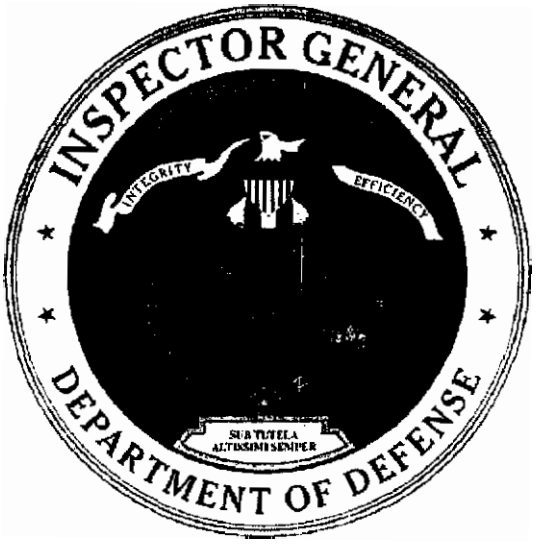

Investigative Policy & Oversight

Review of Criminal Investigations of Alleged Detainee Abuse

Project Number IPO 2004C005

August 25,2006

Office of the Inspector General of the Department of Defense

Additional Information and Copies

This report was prepared by the Policy and Programs Directorate, Office of the Assistant Inspector General for Investigative Policy and Oversight, Deputy Inspector General for Policy and Oversight, Office of the Inspector General, Department of Defense. If you have questions on this evaluation or want additional copies of the report, contact Mr. Frank Albright, Program Director, at (703) 604-8768 (DSN 664-8768).

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AUG 2 5 2006

MEMORANDUM FOR SECRETARY OF DEFENSE

SUBJECT: Review of Criminal Investigations of Alleged Detainee Abuse (Project No. IPO 2004C005)

We have completed our evaluation of the thoroughness and timeliness of criminal investigations into allegations of abuse involving detainees in Iraq and Afghanistan. Our work involved a review of 50 closed investigative case files. The attached report describes our work and presents findings and recommendations. We believe that the problem areas we identified reflect systemic deficiencies.

Forty-eight of the investigations reviewed were conducted by the United States Army Criminal Investigation Command (USACIDC), and two were conducted by the Naval Criminal Investigative Service (NCIS); this ratio is consistent with total detainee caseload among the military criminal investigative organizations. Our review determined that ***25*** of the **50** cases, including both NCIS cases, were timely and thorough. Our review, however, did identify external factors, outside the control of investigative organizations that had an impact on the timeliness and thoroughness of some investigations.

Management comments to the report were received from the Provost Marshal General, USA; the ASD (Health Affairs); U.S. CENTCOM; the Army Inspector General; and the Armed Forces Institute of Pathology. The outstanding area of disagreement concerns the need we identified for joint commanders to promptly refer potentially serious criminal matters to a criminal investigative organization. U.S. CENTCOM believes that commanders have the primary responsibility to investigate such matters under the Rules for Court Martial, while we maintain that Military Department policy **has** further assigned that responsibility to the military criminal investigative organizations. We recommend that U.S. CENTCOM **reconsider** its position and respond to us within 45 days.

We appreciate the courtesies extended to our staff throughout this project. We particularly thank USACIDC, the NCIS, and the Air Force Office of Special Investigations for providing criminal investigators who assisted in the preliminary reviews of case files. See Appendix J for the report distribution.

L. Jerry Hansen
Deputy Inspector General
for Policy and Oversight

Attachment:
Final Evaluation Report

cc:
Assistant Secretary of Defense (Health Affairs)
Auditor General, Department of the fumy
Commander, United States Army Criminal Investigation Command
Commander, United States Central Command
Deputy Assistant Secretary of Defense for Policy (Detainee Affairs)
Director, Armed Forces Institute of Pathology
Director, Naval Criminal Investigative Service
General Counsel of the Department of Defense
Naval Inspector General

Office of the Inspector General of the Department of Defense

Project No. IPO 2004C005 **August 25,2006**

Review of Criminal Investigations of Alleged Detainee Abuse

Executive Summary

Who should read this report **and why?** Members of Congress, Department of Defense and Military Department Secretaries—particularly the Secretary of the **Army as** Executive Agent for the DoD Law of War Program, The Joint **Staff,** and Combatant Commanders, military law enforcement and criminal investigative leaders, DoD health affairs decision makers, and others involved or interested in the investigation of crimes involving detainees should read this report.

Background. Following news media reports of allegations that U.S. personnel were abusing enemy prisoners of war and other detainees held at detention facilities in *Iraq,* Afghanistan and the Naval Base **Guantanamo** Bay, Cuba, 110 Members of Congress formally requested on May **7,2004,** that the Secretary of Defense have the Inspector General of the Department of Defense (IG DoD) ''supervise the investigation of tortured Iraqi prisoners of war, and other reported gross violations of the Geneva Conventions at Abu Ghraib Prison in *Iraq.''* In a May **13,2004,** memorandum, the **IG** DoD announced to the secretaries of the Military Departments the formation of a "multi-disciplinary **team** within **this** office to monitor detainee/prisoner abuse allegations, the purpose of which is to facilitate the timely flow of law enforcement sensitive information to senior leaders of the Department of Defense (including the Military Departments)."

Following that mandate, the **Deputy** Inspector General for Inspections and Policy (now Policy and Oversight (DIG-P&O)) authorized the formation of a task force to evaluate the thoroughness and timeliness of criminal investigations into allegations of detainee abuse in **order** to develop recommendations for improvement in those **areas.** To accomplish the objective we reviewed the first 50 closed case files for which all documents were available.[1] We did not review cases under investigation or those in the judiciary process. At the time, the USACIDC had opened **93** investigations involving allegations of detainee abuse.

This report addresses the results of that review. Although some investigative shortcomings may stem from the hostile nature of the environment, we believe that some reflect systemic deficiencies. Of the investigations reviewed, **48** were conducted **by** the United States Army Criminal Investigation Command (USACIDC), and **2** were conducted **by** the Naval Criminal Investigative **Service (NCIS),** a ratio consistent with

[1] There was so i c ul y at fi ng q u a file documentation since some documents we considered important for review purposes were maintained in USACIDC field offices in Iraq.

total detainee caseload among the Military Criminal Investigative Organizations (MCIOs).[2]

Results. Of the 50 cases' reviewed, 21 involved alleged assaults, 4 of which were not substantiated; 19 involved deaths (13 natural causes, 1 in a mortar attack, 4 alleged murders, and 1 false complaint); 6 involved thefts or robberies; and 4 involved misconduct allegations (for example, unauthorized photography of detainees).

We found that 25 of the 50 cases, including both NCIS cases, were substantially timely and thorough, and unhampered by external factors – events or conditions beyond the control of the investigative organization. These investigations were conducted in unusual operational circumstances, in the midst of ongoing combat and counter-insurgency operations. The environment often limited access to witnesses and documentary evidence. Stateside, where conditions are more ideal, the USACIDC reports 90 percent thoroughness and 92 percent timeliness averages while NCIS reports an 80 percent average for both thoroughness and timeliness.

Of the 25 remaining cases, we determined that five investigations of detainee death, caused by medical conditions, did not sufficiently examine the extent to which the detainees' medical conditions were known and/or treated by U.S. personnel. In three additional cases, key investigative steps were not taken. Due to lack of documentation, we could not determine if those steps would have altered the investigative results.

External factors affected a significant number of the other cases we reviewed. In 13 cases, the involved Army unit delayed notification to the USACIDC, frequently while conducting its own investigation. This impacted the criminal investigator's timely collection of relevant evidence. In seven cases, the units returned the detainee bodies to the Iraqi government or family control without first conducting autopsies and, in nearly all cases, before notifying criminal investigators, thereby limiting the collection of evidence. We believe that in a few of these cases, prompt referral to criminal investigators and/or evidence collected through autopsy may have changed the outcome of the investigation?

Finally, in three cases involving the use of deadly force against detainees inside a detention facility, we found that the investigations did not resolve questions on the use of deadly force or apparent inconsistencies between the written rules, the on-scene verbal orders, and the actions of the soldiers involved. We referred two of the three cases back to the Army for further legal review. Their review confirmed the initial legal opinions that led to the investigative findings.

