completed its winter relief training and MRE by the time the MRE mentioned in this document (and the previous document) was planned to start.

56. The review of these documents indicates that the emphasis for the MRE was on the preparation for SOTG and FE . The review would also appear to support the

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statement quoted previously by Major 1 that "We (FE) were just playing second fiddle to ... as far as the MRE activity itself was also concerned."

57. From the statements provided from the key staff of FE , it appears that the MRE for FE was largely planned, conducted and directed by the command team of FE with little or minimal input from higher command. Although approved at HQ 1 CDO Regt, the scenarios on which the FMP activities were based were adjusted and updated by FE Captains 1 and 2 from previous scenarios used by . Higher exercise inputs were provided by FE staff acting as a higher command net.

58. While a Force Command Element (FCE) was established to command the FE conducting its MRE immediately after FE , no FCE was established for FE for the conduct of the FMP within its MRE. Major 2 states in his evidence that "As the XO of the incoming SOTG I ran FCE training with the view to then tie into the FE MRE and ran the FCE for that. (This was) so that my staff on the headquarters could link in with the FE staff and the SOCC and run those sorts of processes. That was not done for FE ."

59. Although an FCE is not necessarily established for each FE conducting an MRE, it is considered unusual that an FCE was established only for FE which was a regular FE and was preparing to deploy to Afghanistan to take over from FE . The lack of a higher HQ exercising, 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. No unexpected or surprise events were injected into the FMP by a higher HQ to allow a reasonable assessment of the capacity and the ability of the FE command team, in particular OC FE Major 1 , to respond to the pressures of the unexpected.

60. Moreover, 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.

61. A number of senior SF staff visited to observe FE training and the MRE. SOCAUST visited and observed the latter stages of the training immediately preceding the FMP. The Acting /CO 1 CDO Regt, Major 2 visited the training in the period prior to the MRE. He was not present at to observe the FMP conducted by FE . Lieutenant Colonel 1 observed the first FMP and Lieutenant Colonel 2 observed the second FMP.

62. No senior Special Operations officer observed and assessed the full MRE, in particular the two FMP. While observations on the capability of FE were made by both Lieutenant Colonels 1 and 2 , these observations and assessments were based on viewing only one of the two FMP. Major 2 , as the Acting/CO of 1 CDO Regt could reasonably have been expected to have observed and assessed the majority of the MRE, particularly all of the FMP activities. However, due to his

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imminent deployment and involvement in the training for SOTG , he was available to observe only the lead up training prior to the FMP activities.

63. As a result, consistency in assessment was difficult to attain. The assessment report provided by Lieutenant Colonel 1 was in the form of a Minute to SOCOMD in which he provides a series of general comments about his observations and the general levels of competency of FE . The report by Lieutenant Colonel 2 is based on a check list of necessary tasks and comments against each task and competency. It is a report more consistent with a detailed assessment. Besides commenting on the levels of competency achieved by FE , Lieutenant Colonel 2 report raises a number of reservations about the capability and readiness of FE to deploy. In his report and in his statement to the Inquiry, Lieutenant Colonel 2 indicated that he was disappointed in the level of support provided to FE and had raised these concerns with SOHQ. He further stated that he was of the opinion that FE would require more training in certain areas before they were considered ready to deploy. These levels of concern are not apparent in the final assessment made by Major 2 . While a more consistent approach to the assessment of FE might not have ensured that these concerns were identified, the possibility of such concerns being raised earlier and thereby allowing greater rectification time is considered more likely.

Findings

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 exercising, 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 I .

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

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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.

Handover and Training in Afghanistan

72. When FE arrived in Afghanistan, it underwent a detailed handover program with the outgoing FE . This training involved with FE , mentoring by members of FE at all levels and . From the statements of witnesses, this training was effective, appropriate and well conducted.

73. The conclusion to this handover training was the conduct by FE of a FMP. The intent of this FMP was to allow CO SOTG, Lieutenant Colonel 3 the opportunity to assess FE readiness and capability to commence operations outside the wire. As a result of this FMP, a number of issues were identified that required further work to achieve the necessary competence for operations. These issues mainly revolved around the actions by the FE on target. A second FMP was conducted to confirm that the issues identified in the first FMP had been rectified. As a result of this second FMP, FE was considered by Lieutenant Colonel 3 to be ready for operations.

74. From the statements provided to the Inquiry, there is a consistent response that the training received in Afghanistan was effective and well conducted. This training is described by many as the MRE that they wish they had had in Australia prior to deploying.

Finding

75. The training provided to FE in Afghanistan was effective and well conducted.

CERTIFICATION OF FORCE ELEMENT

76. SOCAUST, Major General Tim McOwan, told the Inquiry that whilst he believed that the methodology for MRE and certification used during FE preparation was best practice at the time, it was still an "emerging process." Indeed he thought it was a relatively recent innovation in SOCOM. He described it as a robust, developing process whereby he certifies to Chief of Army the ability of a unit to operationally deploy based on available evidence, and the advice and experience of senior SOCOM staff who have witnessed the individual and collective training of the unit being certified.