[2] Most allegations of abuse were directed at soldiers or marines, investigated by USACIDC and NCIS. Since several cases involved more than one *category*, the case is addressed in the more severe *category*.

[4] The *Secretary* of Defense clarified policy on the need for detainee death case autopsies in his June 9, 2004, policy memorandum (Appendix F).

Recommendations. Based on our findings, we recommend (a) command emphasis on the requirement for expeditious referral of detainee deaths and other serious matters to the appropriate MCIO; (b) continued emphasis on the requirement for autopsies in all detainee deaths; (c) a review of the implementation of the rules for the use of deadly force against detainees and increased focus on those rules in pertinent criminal investigations; (d) increased investigative emphasis on medical records and prior medical care in cases involving detainee deaths from various medical conditions; and (e) other case-specific investigative actions.

Management Comments: We published a draft report on March 1,2006, and distributed a revised executive summary on March 30,2006. We received comments from the Armed Forces Medical Examiner (AFME) on March 29,2006; from the Assistant Secretary of Defense for Health Affairs (ASD(HA)) on April 4, 2006; from U. S. Central Command on April 15,2006; from the Office of the Inspector General, Department of the Army, on May 1,2006; and from the Provost Marshall General of the Army (on behalf of the Secretary of the Army) on May 9,2006. On July 25,2006, we met with representatives of the Office of General Counsel and reached consensus on their concerns. We received only draft comments from the Office of Detainee Affairs.

The comments received did not materially change the substance of this report. The AFME clarified procedures for conducting autopsies in theater versus at the Dover Port Mortuary and added that the decision to conduct an autopsy is made by the medical examiner alone. The ASD(HA) concurred with our recommendations. The U.S. Central Command non-concurred with the principle that potential criminal matters, particularly all felonies, involving the Army should be expeditiously referred to the USACIDC. They cited the authority of commanders, under Rule for Court Martial (RCM) 303, to make preliminary inquiries into suspected criminal offenses, and suggested that U.S. Central Command commanders "consult" with USACIDC rather than making referrals mandatory. The Army Inspector General commented on the wording of one sentence. The Provost Marshall General of the Army, commenting principally on the revised executive summary, substantially concurred with the report findings and further explained certain aspects of the findings for clarification. The Office of General Counsel corrected certain references made to the Geneva Conventions and the Law of War Program, and clarified certain aspects of policy concerning DoD's relationship with the International Committee of the Red Cross (ICRC). The complete text of management's written comments is at Appendix I.

We appreciate the comments from management. The comments are generally responsive, with the exception of the U.S. Central Command comments concerning referrals of potential criminal matters to USACIDC. We maintain that, while RCM 303 assigns responsibility to commanders for military justice matters, Military Department policies further clarify that criminal matters, particularly serious crimes such as felonies, must be referred to the appropriate MCIO. Further, the technical requirements associated with the collection of evidence in such cases are beyond the capability of local commanders to investigate, thus requiring the expertise of specially trained criminal investigators. We recommend that the Commander, U.S. Central Command, reconsider his position and respond to this office within 45 days.

Table of Contents

Review of Criminal Investigations Of Alleged Detainee Abuse

Part I. Introduction

Background

Following news media reports of allegations that U.S. personnel were abusing enemy prisoners of war and other detainees (hereafter referred to collectively as detainees') held at detention facilities in Iraq, Afghanistan and the Naval Base Guantanamo Bay, Cuba (GTMO), 110 Members of Congress formally requested on May 7,2004, that the Secretary of Defense have the IG DoD "supervise the investigation of tortured Iraqi prisoners of war, and other reported gross violations of the Geneva Conventions at Abu Ghraib Prison in Iraq." In a May 13,2004, memorandum, the IG DoD announced to the secretaries of the Military Departments the formation of a "multi-disciplinary team within this office to monitor detainee/prisoner abuse allegations, the purpose of which is to facilitate the timely flow of law enforcement sensitive information to senior leaders of the DoD (including the Military Departments)." Following that mandate, the DIG P&O authorized the formation of a task force to evaluate the thoroughness and timeliness of criminal investigations into allegations of detainee abuse in order to develop recommendations for improvement in those areas. The review began May 19,2004. This report addresses the results of that review.

To accomplish the objective, we reviewed the first 50 closed case files for which all documents were available. At the time, the USACIDC had opened 93 investigations involving allegations of detainee abuse. While we recognize that some investigative shortcomings may stem from the hostile (armed conflict) nature of the environment, we believe that the problem areas identified reflect systemic deficiencies.

A thorough discussion of our scope and methodology is at Appendix B. A detailed presentation of background information, including a discussion of the operational environment and applicable policy guidance, is at Appendix C. Appendix E is a glossary of investigative terms, useful in understanding the oversight review results and this report.

[5] While there are legal distinctions among EPOWs, civilian internees, retained personnel, and others captured or detained by U.S forces, this report focuses on investigations of matters involving persons who were in the custody of the United States military, without regard to the status of the person in custody. The same investigative standards apply to all such investigations.

Investigative Responsibility

The MCIOs – the U.S. Army Criminal Investigation Command (USACIDC), the Naval Criminal Investigative Service (NCIS), and the Air Force Office of Special Investigations (AFOSI) – are responsible for investigating felony crimes[6] committed in their respective Military Departments. The Army military police, the Navy shore patrol or Navy Masters-at-Arms, the Air Force security forces, and the Marine Corps Criminal Investigative Division are responsible for investigating misdemeanor (non-felony) crimes for their respective Military Services. The MCIOs and Service police organizations conduct investigations in joint environments as well. In May 2004, the Commander USACIDC[7] announced that USACIDC would investigate all detainee abuse allegations (rather than only felonies) involving detainees under the control of U.S. Army personnel or within U.S. Army facilities. Since the vast majority of ground forces engaged in the Iraq and Afghanistan theaters of operation belong to the Army, and since the Army has primary responsibility for detention operations, 48 of the 50 detainee abuse cases reviewed concerned the Army with USACIDC conducting the investigations. The remaining two cases concerned the Navy and/or the Marine Corps with NCIS conducting the investigations.

Related Reviews

Immediately after the detainee abuse allegations became known, in addition to USACIDC, the Office of the Secretary of Defense, the Combatant Commands, and/or the individual Military Departments began special inspections, inquiries, and other reviews into the alleged abuses. These related reviews and resulting reports are identified in Appendix D.

Part II. Oversight of Criminal Investigations Involving Detainees

The DIG-P&O directed the Office of Investigative Policy and Oversight (OIPO) to: (1) monitor ongoing cases in order to keep the Secretary of Defense fully and currently informed, and (2) review in detail selected closed criminal investigative cases to determine if the investigations were thorough and timely, and identify areas where improvement is needed. Those areas of improvement could either concern MCIO processes and

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6 A felony crime is one for which the prescribed punishment includes death or incarceration exceeding one year. There are some exceptions; however, none apply to the cases we reviewed.

7 The Commander, USACIDC, also serves as the Provost Marshal General of the Army, a position over both criminal investigations and military police functions.

procedures or concern the command structure insofar as that structure affects investigations and the criminal justice process. To accomplish the twofold objective, OJPO tasked the MCIOs to provide ongoing summary updates on detainee-related cases as well as copies of all case file documents pertaining to closed investigations.

A. Review and Dissemination of Information Concerning Ongoing Cases

In May 2004, the DIG-P&O began reporting summary detainee case information to the Senior Military Assistant to the Secretary of Defense on a weekly basis. In November 2004, the frequency was changed to bi-weekly. The updates include information concerning criminal investigations and a matrix summarizing the status of all investigations and evaluations conducted by the Military Departments, the Combatant Commands, and by other DoD-level organizations. Following is a table, taken from our January 5,2006, report, which summarized all detainee-related criminal investigative cases:

Open Cases	**124**
Closed Cases	**483**
Total	**607**
By case type:	
Assault/Theft	**499**
Death	**108**
By investigative organization:	
NCIS	**50**
DIA	**1**

Through January 5,2006, USACIDC opened 551 cases involving detainee abuse or related allegations (91 percent of total). NCIS opened 50 (8 percent), of such investigations. AFOSI opened five cases and the Defense Intelligence Agency Inspector General opened one (one percent combined). Overall, 380 (63 percent) involved allegations of detainee abuse-related crimes occurring inside a detention or other U.S. facility, and 227 (37 percent) involved allegations of such crimes committed elsewhere. Alleged crimes primarily included assault, murder, and theft.

The majority of the cases involved Iraqi detainees or citizens' and the rest involved Afghanistan detainees or citizens, as well as detainees held at GTMO.

B. In-depth Review of 50 Cases

Summary Characteristics

The majority of alleged incidents in the 50 reviewed cases occurred in the Iraq Theater of Operations. Undetermined locations are reported for two cases due to the lack of geographical information available or provided by the complainant. The 50 investigations include incidents occurring inside U.S.-controlled prisons and detention facilities, as well as incidents occurring outside of facilities involving individuals under the control of U.S. forces in the field (for example, check points, random searches in homes).

The following table depicts the attributes of the cases we reviewed

Case Type	Qty
Assault	*21*
Death/Murder	*19*
Theft/Robbery	*6*
Other	*4*

Three cases – one assault, one death allegation, and one robbery – were determined through investigation to be false complaints. Additionally, three of the four "other" cases involved unauthorized photographs of detainees, and one case was an assault on U.S. personnel by a detainee, rather than detainee abuse.

Death Cases:

Procedures to be followed during detainee death investigations include documenting the "cause" and "manner" of death[8]. The cause of death identifies the disease, injury, or injuries that resulted in the detainee's death, usually determined at the scene by a medical authority or by a pathologist. Manner of death is the legal classification of death: natural, suicide, homicide, accident, or undetermined, and is normally determined by a pathologist following an investigation.

Of the 13 cases determined by medical examination to be death by natural causes, several were caused by pre-existing disease conditions. Some detainees declared

[8] A small number of cases involved local nationals who were *not* detainees, but were engaged by military forces near detention facilities or military forces.
See, for example, AR 195-2 and CIDR 195-1 which provide direction for USACIDC to investigate to determine cause *and* manner of death

those conditions during intake medical screenings; however, in other instances the conditions were not known by facility personnel until the fatal incident occurred. USACIDC would typically not investigate a death absent some evidence of foul play or if the death was unattended. However, given the attention to cases of potential detainee abuse, USACIDC began investigating all detainee deaths on May 4,2004, hence the emergence of USACIDC cases involving "natural" or "accidental" deaths.

The following table characterizes the 19 death cases we reviewed:

Type of eath Investigated	Qty Cases
tural[10]	13
Murder[11]	4
Mortar attack (not abuse)	1
False complaint	1

Of the 19 actual deaths investigated, 11 autopsies were performed. An autopsy was not conducted on the remaining eight. When autopsies were not conducted, circumstances included early release to the Iraqi government or family members prior to MCIO notification, and reliance on a determination of cause of death made by an attending physician rather than by a medical examiner.

In one case, the investigator cited lack of mortuary support services as the reason why an autopsy was not conducted. However, the Armed Forces Medical Examiner (AFME) advised that an Armed Forces pathologist was available on-call during the entire period covered by this evaluation. Specifically, the AFME stated that seven Armed Forces Institute of Pathology (AFIP)-certified pathologists were deployed as needed from the beginning of operations. Most of their time was spent at Dover, Delaware, examining U.S. personnel casualties. However, upon notification of a detainee's death, the AFME would deploy a pathology team to conduct the examination. Detainee examinations are now accomplished at Dover, *after* which the remains are returned to Iraq and the family.

Assault and Theft Cases:

Of the 50 cases, 21 involved alleged assault, 6 involved theft/robbery, and 3 involved other misconduct, including authorized photography of detainees. One case involved assault on U.S. guards by a detainee.

[10] Includes two *cases* where detainees died during self-imposed hunger strikes.
[11] One case involved two deaths that were investigated concurrently.

Findings

We found that 25 of the cases, including both of the NCIS cases, were substantially timely and thorough, and were unhampered by extemal factors – events or conditions beyond the control of the investigative organization. Of the 25 remaining cases, however, 13 were negatively affected by delayed referrals to USACIDC by the affected command contrary to U.S. Army policy; 7 were not thorough because an autopsy was not conducted, 5 were not thorough because a detainee's medical care prior to death was either not investigated sufficiently by USACIDC or not documented, by medical personnel; 3 involved questionable execution of the rules for the use of deadly force and inadequate coverage of those rules in the report of investigation; and, 3 were not thorough because they lacked key investigative steps." These investigations were conducted in unusual operational circumstances, in the midst of ongoing combat and counter-insurgency operations. The environment often limited access to witnesses and documentary evidence. Stateside, where conditions are more ideal, the USACIDC reports 90 percent thoroughness and 92 percent timeliness averages while NCIS reports an 80 percent average for both thoroughness and timeliness.

Finding A. Army commanders frequently did not refer apparent criminal matters to USACIDC expeditiously.

Delays in investigations frequently result in evidence degradation due either to the natural deterioration, removal, etc., of physical evidence, or to less reliable testimonial evidence as memories fade. Military commanders who do not refer potentially *criminal* matters to MCIOs in a timely fashion also may contribute to perceptions of conspiracies and "cover-ups." Additionally, a commander's administrative investigation into a criminal matter may prematurely influence witness testimony in a subsequent *criminal* investigation, or eliminate the possibility of interviews by trained, full-time investigators when interviewees invoke their right to counsel.

Department of the Army reporting criteria for the detainee abuse allegations reviewed in this review fall under reporting requirements published in Army Regulation *(AR)* 190-40, "Serious Incident Report," November 30, 1993." A serious incident is "[a]ny actual *or* alleged incident, accident, misconduct, or act, primarily criminal in nature, that, because of its nature, gravity, potential for adverse publicity, or potential consequences,[14] warrants timely notice to Headquarters Department of the Army (HQDA)."

There are two categories of serious incidents with reporting requirements to HQDA.

Multiple shortcomings were identified in some cases.

13 AR 190-40 was since revised on February 9, 2006, The referenced provisions did *not* change.

AR 190-40, Serious Incident *Report,* November 30, 1993, Glossary Section II

- Category 1 is of immediate concern to HQDA and includes actual or alleged incidents involving, for example, "war crimes, including mistreatment of enemy prisoners of war, violations of the Geneva Conventions, and atrocities."" Those serious incidents must be reported to the "Army Operations Center immediately upon discovery or notification at the installation level,"[16] followed by a written report or electronic message to HQDA within 12 hours of discovery or notification.

- Category 2 is of concern to HQDA and includes, for example, actual or alleged incidents involving prisoners or detainees of Army confinement or correctional facilities to include escape from confinement or custody, disturbances that require the use of force wounding or serious injury to a prisoner, and all prisoner deaths." Those serious incidents must be reported to HQDA within 24 hours of discovery or notification made at the installation level.

To meet law enforcement reporting requirements for criminal incidents identified in Categories 1 and 2, commanders must ensure that USACIDC is included as an addressee for all Serious Incident Reports (SIRs). The SIRs are not to be delayed due to incomplete information. All pertinent information known at the time of SIR submission must be included; additional required information is to be provided in subsequent supplemental reports.

AR 195-2, "Criminal Investigation Activities," October 30, 1985, additionally states that USACIDC is the "sole agency within the United States Army responsible for the investigation of felonies . . . ."[18] It requires Army commanders to ensure that criminal incidents or allegations are reported to military police, and requires military police to "promptly refer" all crimes or incidents falling within USACIDC investigative responsibility to the appropriate USACIDC element for investigation. AR 195-2 also confers on USACIDC the responsibility for investigating non-combat deaths "to the extent necessary to determine whether criminality is involved," and for investigating suspected war crimes, e.g., certain violations of the Geneva Conventions.

AR 15-6, "Procedure for Investigative Officers and Boards of Officers," September 30,1996, addresses procedures for administrative investigations typically conducted by Army commanders in the field. A number of the reviewed cases investigated by USACIDC were first investigated by commanders under the authority of this regulation. In its purpose statement, the regulation states that the policy is limited to investigations "not specifically authorized by any other directive."" And, where policies may conflict, it provides, "In case of a conflict between the provisions of this regulation, when made applicable, and the provisions of the specific directive authorizing the

[15] AR 190-40, Serious Incident Report, November 30,1993, Appendix B para B-1.b.