77. Brigadier was Chief of Staff Special Operations Command for the first six months of 2007 and again from September 2008 until early 2009. He gave evidence that the extant SF method of certification was "unit led and HQ overseen," noting that were well staffed to provide that leadership to sub

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unit certification through their COs. These certifications had traditionally resulted in a one page statement of certification for CA. It had been recognized that a different approach was required for the less well staffed 1 CDO Regt. SOHQ was required to provide additional direction, coordinating support from other SO organizations and channeling it through the CO 1 CDO Regt. He further stated that a more robust certification document had been required in order to lay out strengths and weaknesses and to prove the path from individual qualification to collective competence. A comparison of the extant, brief template for certification then in use by SOCOMD and the certification letter for FE indicates that this change was put into effect. An in country final check by the CO SOTG was also to be recognized as an important part of the total certification process.

78. Lieutenant Colonel 3 , the CO SOTG who was to initially employ FE was asked what certification meant to him. His response was:

79. "To me, certification means that the entire capability from the subunit commander down is ready for deployment and they can undertake the missions expected of them of the deployed CO and it's a culmination of much more than just the MRE. It's the culmination of all the administration necessary to have people deployed overseas. The individual and collective training they do leading up to the MRE, performance on the MRE and any subsequent corrective action that had to occur after the MRE being completed. Once all that is done, to me, that - they're certified ready for operations if they've passed all those requirements."

Finding

80. The Inquiry accepts that there is a reasonable and logical common understanding of the desired process and end state for certification.

Direction by Brigadier

81. Brigadier stated that he specifically sought to ensure that the certification process for FE comprehended the differences that resulted from their status as a reserve subunit. As such he required a certification report from Major 2 , Acting/CO 1 CDO Regt, an independent assessment from CO SOTC, Lieutenant Colonel 2 and the active support to both of Lieutenant Colonel 1 , CO who was also the immediate past CO of 1 CDO Regt. He thought that he verbally directed this to the three officers.

Lieutenant Colonel 1's Understanding of his Responsibilities and his Actions

82. Lieutenant Colonel 1 does not recall being given any specific direction with respect to the certification of FE and believed that the company was going through the same assessment process as previous company groups. He was aware however of high level concerns about the company's capabilities before the decision to deploy them was made and it is reasonable to believe that these concerns carried through to his own efforts

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to ensure FE readiness. He observed the first full mission profile (FMP) in the MRE because he felt that he had an obligation as the previous CO and as a senior Commando officer to assist in providing the CO SOTG with information as to their capability.

83. Lieutenant Colonel 1 wrote a report for SOCAUST on his impressions of FE readiness for operations based on his observations during a visit to the MRE at where he observed the first Full Mission Profile (FMP). In that report he noted that the FE was ready for deployment but he cautioned about specific weaknesses including a lack of collective training to test capabilities under pressure and the lack of close quarter battle skills. He saw the FE's relative inexperience as a threat to success if there was to be a fast track approach to their employment on arrival in theatre leading to the need for an extended hand over take over with FE. Taking all this and the of FE into account, he noted that the campaign for the winter period should recognize the employment of FE in comparison to the capability that it would relieve.

Lieutenant Colonel 2's Understanding of his Responsibilities and his Actions

84. Lieutenant Colonel 2, given his position as Commandant SFTC and future responsibility as CO SOTG, on his own initiative, suggested to SOHQ that he might observe part of FE MRE. This was agreed by the staff at SOHQ staff and 2 took that to mean that he had the approval of the SOHQ executive. He subsequently provided a written report on his observations. He attended the MRE sometime between 2008 for two to two and a half days, observing the second FMP and noting in his report that his observations were brief. He later said that he believed that what he saw and what he reported was not a final assessment of FE

85. The relevant aspects of Lieutenant Colonel 2's report include:
- a. The MRE was a 1 CDO Regt generated and executed activity with little external input, support or active mentoring for the FE;
 - b. What he saw was the first tactical level activity with attachments conducted by FE;
 - c. The issues he identified and debriefed to the OC were to be addressed during three to four subsequent company group collective training activities to be conducted prior to deployment;
 - d. He assessed reaction to contingencies as good but noted that he only saw those generated by the OC;
 - e. He noted that key players occasionally took on an inordinate amount of tasks when assessing the allocation/delegation of tasks as "fair". (He later said that this referred to the oversight and logistics of the MRE due to lack of external support thus preventing these personnel from gaining maximum benefit from the exercise.);

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- f. He gave an overall assessment of FE capability for Commando Company Group (CCG) operations as part of SOTG-AFG as "Good, once above issues remediated via further CCG level exercising prior to deployment, comprehensive handover-takeover and further FE workup with tactical vehicles/heavy weapons in theatre."

86. Lieutenant Colonel 2 had in fact observed the last formally assessed exercise prior to deployment and the last collective training in Australia that the OC would attend in full.

Major 2's Understanding of his Responsibilities and his Actions.

87. Major 2 was Acting/CO of 1 CDO Regt at the time of FE MRE and certification. As such he was nominally responsible for oversight of the collective training and certification of FE. He was also the nominated of the next SOTG and was engaged in conducting his own force preparation and command element training, quite separately to FE, but at the same time. He attended a day of the live fire part of FE MRE with SOCAUST and attended three days of the post MRE training at . He did not attend any other part of the MRE or the second post MRE collective training at . He deployed into theatre on 2008.

88. Major 2 knew that the original standards to be achieved by FE had been set and agreed by Lieutenant Colonels 3, 1 and 2 and he knew that Lieutenant Colonel 3 was now the receiving SOTG and that Lieutenant Colonels 1 and 2 would both attend parts of the MRE. He was also clearly aware of his formal role in the certification process as Acting/CO and he wrote the appropriate letter to SOCAUST, based on limited observation of his own, discussion with Lieutenant Colonels 1 and 2, Lieutenant Colonel 1's letter and Lieutenant Colonel 2 email. Lieutenant Colonel 2 email report was not generated until 1800 hours on the day that Major 2 drafted his own report to SOCAUST.

How the Certification Process was Conducted.

89. Lieutenant Colonel 1 observed the first Full Mission Profile (FMP) at the MRE and wrote a report for SOCAUST dated , after the MRE but before collective training was completed. Lieutenant Colonel 2 sent an email on reporting his observation of the second FMP between and the caveats that he placed on his assessment, including the need for further collective training. He noted in the email that he did not believe that his involvement constituted a final assessment. On Major 2 drafted a submission for certification of readiness to Chief of Staff (COS) SOHQ, Brigadier . Using the available documentation, COS SOHQ drafted a certification of readiness to CA which

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was signed by SOCAUST on _____ On _____, CA advised CJOPS that FE _____ was ready to deploy.

90. On arrival in Afghanistan FE _____ were subject to further training and two FMP where the CO SOTG made an assessment of their capabilities, concluding that they demonstrated that they were more than capable of conducting the types of operations that he expected of them.

Major 2's _____ Submission for Certification.

91. Major 2's _____ submission for certification is at Attachment 11. This report is a little confusing. It notes that FE _____ had limited opportunity to conduct progressive collective training. On the other hand whilst also acknowledging a collective shortfall of experience within the FE it says that this is mitigated by the extensive preparations that had been undertaken.

92. The submission notes that support provided by 4RAR (CDO) and SOHQ to the development of FE _____ was "extensive and essential." Whilst this may have been the case in an administrative sense, the weight of other evidence given to this Inquiry is that external support to the development of FE _____ as an _____ subunit was negligible.

93. The submission reports that FE _____ was certified as competent by CO 4RAR (CDO) and CO SFTC to conduct all tasks outlined in its mission essential task list. There is no evidence to support a formal process of certification by either Lieutenant Colonels 1 _____ or 2 _____ but Lieutenant Colonel 1 _____ does say that they were ready for deployment and Lieutenant Colonel 2 _____ says that they were deployable. However, both place significant caveats on their assessments. The submission does caveat its own overall endorsement of FE _____ capability with a recommendation that an extended handover take place in theatre to overcome the one acknowledged shortcoming of FE _____ namely its ability to conduct the planning of complex _____ activities within an SOTG construct.

94. The submission concludes that FE _____ was fully equipped, trained and prepared and was ready to conduct the full spectrum of _____ tasks as directed by higher authority. No mention is made of the caveats with respect to further training in Lieutenant Colonel 2 _____ assessment or of any action that was taken to remediate them.

Certification by SOCAUST to CA

95. SOCAUST's certification letter is drawn from Major 2 _____ submission. It uses much of the same language and similarly does not give any weight to the negative observations available to it about external input in the MRE or caveats concerning further training in Australia.

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Major 1's Views on Certification

96. The OC of FE , Major 1 , stated that he did not believe that the MRE at was a certification activity because he had been told that it was his activity to plan and conduct to suit his needs. He could not recall any formal, or indeed informal, assessment of the FE's strengths and being given to him other than Lieutenant Colonel 2 emailed observations and advice from Lieutenant Colonel 1 to continue training on arrival in Theatre

Visit to MRE by Inquiry Assistant

97. During his visit to an MRE being conducted at at the end of May 2009, Brigadier Roche observed an FE from conducting an FMP as part of its MRE. The main observations from this visit were that:

- a. The MRE was well supported by staff from SOHQ.
- b. The OC of the FE was placed under direct pressure by the injection of surprise and the unexpected into the activity by SOHQ staff.
- c. The CO and the SOHQ staff were both able to provide independent assessment of the capability of the OC, his command team and the FE as a whole.
- d. That the shortcomings experienced by FE had been addressed and that the MRE was a well orchestrated, realistic and effective activity which provided a suitable means by which the FE could be assessed and certified as ready for deployment.

Findings

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

101. The certification process was deficient in that the documentation chain failed to recognize the limitations and reservations expressed by either Lieutenant Colonel 1 or Lieutenant Colonel 2 whose reports were used as the main supporting

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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.

LEADERSHIP OF FORCE ELEMENT

Appointment of FE Senior Personnel

105. Major 1 was appointed as OC 1 CDO Coy in January 2007.

106. Captain 1 was posted as 1 CDO Coy

107. Warrant Officer 1, been a member of 1 CDO Regt

108. Another key figure, Warrant Officer 3,

Prior Knowledge of Major 1 by Key Players and How Any Misgivings Were Dealt With.