[16] AR 190-40, Serious Incident Report, November 30,1993, para 3-2.a.

[17] AR 190-40, Serious Incident Report, November 30,1993, Appendix C, para C-1.g. & m.

[18] Felonies are defined as offenses punishable by death or confinement for more than 1 year. There are some exceptions; however, none apply to the cases we reviewed.

[19] AR 15-6, Chapter 1, Paragraph 1-1.

investigation or board, the latter will govern." The regulation also provides that procedures under the regulation may not "hinder or interfere" with a concurrent investigation "being conducted by a criminal investigative [organization] [sic]."[20] Thus, it is clear that commanders' inquiries are subordinate to criminal investigations.

Finally, the issue of commander-directed administrative inquiries of death cases conducted in parallel with criminal investigations was addressed in a January 1996 OIG DoD report, "Review of Department of Defense Policies and Procedures for Death Investigations." The Military Departments concurred with a recommendation that commanders avoid administrative investigations to gather additional information [in death investigations by criminal investigative organizations] whenever possible.""

We found that a delay occurred in reporting potential felony crimes to USACIDC in 13 of the 50 cases we reviewed (26 percent). This delay may have adversely affected the collection of evidence and/or subsequent punitive or remedial action. The following cases are illustrative:

Case No. 1

Allegation: During an interrogation, a U.S. soldier assaulted a detainee by punching him in the face with a closed fist.

Assessment: While investigating another detainee-related case reported by a New York Reserve military police unit, USACIDC agents in New York learned of this incident that occurred approximately four months earlier when the unit was deployed to Iraq. The subject's unit conducted an AR 15-6 investigation while the unit was still in Iraq. Based on information gathered during that investigation, the subject's commander imposed non-judicial punishment under Article 15, Uniform Code of Military Justice (UCMJ) on the subject. Once notified, USACIDC conducted only limited investigative work – interviewing the AR 15-6 investigating officer (IO) and the subject. Additionally, USACIDC was unable to review the AR 15-6 investigative report, containing statements of those interviewed, because it was reportedly en route to the U.S. The statements of the IO and the subject differed concerning whether the detainee was handcuffed when he was struck and how many times he was struck. The subject also advised that he struck the detainee in self-defense. The IO stated that when he interviewed the detainee, others present were the interpreter, a soldier in the adjacent tent, an ICRC representative, and the detainee "mayor."" USACIDC did not send leads to agents stationed in Iraq so they could interview the victim and the interpreter, who was present when the assault allegedly occurred. When asked during his interview if the incident was ever referred to USACIDC, the IO replied, 'The chain of command handled this incident." The case file

[20] AR 15-6, Chapter 1, Paragraph 1-4 (d).

"Review of Department of Defense Policies and Procedures for Death Investigations," January 26, 1996, pp. 33-34.

[22] Individual chosen to represent the other detainees.

reflected that USACIDC initiated the criminal investigation only to place the subject's information into the Army Crime Records Center database.

Assaulting a prisoner violates the Geneva Conventions and the UCMJ. The matter should have been immediately refmed to USACIDC; and, in order to be thorough, the USACIDC investigation should have included a review of the complete file and interviews of the detainee and the interpreter.

Case No. 2

Allegation: Murder of an Afghan detainee by four members of an Army Special Forces (SF) unit. Other charges included conspiracy, dereliction of duty, and obstruction of justice.

Assessment: USACIDC was notified of the death approximately one month after it occurred, because the command first conducted an AR 15-6 inquiry. The detainee was pronounced dead by a SF soldier trained as a medic, not by a physician. No autopsy was performed and no death certificate was produced. The SF unit released the body to tribal elders the same day the shooting occurred. Following their notification, USACIDC requested exhumation of the body in order to collect relevant evidence; however, due to religious/cultural beliefs, tribal elders would not allow the exhumation. The commanding general in the area reportedly chose not to further pursue exhumation of the body, although the USACIDC file indicated that had more time been devoted to developing a closer relationship with the elders, they may have agreed to exhume the body. Most problematic in the case was the comparison of the digital photographs taken of the body at the scene by a Military Intelligence (MI) specialist to the account of the incident provided by the four soldiers involved. Two of the soldiers claimed to the AR 15-6 investigator that they shot the detainee in self defense from the front, as he raised an AK-47 at them. The photographs appear to depict – and the MI specialist who took them related – that the detainee was shot in the back. The MI specialist told USACIDC that the ranking SF member, a captain, later reviewed the photographs and persuaded the MI specialist to delete the photos that explicitly depicted the detainee's wounds. However, the MI specialist had already provided a copy of all of the photos to his intelligence functional contacts and provided them to USACIDC. Additionally, the deceased detainee was found clenching religious beads in his right hand, casting doubt on whether or not he also could have been holding or aiming a rifle. The captain, who was serving as a look-out (not one of the shooters), received a letter of reprimand – reportedly for having improperly "influenced"[23] the selection of pictures that the MI specialist deleted before sending them forward. The remaining soldiers, all subordinate in rank, were not punished.

[23] The MI specialist first reported that the captain directed him to delete *the* more inflammatory photos. He apparently later changed his story to reflect that the captain merely asked him which pictures he was going *to* include – in a manner *the* specialist believed was intended to influence him not to include certain photos.

The USACIDC investigation was thorough (although the four soldiers requested counsel and were not available for interview by USACIDC), but without the evidence an autopsy would likely have provided, the case could not be proven conclusively. The command should have contacted USACIDC immediately, and an autopsy should have been requested.

Case No. 3

Allegation: An Army soldier assigned to a detainee collection point shot and killed a detainee who was allegedly trying to escape. The detainee, whose hands were cuffed behind his back, was in an isolation cell behind a concertina wire barrier.[24]

Assessment: The shooting occurred on September 11,2003. The unit completed an AR 15-6 inquiry, before notifying USACIDC on September 15,2003. There was no information in the file to indicate why USACIDC was not immediately notified. Based on the unit inquiry, the Staff Judge Advocate (SJA) opined that the subject did not follow the rules of engagement when he shot the detainee, who was handcuffed and behind a concertina wire barrier. The SJA contacted USACJDC and provided a copy of the AR 15-6 investigative report. USACJDC agents went to the scene, photographed and sketched the facility, but did not reinterview witnesses. Instead, USACIDC chose to rely on the AR 15-6 investigation, which included interviews of all present or involved in the incident. However, the AR 15-6 investigation did not include collection or examination of physical evidence. The deceased's body had been turned over to his family before USACIDC was notified, thus precluding an autopsy and the collection of evidence from the body. Responding medics saw what appeared to be an entrance wound in the abdomen, but did not observe an exit wound. USACIDC interviewed the subject on October 23,2003; however, he invoked his right to counsel and refused to answer questions. He had earlier provided a statement during the unit's initial inquiry, but without prior rights advisement. Two soldiers were nearby in the facility when the shooting occurred; however, neither actually saw the subject pull the trigger. On November 20,2003, the SJA advised USACIDC that probable cause existed to believe that the subject committed the offense of murder, but also advised that an Article 32 hearing had already been conducted, after which the commander concluded that the case would not proceed to trial but that the subject would be granted discharge in lieu of court-martial?' The subject subsequently was reduced to the grade of E-1 and discharged from the Army.

Although the testimonial evidence in this case was fairly strong, immediate notification of USACIDC coupled with (1) physical evidence from an autopsy, (2) examination of the rifle used, and (3) examination of the retrieved bullet would have given the commander

[24] The rules for the use of force allowed for deadly force against an escaping detainee only when the detainee cleared the outside wire and was *continuing* to escape. See Chapter 10 of AR 635-200.

stronger evidence to consider in his decision to grant the discharge or proceed to trial. This is especially true given the lack of a direct eyewitnesses and the lack of testimony (under rights advisement) from the subject.

Recommendatwn I: The Secretaries of the Military Departments and the Commander, U.S. Central Command, stress to commanders the need to refer matters involving apparent war crimes orfelonies to the appropriate Military Criminal Investigative Organization expeditiously in accordance with DoD Instruction 5505.3 and military departmental policies. Command investigations into such matters should not be conducted without such prior coordination.

Management Comments and OIG DoD Response: The Provost Marshall General, on behalf of the Secretary of the Army, essentially concurred with the original recommendation, suggesting slightly different language to describe serious *offenses* and suggesting that the recommendation be addressed to the appropriate MCIO rather than to USACIDC only. The Provost Marshall General also commented that DoD Instruction (DoDI) 5505.3 requires commanders at all levels to ensure that criminal allegations or suspected criminal allegations involving persons affiliated with the DoD or any property or programs under their control or authority are referred to the appropriate MCIO or law enforcement organization.

The Army's comments were responsive. We have revised our report to include reference to DoDI 5505.3 and our recommendation to direct action to each Military Department Secretary and their respective criminal investigative organization rather than to the Secretary of the Army and USACIDC only. We note, however, that our findings on delayed referrals concerning the 50 cases reviewed were limited to the Army.

U.S. Central Command did not agree that referrals to USACIDC were delayed, stating that in the majority of situations, cases were referred within appropriate time limits given the nature and pace of operations and other environmental factors. The U.S. Central Command also replied, citing the RCM, that authority and responsibility is placed on commanders to conduct preliminary inquiries into potential *criminal* matters. U.S. Central Command additionally suggested that commanders not be required to refer particular criminal matters to USACIDC, but should merely "consider consulting" with USACIDC.[26] The U.S. Central Command response explained that it is a tactic of the enemy to allege cruelty and maltreatment, and that commanders have the necessary means to investigate such matters and should have the discretion to decide which cases are refmed to USACIDC.

While we agree that the RCM place responsibility on commanders for action within the military justice system, it is also true that the DoD and the Military

[26] The findings in this review happened *to* concern USACIDC. The same principle would apply *to* referrals to *the* other *military criminal* investigative organizations.

Departments have each implemented policy[27] to assist commanders in the investigation of serious criminal matters through referrals to the Defense Criminal Investigative Organizations. Such organizations are equipped to properly collect and store forensic and other evidence by using specialized investigative techniques appropriate to the crime, while safeguarding the rights of the victim and the accused. Any delay in referrals could mean the loss of valuable evidence, as we found in the cases described above, and adversely impact the administration of military justice. We conclude that prompt referrals to criminal investigative organizations are crucial to the proper resolution of such cases, additionally avoiding the appearance of undue command influence in an investigation.

We recommend that the Commander, U.S. Central Command, reconsider his position and respond to this office within 45 days.

Finding B. The lack of autopsies to assist in determining cause and manner of death resulted in insufficient documentation of some death cases.

A joint policy[28] requires that AFME be notified "expeditiously by the casualty branch, safety center, or investigative agency of the death of. . . any individual, regardless of status, who dies on a military installation, vessel, or aircraft. . . ." "Expeditiously" is described as being within 24 hours following the death. The AFME is responsible for determining that the need exists for a forensic pathology investigation. Section 1471 of Title 10, United States Code, states that forensic pathology investigations are permitted and justified when, inter *alia:*

- Circumstance1

  (A) "it appears that the decedent was killed or that, whatever the cause of the decedent's death, the cause was unnatural;

  (B) the cause or manner of death is unknown;

  (C) there is reasonable suspicion that the death was by unlawful means . . .," and one or more of the following circumstances exists:

- Circumstance-2

  (A) "the decedent was found dead or died at an installation garrisoned by units of the armed forces that is under the exclusive jurisdiction of the United States . . .

  (B) in any other authorized DoD investigation of matters which involves the death, a factual determination of the cause or manner of the death is necessary. . . ."

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27 See, for example, for example, DoDI 5505.3 and *AR* 195-2.

28 *AR* 40–57/BUMEDINST 5360.26/AFR 160–99 - Armed Forces Medical Examiner System, 1-5.b.

Although the AFME provides consultative services to local operational commanders and appropriate physicians at military treatment facilities (MTFs) for determining the necessity and/or extent of medicolegal investigation, the final decision rests with the AFME. And, in field locations where no medical or command authority is present, the AFME determines the need or extent for a medicolegal investigation. When conducting a medicolegal investigation, the medical examiner and investigator are responsible for maintaining custody of the collected evidence.

In addition to the joint policy, AR 195-2 assigns USACIDC responsibility for investigating non-combat deaths to the extent necessary to determine whether criminality is involved. USACIDC Regulation 195-1 further states that "a complete investigation will include the results of any autopsy or similar medical/laboratory tests . . . ."[29] Nevertheless, autopsies were not performed in many cases involving detainee deaths. A June 9,2004, Secretary of Defense memorandum, attached at Appendix F, clarified the need for autopsies, stating that upon the death of "enemy prisoners of war, retained personnel, civilian internees, and other detainees, ... while in custody of the Armed Forces of the United States, ... an autopsy shall be performed, unless an altemative determination is made by the Armed Forces Medical Examiner." (NOTE: Each of the five investigations we reviewed that lacked an autopsy was initiated prior to the Secretary's memorandum, thus validating the need for the memorandum. A cursory review of the detainee death cases conducted since the date of the memorandum revealed the policy was being followed, with only one exception.)

In 6 of the 19 actual deaths reviewed, failure to conduct autopsies resulted in lost evidence that would have been valuable in determining and/or documenting cause and manner of death. In addition to Case No. 2 and Case No. 3 highlighted above, the following cases illustrate this finding:

Case No. 4

Allegation: An Iraqi detainee was found dead in a detention facility, lying on his back underneath a blanket with his hands cuffed behind him and an empty sandbag covering his head. No prior medical condition was noted in his records.

Assessment: The USACIDC report indicated that the deceased was restrained with flexible handcuffs to keep him from removing the empty sandbag that was used as a blindfold. The medical examination disclosed a small laceration on the back of the deceased's head that was not further explored during the investigation, as well as ulcers[30] on the wrists in the location of the handcuffs. Guards and interrogators were interviewed; however, a physician's assistant, present during the examination, was unexplainably not interviewed. No autopsy was conducted. An agent's note in the case file reflected, "Battalion and group ruled no autopsy & the body can be released to the NOK [next of

[29] USACIDC Regulation 195-1, "Criminal Investigation Operational Procedures," June 15,2004.
[30] A break in the skin/open sore.

kin]." When the USACIDC battalion forensic officer reviewed the case five months later, he expressed concern about the lack of an autopsy, as well as the failure to identify the "battalion and group" representatives who determined an autopsy was not necessary and why. The deceased's death certificate reflected cause of death as "unknown" and manner of death as "natural." An autopsy in this case would have assisted in determining, for example, whether the detainee died as a result of an otherwise undetected injury or suffocation.

Case No. 5

Allegation: A detainee who was being treated for chest pains at an Army Combat Support Hospital, fell out of bed, struck his head on the floor, and lapsed into a coma. A CAT scan and neurosurgery revealed inter-cranial bleeding and a prior brain injury, which the surgeon estimated to be three to four weeks old. The detainee subsequently died.

Assessment: USACIDC was notified of the death *after* the body was sent to the Iraq Ministry of Health and released to the family. An autopsy, which may have produced additional evidence relevant to the prior brain injury, was not performed. The investigative report listed the cause of death as undetermined, however, according to the neurosurgeon, the detainee died from a brain hemorrhage. When queried as to whether the fall was the only cause of death, the neurosurgeon stated that the detainee would have died anyway if the prior brain injury had remained untreated.

Based on the neurosurgeon's statement, the investigation should have been expanded to include determining the date the detainee was taken into custody and, if custody began prior to the 3-4 week age of the prior brain injury, determining the likely cause of that injury.

Recommendation 2. The Secretary of the Army, the Commander, U.S. Central Command, and the Military Criminal Investigative Organizations take steps to ensure that the policy outlined in the June 9, 2004, Secretary of Defense memorandum requiring autopsies in detainee death cases is implemented fully and enforced

Management Comments and OIG DoD Response. Management concurred with this recommendation. U.S. Central Command responded that fragmentary orders requiring compliance have been issued and major subordinate commands are conducting such autopsies as a matter of practice.

Finding C. (1) Investigations concerning the potential use of excessive force against detainees did not adequately focus on the Rules for the Use of Force (RUF) concerning detainees, and (2) RUF applied at the local level varied from written directives.