109. As might be expected, all of the senior SF officers interviewed knew Major 1 reasonably well and most had served with him. Some also expressed some reservation about his command capabilities as a result of that knowledge.

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110. SOCAUST

111. Lieutenant Colonel 1

112. Lieutenant Colonel 2

Lieutenant Colonel 3

Colonel

Brigadier

113. Captain 1

Finding

114. The view most often expressed to the Inquiry is that Major 1 was seen by most as a solid if unspectacular officer. Those who had doubts about his ability sought and received assurances about his progress with and command of FE. It is difficult to believe that this is a true representation of fact as there is evidence enough to suggest that there were indeed deep seated suspicions as to his command competence.

Formal Reporting on Major 1

115. The performance appraisal reporting on Major 1 is generally positive although it does contain some glaring contradictions.

116.

117.

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118. The most telling assessment was made as Major 1 was nearing the completion of the preparation of his company for operations in Afghanistan. Whilst still described as a positive and responsible leader specific comments were made about the need for him to adjust

Finding

119. There is little in Major 1's reporting history that would have given rise to doubts about his command ability other than that which was written as he was about to deploy. This qualification did not appear in any formal assessment of FE capability prior to deployment.

Evidence as to the Testing of Major 1

120. Lieutenant Colonel 1 said that had sent Major 1 to command the in order to give him some grounding as a company commander. As already noted, Major 1 received a positive report from that experience. Of relevance here, his leadership qualities were noted as a particular strength. In Lieutenant Colonel 1 own words, the report gave an unqualified backing of his performance

Finding

121. A conscious effort was made by Lieutenant Colonel 1 to give Major 1 some operational grounding as a Company Commander and Major 1 was reported as having done well in that circumstance

Expectations of FE Employment which may have led to Acceptance of less than Satisfactory Leadership by Higher Authority.

122. The very concept of 'winterization,' in Afghanistan, implies at first glance an acceptance of lesser standards of capability. If such were indeed the case it would be disturbing, because it would carry a degree of risk which is probably unacceptable.

123. The Inquiry was assured at all levels that whilst there was an expectation that the winter conditions those operations that might be

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conducted would be expected to be of similar complexity and intensity

Thus, reduction in capability was not. Lieutenant Colonel 1 said that SOCAUST made it clear that FE

124. Notwithstanding these assurances, deficiencies in the oversight given to the training, certification and equipping of FE and evidence from those within FE all as discussed elsewhere in this report, suggest that an element of this less demanding way of thinking about FE deployment may have existed in Australia. However, there is no evidence to directly connect it to expectations of the leadership of FE Nor is there any doubt that in theatre, the CO SOTG was determined to continue to pursue all the lines of operations that the preceding FE had conducted.

Finding

125. No connection has been shown between expectations of the operational demands and the standard of leadership expected from the OC FE

Evidence and Reporting of Disquiet About Leadership Within FE

126. Captain 1, Warrant Officer 1 and Captain 2, in this and in the initial inquiry into Lieutenant Fussell's death, have given consistent evidence as to the manner in which Major 1 exercised his command and the resentment towards him that created throughout 1 CDO Coy. Warrant Officer 3 has told this Inquiry of his similar concerns.

127. Captain 1 says that as early as 2008 he was having conversations with Lieutenant Colonel 1 about the issue. He then says that he was approached by Lieutenant Colonel 1 at a farewell barbeque on where the issues were again discussed. By this time Captain 1 regarded the issue as of great importance and he asked that Major 1 be removed from his command. Following this Captain 1 emailed his specific concerns to Lieutenant Colonel 1 and a further phone call from Lieutenant Colonel 1 to Captain 1 eventuated.

128. Capt 2 On arriving in Afghanistan he passed his concerns to Major 3 in the SOTG HQ. He says Major 3 passed them to the XO SOTG, Major 4

129. Warrant Officer 1 says that he discussed his concerns about command in the company with the Regimental Sergeant Major (RSM) of 1 CDO Regt.

130. Warrant Officer 3 stated that on return from the MRE he was concerned enough about Major 1 command inadequacies to inform the Acting/CO 1 CDO Regt, Major 2 He further said that he was aware of similar discussions between Captain 1 and Lieutenant Colonel 1 He said that it was

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common knowledge within 1 CDO Regt that if FE [redacted] was lucky enough to get outside the wire on its deployment that it would be Captain 1 [redacted] who led in the field, not Major 1 [redacted]

131. Major 2 [redacted] says that in a report written to SOCAUST by Lieutenant Colonel 1 [redacted] on [redacted] 2008 friction amongst personalities in the company was mentioned. This is not borne out by reading of the report as provided by Lieutenant Colonel 1 [redacted]. Morale was assessed as high and key appointments were described as "approachable". Major 2 [redacted] further says that Warrant Officer 3's [redacted] concerns did not mention the OC by name or his inadequacies; however he passed on what he was told to Lieutenant Colonel 1 [redacted]. Major 2 [redacted] told Warrant Officer 3 [redacted] that he would speak to Warrant Officer 1 [redacted] and Captain 1 [redacted]. He did not do this; instead he rang Major 1 [redacted] and asked him what was going on. No further action was taken by Major 2 [redacted]