Definition of Rules of Engagement

Rules of Engagement (ROE)" are directives issued by competent military authority to delineate the circumstances and limitations under which naval, ground, and air forces will initiate and/or continue combat engagement with other forces encountered.[32] They are the means by which the Secretary of Defense and operational commanders regulate the use of armed force in the context of applicable political and military policy and domestic and international law. In effect, they are the commander's rules for the use of force (RUF).

Purposes of ROE

ROE perform three functions: (1) provide National Command Authority guidance to deployed units on the use of force; (2) act as a control mechanism for the transition from peacetime to combat operations (war) and then to peacekeeping; and (3) provide a mechanism to facilitate planning. ROE provide a framework that encompasses national policy goals, mission requirements, and the rule of law.

ROE restrain a commander's action consistent with both domestic and international law, and may impose greater restrictions on action than required by law. Military doctrine calls for a higher-echelon commander to establish ROE for immediate subordinate echelons. In turn, these subordinate echelons disseminate ROE that are consistent with those of higher headquarters but tailored to the particular unit's mission?'

Department of Defense ROE

As approved by the Secretary of Defense, the Chairman, Joint Chiefs of Staff (CJCS), issued an Instruction (CJCSI) 3121.01A on January 15,2000, with guidance on the Standing ROE (SROE) for U.S. forces. This guidance promulgated the Secretary of Defense approved SROE, which implemented the inherent right of self-defense and provided for the application of force for mission accomplishment.[34] The secretary of Defense approved the successor Standing Rules of Engagement/Standing Rules for the Use of Force, issued as CJCSI 3121.01B, on June 13,2005.

[31] ROE are commanders' rules for the use of farce. (FM 27-100, para. 8.2.1)
[32] FM 27-100, ¶ 8.2.5 quoting Joint Publication 1-02.
[33] FM 27-100, para 8.4.2.
[34] Enclosure A to CJCSI 3121.01A.

Underlying the SROE is the concept of the inherent right of self-defense. This concept recognizes a commander's authority and obligation to use all necessary means available and to take all appropriate actions to defend that commander's unit and other U.S. forces near a hostile act[35] or demonstration of hostile intent.[36] CJCSI 3121.01A describes the elements of self-defense in terms of necessity (exists when a hostile act occurs or when a force or terrorist exhibits a hostile intent) and proportionality (force used to counter a hostile act or demonstrated hostile intent must be reasonable in intensity, duration, and magnitude to the perceived or demonstrated threat based on all facts known to the commander at the time).

Combined Joint Task Force -7 Operation Orders (OPORD) 071-033 and 071-036 contain the ROE governing operations for the criminal investigations used in this review. OPORDs 071-033 and 071-036, including the ROE, were modified by fragmentary orders (FRAGOs) to adjust the ROE to the changing local conditions.

Rules of Engagement/Rules for the Use of Force

The ROE for U.S. forces in Iraq flow from the SROE. They call for using necessary and proportional force, including deadly force, against persons or forces that demonstrate hostile intent or commit a hostile act against coalition forces. The ROE also provide guidance on the RUF in detention facilities and against escaping detainees. Written guidance established that deadly force against an escaping detainee constitutes an "extreme measure" to be used only as a last resort. Chapter 7 of the Standing Operating Procedures for Camp Vigilant, DRAFT update October 20,2003, for example, describes six force levels to provide options for controlling or subduing detainees. The force levels range from officer presence to using deadly force. The particular force that may be selected/used depends on the level of threat posed to U.S. forces.[37] Such rules are consistent with the multi-Service regulation on detainees,[38] which requires guards to shout "Halt" three times at prisoners attempting to escape, and to use the least amount of force necessary to halt the detainee. If no other means of preventing escape exists, the regulation allows for the use of deadly force.

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[35] Hostile act is defined as "An attack or other use of force against the United States, U.S. forces, and in certain circumstances, U.S. nationals, their property, U.S. commercial assets, and/or other designated non-U.S. forces, foreign nationals and their property. It is also force used directly to preclude or impede the mission and/or duties of U.S. forces, including the recovery of U.S. personnel and vital U.S. Government property. (CJCSI 3121.01A, Enclosure A, para 5.g.)

[36] Hostile intent is defined as "The threat of imminent use of force against the United States, U.S. forces and in certain circumstances, U.S. nationals, their property, US. commercial assets, and/or other designated non-U.S. forces, foreign nationals and their pmperty. Also, the threat of force to preclude or impede the mission and/or duties of U.S. forces, including the rewvery of U.S. personnel and vital U.S.G. property. (CJCSI 3121.01A, Enclosure A, para 5.h.)

[37] A similar 6-level Use of Force Continuum is contained in the "ABU GHURAYB PRISON INITIAI OPERATING SOP, DRAFT - 09 AUGUST 2003"

[38] NWP 1-14M/MCWP 5-12.1/COMDTPUB P5800.7A, 190-8/OPNAVINST 3461.6/AFJI 31-304/MCO 3461.1, Enemy Prisoners of War, Retained Personnel, Civilian Internees and other Detainees, 1 Oct 1997

The "800th Military Police Brigade Rules of Engagement for Operations in Iraq," in effect June 24,2003, states, "[I]f a detainee attempts to escape, the guard must **SHOUT HALT (KIFF) 3** times (emphasis in original). If the attempt to escape is from a fenced-in enclosure, the detainee will not be fired upon **unless** the person **has** actually cleared the outside compound wire and is continuing their efforts to escape" (Appendix G).

During our review, we found an undated group of training slides used in-theater entitled, "Rules for the Use of Force for Detention Facilities" (Appendix H) that provided clear guidance on the practical application of use-of-force principles by military members *guarding* detainees. The use of **"graduated** response" and the fact that deadly force against an escapee was an "extreme measure" are emphasized throughout the training. The fact that a guard could not use deadly force against a detainee attempting to escape when other means to stop the escape are available was also stressed.

Review Findings Concerning RUF

Three of the SO cases reviewed involved the use of deadly force against detainees inside a detention facility. In two cases, inadequate attention was given to the RUF. This included failing to include a copy of the written RUF in effect at the time of the incident in the investigative report, failing to compare verbal orders given on scene with the Written rules, and structuring the investigation without regard to collecting evidence to prove or disprove that the RUF were properly followed. We found that deadly force was used inside the Abu Ghraib facility against detainees who were (1) not immediately threatening the life of the guard(s), and *(2)* were not beyond the "outside wire" when continuing an attempt to escape. Such use of deadly force contradicts Written ROE/RUF, although possibly conforming to verbal orders given at the time. To illustrate:

Case No. 6

Allegation: Two detainees were shot and killed in separate incidents during a prison riot.

Summary: In the first incident, which occurred at approximately 9:30 p.m., an Army guard shot a detainee who had climbed out of a damaged window at a hard site[39]—Tier 1SB—at the Abu Ghraib confinement facility." **(NOTE:** Earlier, the *guard* had fired five non-lethal rounds in response to inside detainees breaking "concrete windows" and throwing rocks and pipes out at the guards from inside the building.) A concertina wire fence separated the detainee and the prison *guards.* The *guards* ordered the detainee to "Halt." When the detainee did not respond to the verbal orders and continued his escape, one of *three* guards fired one shotgun round, hitting the detainee in the back. The guard

[39] Building used to house prisoners as opposed to tents or soft structures used as *temporary* confinement facilities. The hard site itself was within the Abu Ghraib compound.

[40] Earlier, the *guard had* fired five non-lethal rounds in response to detainees breaking *"concrete* windows" and throwing rocks and pipes from inside the building at the guard.

advised that the Military Police (MP) battalion commander authorized using deadly force if any detainee "physically got outside the tier." The guard said he was afraid that the detainee, later determined to be unarmed, "would attack us or that he would try to escape." The two other guards advised that the shot was fired after the detainee started to run. The investigative report merely reflected that the battalion commander "briefed all military police working at the prison the rules of engagement, which included the use of deadly force if a detainee attempted to escape."