132. Lieutenant Colonel 1 [redacted] says that just prior to the beginning of the deployment of FE [redacted] he was informed by Major 2 [redacted] of leadership concerns within FE [redacted]. He undertook to take the issue up at the farewell barbeque, which he did by talking to Captain 1 [redacted]. Captain 1 [redacted] followed up this discussion with a subsequent email to him and Lieutenant Colonel 1 [redacted] had a further telephone conversation with Captain 1 [redacted]. Lieutenant Colonel 1 [redacted] says that at about the same time he heard information along the same lines from one of his [redacted] OCs. He states that he had not heard of these concerns at any earlier time. Lieutenant Colonel 1 [redacted] was concerned enough to email [redacted] and then have a long conversation with Lieutenant Colonel 3 [redacted] in Afghanistan about the issues. This email and conversation took place during the period [redacted] 2008, before FE [redacted] arrived in Afghanistan. In that email Lieutenant Colonel 1 [redacted] advised that he had told Captain 1 [redacted] that it was too close to deployment to act on his information and that he was to support his OC. He further advised Lieutenant Colonel 3 [redacted] that he had told Captain 1 [redacted] that the issue was to go no further (noting that Warrant Officer 1 [redacted] had discussed it already with Major 5 [redacted]) and that Captain 1 [redacted] was aware of the implications for himself as an officer and for his employment within SOCOMD.

133. Lieutenant Colonel 1 [redacted] has no memory of being questioned specifically by anybody else as to Major 1 [redacted] ability. Nor did he refer any concerns to higher authority after becoming aware of them and he maintains that, given that none of the concerns had been manifest in the force preparation, the only advice that he would have given would be to that effect that Major 1 [redacted] should remain as OC of FE [redacted]. At no time did Lieutenant Colonel 1 [redacted] raise any of these issues with Major 1 [redacted]

134. Lieutenant Colonel 3 [redacted] says that he was unaware of any friction in the leadership of FE [redacted] until after Lieutenant Fussell's death when he saw an email alluding to it (probably Lieutenant Colonel 1 [redacted]). He knew Major 1 [redacted] having served

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with him three times before and thought his leadership was strong. He said that had he been informed that Major 1 was having command problems before he deployed he would have raised concerns.

135. Lieutenant Colonel 3 took some measures to reassure himself of the capability of FE leadership during its training in theatre and was satisfied with the outcome. This is confirmed by Major 6, the OC FE who handed over to FE and conducted their first FMP in Afghanistan.

Formal Recognition of Inadequacies in Major 1's Leadership

136. After Lieutenant Fussell's death, Lieutenant Colonel 3 was alerted to a potential problem by the evidence of Major 1 conduct on the night of the death and his failure to subsequently take any action to overcome apparent shortcomings in FE relevant TTP knowledge and practice. He also received direct representation from senior members of FE asking to be relieved of their positions. This led Lieutenant Colonel 3 to put in place a further observation of Major 1, deploying his RSM on the next FE mission. He also discussed the issue with Major General Hindmarsh, Commander Joint Task Force (CJTF) 633, and SOCAUST around mid December.

Findings

137. Captain 1, Captain 2, Warrant Officers 1 and 3's evidence supports a long history of concern over Major 1 ability from 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 the 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.

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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

TACTICS, TECHNIQUES AND PROCEDURES TRAINING

Tactics, Techniques and Procedures (TTP)

143. The TTP employed on the night that Lieutenant Fussell died was the standard method employed by SOTG FE to indicate to members of the FE the route that they should follow A

Each member of the FE is trained to follow
thereby ensuring that the FE

While this TTP does not guarantee that the route
it has proven highly effective in reducing the IED threat and to increasing the security of
movement in high IED threat environment.

144. Within SOCOMD, the responsibility for the development of training in this TTP rests with Except for minor adjustments and refinements, this TTP has remained largely unchanged over the past few years of its use. This consistency is a reflection of the effectiveness of the TTP and has also contributed to a generally consistent understanding and application of the TTP.

145. However, no formal publication has been identified by this Inquiry that includes details of this TTP or instruction in its employment. In an email to the Inquiry, the Commanding Officer of states that training in the use of the TTP has traditionally been provided using a series of Power Point slides. Given that this TTP is now a standard and widely used practice, it is considered reasonable that documentation covering the training and employment of this TTP should be formalized.

Findings

146. The TTP employed on the night that Lieutenant Fussell died was an appropriate TTP.

147. Documentation covering the training and employment of the TTP should be formalized.

Lieutenant Fussell TTP Training

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148. Lieutenant Fussell was initially trained in the use of the TTP during his posting to 4 RAR (CDO). Subsequent training in the TTP occurred when Lieutenant Fussell attended the Commando Selection Course and the Mission Rehearsal Exercise (MRE) conducted at [redacted] with the [redacted] Company training to deploy as FE [redacted]. After joining FE [redacted] in Afghanistan, Lieutenant Fussell received further training in the TTP during FE [redacted] handover training with FE [redacted].