In the second incident, 14 prisoners escaped from Tier 5A during the dark at approximately 4:00 a.m. the following morning. Thirteen were re-captured; however, one remained at large. Two Marine guards, involved in the recapture efforts, were assigned to continue the search for the missing detainee. The two guards were aware of an earlier radio report that a shot had been fired but were not aware that the report involved an accidental discharge of a soldier's shotgun approximately 6 hours earlier. Using night vision goggles, one guard spotted the escapee approximately 50 meters away, crawling on the ground toward the guard. Although the guard could not see if the detainee had a weapon, he was afraid the detainee might. The guard advised that he knew from previous briefings that "deadly force was authorized for anyone threatening a Marine." He added that "an Army sergeant told us earlier that night deadly force was authorized to stop an escape or an escaped detainee once they left the hard site." The guard stated that he "didn't have time to think, I just shot to protect myself and [my partner]." The guard also identified a briefer who had earlier informed them of intelligence indicating an attack was planned – that the prisoners were planning to riot, escape, get weapons, and take over the compound. The briefer was not located or interviewed during the investigation. The Sergeant of the Guard (SOG) was interviewed and reported that he briefed his personnel that deadly force was authorized if Marines or Coalition Forces were ''threatened, or in fear of grievous bodily harm." The SOG added that an Army sergeant (not identified or further investigated) briefed the Marines that deadly force was authorized to capture detainees who had escaped from the hard site. The USACIDC investigative report indicates the battalion commander stated he briefed all military police at the prison on the ROE, "which included the use of deadly force if a detainee attempted to escape." The report indicates that the command judge advocate opined that no crime had been committed and that the shootings were justifiable homicides.

Assessment: The investigation lacked sufficient information concerning the ROE/RUF. The written RUF were not obtained, reviewed, or included in the report. The variances in the prerequisites for using deadly force communicated by those interviewed (e.g., deadly force authorized "to stop an escape" versus if the detainee "physically got outside the tier," or "for anyone threatening a Marine") were not adequately pursued and resolved. More importantly, there appears to be a significant variance in the written ROE/RUF we obtained and those briefed to the soldiers the night the detainee was killed. The written RUF allow using deadly force against detainees only when a Service member is in fear of death or serious bodily harm to himself or another, and as a last resort if an escaping detainee is outside the compound wire and no other means of retrieving the detainee is available.

In light of our concerns, we provided a copy of this case file to the Office of the Army Judge Advocate General (OTJAG) for review. OTJAG responded that the detainees were justifiably shot in self defense and to prevent escape. We agree that the guards may have been acting in accordance with the instructions on which they were briefed; however, based on the accounts provided by those interviewed, we believe the briefings were unnecessarily vague and not in agreement with the written guidance from higher headquarters. We believe that additional investigative focus on this important point was necessary.

Case No. 7

Allegation: During a riot in a fenced, outdoor area of a prison, a detainee was shot (not fatally) by a guard.

Summary: The investigation disclosed that during the riot, detainees threw rocks, water bottles filled with sand, and cans at a guard in an observation tower located outside the compound wire. According to the case file, the base of the observation tower, which was approximately 30 feet high, was approximately 35 feet away from the 3 rolls of concertina wire that separated the tower from the detainees. No detainee breached the wire during the incident. Non-lethal force was initially used against the detainees, but did not stop the detainees from throwing items at the guards who suffered no remarkable injuries. The investigation determined that three guards, stationed at different locations, fired a total of four shots at the rioting detainees. Two used M-16s while a guard in the tower shot a 9mm pistol. The investigation did not determine which shooter actually hit the detainee. The officer in charge stated that he authorized the guards to use deadly force "if they felt threatened or thought they were in danger." He advised that his ROE authorized using deadly force to "stop serious bodily injury." When asked if he felt that "if the prisoner breached the fence the lives of the guards were in jeopardy," the officer replied, "Yes." When asked if he authorized the particular guards to use deadly force, he responded, "It was a general authorization. Every guard mount the Rules of Engagement are covered."[41] One of the guards interviewed related that he heard someone on the radio advise, "If the prisoners are throwing projectiles, lethal force is authorized." One guard related to USACIDC that "the prisoners. . . kept throwing items at the tower after the live rounds were fired and only disbursed after the Quick Reaction Force was sent in. . . ." When asked about the ROE, another guard (who had first fired non-lethal rounds and said he had been "hit by a can but not hurt" on the way to assist the tower guard) explained,

> "The rules of escalation are used for non-lethal. Meaning you shout and tell the prisoner to stop the action that is either hurting a soldier or another detainee *or* is in violation of compound rules. If they don't stop you would shove them or make a move to show that they are to stop. After that you are to show that you intend to use your weapon. *And* finally you would lire. These rules are also used for lethal except you would only use lethal if a soldier's life is m *danger,* or the prisoners

[41] T1 1 gu n is a military term used to denote the meeting wherein instructions/training is given to police and security officers at the beginning of their shift

are escaping from the compound. I don't know who made the request, but my [lieutenant] granted the use of lethal ammo."

One guard, who fired two rounds from his M-16 from the tower where he was assisting the tower guard, said that he was told to shoot if he were in any danger. He related that he felt he was in danger because sand-filled water bottles, metal cans, and large rocks were being thrown at the him and the tower guard.

The written ROE for the particular camp were included in the case file, but not attached to the USACIDC report. The rules for escalating use of force were:

a. Shout verbal warnings.
b. Shove, physically restrain, block access, or detain.
c. Use of Military Working Dogs (MWD)
d. Show your weapon and demonstrate intent to use it.
e. Use of non-lethal munitions.
f. Shoot using lethal munitions to remove the threat of death/serious bodily injury [emphasis added] or to protect designated property. If you must fire:

- (1) Fire only aimed shots, wound if possible. Gain and maintain positive identification of target.
- (2) WARNING SHOTS *ARE* AUTHORIZED BUT MUST BE FIRED IN A SAFE DIRECTION AWAY FROM ALL PRISONERS, CIVILIANS AND US/COALITION PERSONNEL. [emphasis in original]
- (3) Fire no more rounds than necessary.
- (4) Fire with due regard for the safety of innocent bystanders *or* US/Coalition forces.
- (5) Take reasonable efforts not to destroy property.
- (6) Stop firing as *soon* as the situation permits.

In addition to the above provisions, the ROE state that if a prisoner attempts to escape from a fenced compound, the prisoner will not be fired upon with lethal ammunition unless the prisoner has actually cleared the outside wire and continues to escape.

The reviewing SJA opined that the shooting was justified and in compliance with ROE regarding the use of deadly force.

Assessment: The investigation was timely; however it was not thorough in that it did not include a sufficient analysis of the ROE/RUF and did not provide a copy of the written ROE/RUF with the Report of Investigation (ROI). As a result, the discrepancy between the verbal orders given on-scene and the written ROE was not addressed. In this case, none of the detainees breached the wire and the closest detainee was described as being approximately 40 feet from the towers, which were approximately 30 feet high. The guards suffered only very minor injuries. No warning shots were fired with lethal ammunition. According to several of the statements, once lethal rounds were fired, the detainees stopped their actions and were brought under control by the Quick Reaction Force (indicating that means other than deadly force were available to bring the detainees under control)." *Also,* MWDs were not employed.

48/ An internal USACIDC review identified additional investigative deficiencies, with which we concur.

We asked OTJAG to review this case as well. OTJAG opined that the original legal opinion was proper, and that the shooting was justified and in accordance with the ROE.

We believe that the written ROE reflect the principle that deadly force is to be used only as a last resort to prevent death or serious bodily injury, to prevent the continued escape of a prisoner if he has already cleared the "outside wire," and when no other means are available to stop the prisoner. In the cases summarized above, we believe that that the description of the facts in the investigative report may not have indicated the need for deadly force at the time it was employed, and that further investigative emphasis on this issue would have been prudent.

Recommendation 3. The Commander, USACIDC, direct that all investigations concerning the use of deadly force include sufficient analysis to demonstrate conclusively that the ROE/RUF were properly followed, including (a) attaching a copy of the written rules to the ROI, and (b) conducting interviews to determine precisely what orders and/or authorizations were given to security forces.

Management Comments and OIG DoD Response. The Army concurred with our recommendation. The U.S. Central Command recommended that we correct our improper reference to the ROE when we were actually addressing the RUF. We concur and have modified this report accordingly. To be clear, this finding concerns the use of deadly force, the policies and procedures governing such use, and the focus on each during criminal investigations of incidents where such force is applied.