Finding

149. Lieutenant Fussell was appropriately trained in the TTP employed on the night of his death.

FE TTP Training

150. FE [redacted] trained in the TTP on a number of occasions prior to deploying to Afghanistan, most notably during the MRE conducted in [redacted] in [redacted] 2008. On arrival in Afghanistan, further training was conducted with FE [redacted] who they were relieving. Moreover, the TTP had been used by FE [redacted] on operations in Afghanistan prior to the night that Lieutenant Fussell died.

151. From the statements provided to the Inquiry, it is apparent that the members of FE [redacted] were aware of the TTP

There was a general awareness that when following [redacted]

[redacted] ensure that they remained on [redacted] route. Moreover, in his statement Major 1 [redacted] states that FE [redacted] was provided instruction in the TTP by members [redacted], both in Australia and after arriving in Afghanistan. He further states that the lecture provided by [redacted] Warrant Officer (Warrant Officer 4 [redacted]) after FE [redacted] had arrived in Afghanistan was comprehensive and [redacted].

Finding

152. From the general level of awareness within the FE of route [redacted] and the comments on the quality of the training received by FE [redacted] by members of [redacted] it is reasonable to conclude that the level of training received by FE [redacted] both in Australia and after deploying to Afghanistan was adequate.

Failure to Correct an Unsafe Practice

153. The initial Inquiry into the death of Lieutenant Fussell found that track discipline in the minutes prior to Lieutenant Fussell's death was inadequate and that up to [redacted] personnel may have been in a position to stop the unsafe practice [redacted].

[redacted] Statements provided to this Inquiry confirm these statements and indicate that Lieutenant Fussell may have been the first person in the order of march that night to deviate away from the [redacted].

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route and those personnel behind him followed in his footsteps

154. The question is therefore why was Lieutenant Fussell allowed to deviate away without anyone correcting this unsafe action? From the statements provided to this Inquiry, it is clear that personnel were aware that regardless of rank or position of authority, anyone who observed an unsafe practice had a responsibility, expectation and the right to correct that unsafe practice. Earlier during the move that night and prior to Lieutenant Fussell's death, Sapper [redacted] stated that he observed personnel behind him [redacted] and used the platoon radio net to tell them to get back [redacted]. This statement is confirmed by Warrant Officer 4 [redacted] statement. During the previous day, Captain 1 [redacted] states that he had to correct a group of personnel, including Lieutenant Fussell, for not adhering to track discipline. These actions confirm that there was awareness within FE [redacted] of the need to correct an unsafe action and willingness, at least by some, to take action when an unsafe action was identified.

155. It is also clear from the statements provided that there was a degree of confusion as to the [redacted] route being followed on the night that Lieutenant Fussell died. The majority of personnel behind Lieutenant Fussell in the order of march were uncertain whether the route [redacted] had been [redacted] cleared. Witnesses have stated that at the time of Lieutenant Fussell's death

They reasonably deduced that as someone had already walked on the route directly in front of them, they had [redacted] safe route to follow. [redacted] stated [redacted] he believed [redacted] there was a high degree of confidence that [redacted] was clear [redacted]. This statement is consistent with the statement of many of those further back in the order of march. A belief by those behind Lieutenant Fussell that the [redacted] was understood [redacted] would explain why no action was taken to get Lieutenant Fussell back

156. In his statement, Captain 1 [redacted] states that the reason for [redacted] was simply to [redacted] within the unit and [redacted]. While this method [redacted] it might explain why the discipline to follow [redacted] might not have been as rigidly enforced, [redacted] was considered by some at least to be indicative only.

157. A further reason for not correcting an unsafe action can be found in the comments made by Warrant Officer 1 [redacted] where he states that the diversion Lieutenant Fussell made [redacted] was only minor and may not have been obviously apparent to those following behind him.

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158. Warrant Officer I _____ also raises the possibility that Lieutenant Fussell might have diverted only slightly _____ because he was momentarily distracted by his duties as the Joint Tactical Air Controller (JTAC)

_____ He further states that the person _____ Lieutenant Fussell _____ might also have been momentarily distracted _____ While this is speculation only, this situation was of sufficient concern to Warrant officer I _____ to subsequently ensure that a _____ JTAC _____ or JTAC.

159. Finally, a lack of command supervision of the movement of FE _____ on the night that Lieutenant Fussell died could have resulted in a failure to enforce track discipline and prevent an unsafe act.

_____ While Major I _____ cannot be expected to be able to confirm that his entire FE is applying track discipline at night, it is reasonable to expect from him an awareness of the personnel in his immediate area.

Findings

160. From the statements provided to the Inquiry there appears to have been a general understanding within FE _____ that anyone who identified an unsafe action had a responsibility to correct that action.

161. The failure to prevent an unsafe action can be attributed to a combination of:

- a. Confusion on the part of those personnel behind Lieutenant Fussell who assumed that either _____ they were following had been cleared or that _____ by those ahead to be relatively clear
- b. A less than rigid enforcement of track discipline
- c. The diversion from _____ route was only minor and that such a minor diversion was difficult to identify.
- d. An inability to by some members of FE _____ to clearly determine that someone was not necessarily following _____ route.
A lack of control by the OC FE _____ Major I _____ ,

CONTRIBUTING MATTERS TO LIEUTENANT FUSSELL'S DEATH

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168. These deficiencies remained extant within FE notwithstanding that Lieutenant Colonel 3 took extra steps to prove the FE's competence once it arrived in Afghanistan.

169. Major 1 subsequent performance is open to criticism in that he failed to conduct or put in place proper supervision of his company to ensure that they did not stray off the

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 FE operated to increase the risk that such a casualty might occur. Therefore, those deficiencies materially contributed to the death of Lieutenant Fussell.

COMMISSION OF INQUIRY (COI) AND FURTHER ACTIONS

171. It was not specifically directed that this Inquiry make any recommendation as to the need for a Commission of Inquiry into Lieutenant Fussell's death, rather the Appointing Officer stated in the Terms of Reference that he would use the enquiries findings to form a view as to the need for a COI or any further action.

172. In forming that view, the Appointing Officer might consider the following:

- a. Despite inconsistencies in recollections of how the force preparation and training process was evolved and directed it is evident that there was an intent and indeed, a concern amongst all in positions of authority to ensure the adequate preparation of FE . This was followed by a belief at the more senior levels that this had indeed occurred. A COI might resolve some of the inconsistencies but the end result will be the same, the intent was not followed through with appropriate actions.
- b. Whilst the processes of force preparation and certification in Australia were deficient, there was a widely known and agreed final acceptance process for FE in theatre that was followed and even extended beyond that which was normally used.
- c. The accepted methods of force preparation and assessment in agreed use at the time were incapable of exposing ineffective sub unit leadership, particularly in a close knit community of people who had served together for some time.
- d. The Inquiry believes that many of the shortcomings in the oversight of preparation and certification of force elements have been corrected as a result of the failure in the case of FE

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173. Irrespective of any decision on a COI, there are more immediate remedies that can be put in place. At the heart of this unfortunate and tragic death is a failure of leadership. A failure that stems not just from the leadership of FE but from inadequate processes to select, prepare and assess those who are being tasked with command responsibilities on active service. The Appointing Officer might therefore consider it appropriate to have Army undertake a thorough review of its system for assessing officers for command appointments and a similar review into the processes used to train, assess and certify those officers in the course of their force preparation. Whilst the Inquiry believes that issues to do with the wider concerns about the force preparation and certification of FE have been addressed within SOCOM, it would be prudent to further direct an audit of this process, perhaps benchmarking it with Army's methodology for non SF units.

174. A contributing factor to the issues raised in this Inquiry has been the duality that has been placed upon personnel on SOCOMD with respect to operational commitment and training. Some key personnel have been over-committed but the scope of the demands made upon their time has not enabled them to fully fulfill their dual responsibilities. The Appointing Officer might consider that it is now timely for Army to review the need for permanent manpower liability cover for the establishment of appointments to allow for the conduct of MRE and pre deployment assessment of FE. This is to counter the current need to temporarily detach personnel from key appointments to undertake these tasks and allow for consistency in oversight, planning and assessment for deploying FEs.

175. That leaves to be considered this Inquiry's finding that there are material contributions to Lieutenant Fussell's death other than the direct cause. Is that finding sufficient in itself to call for a COI? The Inquiry believes not. The issues of force preparation and certification would be best addressed by the direct action recommended. With respect to Major I his specific leadership shortcomings are not really of his own making. They are the product of a system that has selected the wrong man for the job and then been unable to identify or correct its faults. Again, direct action to correct these issues will serve to more quickly address the problem.

SUMMARY OF FINDINGS

Selection of FE

176. Selection of 1 CDO Rgt was a reasonable response of SOCOMD given the the winter period.

177. There was broad discussion and understanding of the need for a Winterisation FE and that the FE would come from 1 CDO Rgt. Moreover, there was an understanding at the higher command levels that the selection of a part time reserve unit to provide the Winterisation FE required an increased level of force preparation and training to ensure that the selected FE was capable of achieving the standards both individually and collectively necessary to deploy.

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Preparation and Training of FE

178. The initial planning and direction given for the training and preparation of FE was appropriate.

179. From the evidence presented the period of individual training up to late 2008 was satisfactorily supported and conducted.

180. While it was recognized that additional support was necessary to allow 1 CDO Regt to prepare FE for deployment, there was a strong and unified belief within FE that the level of support and direction provided by SOHQ was not as forthcoming as expected.

181. The posting of Lieutenant Colonel 1 from 1 CDO Regt to reduced the capacity and the command oversight of 1 CDO Regt to effectively prepare FE for deployment.

182. The non attendance by Major 1 at all of the FE collective training activities reduced the capacity and the command oversight of FE to effectively prepare FE for deployment.

183. There was a strong and unified perception within FE that they were not receiving similar levels of support to that provided to FE from

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

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

186. 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

187. 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.

188. The lack of a higher HQ exercising, 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.

189. 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

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190. 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.

191. There was lack of consistency in the method of assessment. 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.

192. The training provided to FE in Afghanistan was effective and well conducted.

Certification of FE

193. The Inquiry accepts that there is a reasonable and logical common understanding of the desired process and end state for certification

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

195. 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 Acting/CO 1 CDO Regt.

196. 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

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

198. 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.

199. 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.

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

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The Leadership of FE

201. The view most often expressed to the Inquiry was that Major 1 was seen by most as a solid if unspectacular officer. Those who had doubts about his ability sought and received assurances about his progress with and command of FE. It is difficult to believe that this is a true representation of fact as there is evidence enough to suggest that there were indeed deep seated suspicions as to his command competence.

202. There is little in Major 1 reporting history that would have given rise to doubts about his command ability other than that which was written as he was about to deploy. However this in itself should have formed part of the overall assessment of FE capability.

203. A conscious effort was made by Lieutenant Colonel 1 to give Major 1 some operational grounding as a Company Commander and Major 1 was reported as having done well in that circumstance

204. No connection has been shown between expectations of the operational demands and the standard of leadership expected from the OC FE

205. Captain 1, Captain 2, Warrant Officer 1 and Warrant Officer 3's evidence supports a long history of concern over Major 1 command ability from within 1 CDO Coy.

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

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

208. Higher command in Australia was not informed of any doubts about Major 1 before FE deployed.

209. 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.

210. 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

Tactics, Techniques and Procedures

211. The TTP employed on the night that Lieutenant Fussell died was an appropriate TTP.

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212. Documentation covering the training and employment of the TTP should be formalized.
213. Lieutenant Fussell was appropriately trained in the TTP employed on the night of his death.
214. From the general level of awareness within the FE of route _____ and the comments on the quality of the training received by FE _____ by members of _____ it is reasonable to conclude that the level of training received by FE _____ both in Australia and after deploying to Afghanistan was adequate.
215. From the statements provided to the Inquiry there appears to have been a general understanding within FE _____ that anyone who identified an unsafe action had a responsibility to correct that action.
216. The failure to prevent an unsafe action can be attributed to a combination of:
- a. Confusion on the part of those personnel behind Lieutenant Fussell who assumed that either _____ they were following had been _____ cleared or that _____ by those ahead to be relatively clear
 - b. A less than rigid enforcement of track discipline due to the belief that the _____
 - c. The diversion from _____ route was only minor and that such a minor diversion was difficult to identify.
 - d. An inability to by some members of FE _____ to clearly determine that someone was not necessarily following _____ route.
 - e. A lack of control by the OC FE _____ Major 1

Material Contributions to Lieutenant Fussell's Death

217. 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, certification and leadership of FE _____ operated to increase the risk that such a casualty might occur. Therefore, those deficiencies materially contributed to the death of Lieutenant Fussell.

CONCLUSION

218. The concerns raised in the initial Inquiry Officer's report about leadership and force preparation issues surrounding Lieutenant Fussell's death have a basis of fact.

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219. In an effort to _____ a GRES commando unit was selected to provide the bulk of the SOTG force in Afghanistan over the winter of 2008/9. Recognition that this sub unit would require special attention in its force preparation was forthcoming but this did not translate into adequate levels of support and supervision during the collective training and certification period in Australia. This can in part be attributed to the pressures on _____ personnel and the consequent dual roles played by some people in the process and the personal training obligations of others who themselves were about to be deployed. The most serious outcome of these shortcomings was a failure to detect considerable leadership tensions within the FE and most importantly the failure to note the inability of the appointed OC to exercise effective command in both the force preparation and operational aspects of his position. Even assessment in theatre before clearance for operations, an activity that might be thought to have more urgency in its demands, failed to identify the flaws in the FE.

220. All of this was brought to a head by the death of Lieutenant Fussell very early in the FE's operational employment. Lieutenant Fussell brought about his own demise by not following the known TTP but deficiencies in the prior training, assessment and leadership of the FE materially contributed to his death.

221. It is clear that there was reluctance amongst many witnesses to acknowledge that it was generally thought that Major I _____ No doubt in some parts this can be put down to a strong belief in the processes of natural justice and a fair go. Nevertheless it points to the need for a robust and decisive system to prove the abilities of those entrusted with operational command positions. This did not happen in the case of FE _____ Major I _____ was appointed to a sub unit command when there was no expectation that his company would deploy en masse as a subunit. Thus, it could be said that he was not selected for operational command; rather, it came by default. The Inquiry is left with the feeling that this happened almost by accident, its implications were realized but the evolving assessment process in use at the time was incapable of measuring the risk that was involved. In these circumstances it is difficult to attribute blame and the Inquiry has made no attempt to do so.

RECOMMENDATIONS

222. It is recommended that:
- a. The appointment of a Commission of Inquiry into the circumstances leading to the death of Lieutenant Fussell is not warranted.
 - b. Army undertakes a thorough review of its system for assessing officers for command appointments and conducts a similar review into the processes used to train, assess and certify those officers in the course of their force preparation.
 - c. Army considers the need for permanent manpower liability cover for the establishment of appointments to allow for the conduct of MRE and pre deployment assessment of FE. This is to counter the current need to temporarily

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detach personnel from key appointments to undertake these tasks and allow for consistency in oversight, planning and assessment for deploying FEs.

- d. Army undertakes an audit of SOCOMD's processes for force preparation and certification benchmarking it against its methodology for units.
- e. Documentation covering the training and employment of the TTP should be formalized.



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Inquiry Officer

23 July 2009