Recommendation 4. The Secretaries of the Military Departments and the Commander, U.S. Central Command, review the ROE/RUF from the top down to ensure clarity and consistency, and to ensure they are thoroughly taught and applied

Management Comments and OIG DoD Response. The Army and U.S. Central Command concurred with our recommendation to review the ROE/RUF. The U.S. Central Command recommended that we direct this recommendation to each of the Military Departments since each is responsible for training, whereas the combatant command maintains operational control. We have modified this recommendation accordingly.

Finding D. In some cases involving detainee deaths, investigations were not sufficient to determine if medical conditions contributing to the death existed prior to confinement, or if the conditions of confinement or lack of medical care may have contributed to the death.

The multi-Service EPOW policy[43] calls for initial medical examinations and monthly screenings of detainees. Five of the 50 cases reviewed concerned deaths where investigators either did not obtain and review medical records or did not interview fellow inmates or others to determine the detainee's condition and/or treatment prior to death. In one case, the investigative report indicated a detainee was found to have a medical condition that appeared to go untreated, but this condition was not clearly highlighted in the report. Case examples follow:

Case No. 8

Summary: A detainee collapsed in his cell during morning prayers and died. There were no visible signs of foul play. An autopsy determined the detainee died as a result of Myocarditis; the manner of death was listed as natural causes.

Assessment: Although it is clear that the detainee died as a result of a pre-existing heart condition, the investigation did not establish whether the detainee's condition was noted upon arrival at the detention facility, or whether the detainee was being treated for a heart condition while in detention. Once a physical examination determined that there was no visible sign of foul play, the investigation focused on documenting the circumstances immediately surrounding the death and the autopsy.

Case No. 9

Summary: A detainee collapsed in his cell and died. The examining physician concluded that the death was from natural causes.

Assessment: Interviews and other investigative steps did not commence until nearly one month *after* receiving the examining physician's diagnosis. Neither the detainee who brought the death to the attention of U.S. personnel nor the medics who provided care were interviewed. An autopsy was not performed to validate the attending physician's conclusion. Medical records included in the case file consisted only of a log of all inmates who received medical care at the facility and the deceased detainee's in-processing sheet, which reflected a heart problem. However, a battalion physician stated that he was unaware of the detainee's medical complaints.

Interviews should have been conducted with medical personnel. These interviews could

[43] Joint policy (AR 190-8/OPNAVINST 3461.6/AFJI 31-304/MCO 3461.1)

have explored the heart problem, attempting to determine whether medical care had been given since capture, and whether medical treatment received or not received during detention might have contributed to the death. During his interview, the battalion doctor should have been queried to determine if he or someone else was responsible for reviewing the sheets and providing medical care instructions for detainees with medical conditions. The USACIDC case file notes reflected that agents questioned the level of care provided to the detainee during the period leading up to his death, however, the file also contained a note indicating that follow-up on medical care fell "outside the scope of this review." There was no indication that this issue was briefed to responsible medical authorities. The file indicated that at the time of this death, autopsies were not being performed on detainees. This investigation did not validate that autopsies were not being performed, even though USACIDCR 195-1 provides that a thorough death investigation requires an autopsy.

Case No. 5

Summary: See Finding B, above. Surgery on the detainee following an accidental fall revealed a head injury that may have occurred three to four weeks prior to the detainee's death.

Assessment: The investigation did not attempt to determine whether the head injury occurred while the detainee was in U.S. custody, whether the head injury was being treated properly, or whether the detainee's condition was known to U.S. medical personnel.

Case No. 10

Summary: A 61-year-old detainee was found unresponsive in his bed during morning head count. There was no pulse and rigor mortis had begun.

Assessment: The ROI's investigative *summary* indicates the "investigation established probable cause to believe [the detainee] died of natural causes when it was determined the death was a result of Atherosclerotic Cardiovascular Disease." Close examination of the ROI's exhibits revealed the detainee was captured at his home on January 24, 2004. On February 1,2004, he received a medical screening where it was noted that he was suffering from partial kidney failure and was urinating only one ounce daily. He was observed to have a bloated abdomen. The detainee advised he experienced dizziness when standing and walking. After he died on February 8,2004, a Military Police (MP) soldier who had been guarding him said that the detainee had been ill for "a couple" of days. He added that the detainee had not been coming out "of the cell as was usually required for headcount but instead had been accounted for while he remained in his bunk." The MP related that he was "unaware of any specific medical guidance regarding this particular detainee." A note in the Agent's Activity *Summary* located in the case file

reflected, "Briefed [name], SJA, who related she did not see us pursueing [sic] negligence charges. [The SJA] stated she would confer with the division surgeon and contact this office upon completion of discussion." No further comments were reflected in the file.

While a crime was not likely committed, it is apparent that the detainee was observed to need medical care at his medical screening and that in the days preceding his death did not receive that care. In this case, the investigator should have pursued further and documented the detainee's condition and medical care to determine whether a lack of appropriate care contributed to the detainee's death.

Case No. 11

Summary: On February 19,2004, at approximately 12:15 p.m., a detainee at Abu Ghraib prison was experiencing symptoms of dehydration and was told by guards to drink two bottles of water. About two hours later, the detainee was still not feeling well. Medics responded, examined the detainee, and told the noncommissioned officer in charge to call if his condition worsened. One medic stated that at approximately 6:30 p.m., he was notified that the detainee was having trouble urinating and was feeling dizzy. The medic responded; obtained the detainee's vital signs, which the medic advised were normal; and told the detainee he would return after he consulted with a doctor. The same medic reported that about 30 minutes later the detainee, who was feeling worse, was being assisted to the front gate. On the way to the medical in-processing station, the detainee lost consciousness. Efforts to resuscitate him failed. An autopsy determined the cause of death was "acute peritonitis secondary to a perforating gastric ulcer. The manner of death was listed as "natural."

Assessment: The USACIDC case file does not reflect that the deceased detainee's medical records were reviewed to determine the extent to which prior symptoms were recorded or treated.

Recommendation 5. The Commander, USACIDC, require a medical records review in all detainee death cases to determine if relevant historical entries were made and follow-up medical care provided (see CIDR 195-1, Section 5-21.i andj)." Apparent discrepancies should be reported to command and medical authorities and, when criminal negligence is indicated, further investigated

Management Comments and OIG, DoD Response. The Commander USACIDC and the ASD(HA) concurred.

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44 CIDR 195-1, in part, allows for early termination of a death investigation only when the death is not the result of a criminal act or omission and no other offenses are involved. It further states that in cases where it is determined that a death resulted from a criminal act or omissions on the part of any person, that person will be listed as the subject of the investigation.

Finding E. Unique Issues

The following cases resulted in specific findings unique to each case:

Case No. 12

Summary: An Iraqi detainee died in prison. The investigation included an autopsy; the conclusion was death by natural causes (heart attack). The autopsy disclosed that the deceased's 5th and 6th ribs were broken (believed to be due to CPR), and a small metal object was removed from the detainee's buttocks. A laceration was also found on his nose.

Assessment: The investigator requested a logical investigative step, to interview the deceased's cellmates, but the interviews were not conducted because the brigade commander overseeing the confinement facility denied access to USACIDC investigators. While it appears that the death was from natural causes, the investigation was not thorough because cellmates were not interviewed. No apparent effort was undertaken during the investigation to identify the metal object and/or to determine how it got inside the detainee. The object was initially seized as evidence; however, for reasons not reflected, the agent was instructed to dispose of the evidence upon higher level USACIDC review. There was no apparent attempt to determine the cause of laceration.

Recommendation 6. The Commander, USACIDC, initiate a review of this investigation to (a) ensure the brigade commander's refusal to grant USACIDC agents access to the facility has been addressed and corrected, and (b) review the propriety of the direction to dispose of potential evidence. Based on the review results, the Commander, USACIDC, take appropriate action to ensure that these factors do not limit investigative thoroughness in future detainee investigations

Management Comments and OIG DoD Response. USACIDC contacted the commander of the brigade in question and learned that he was unaware of the denial of access until after the action occurred, and that it occurred when an inexperienced subordinate dealt with a similarly inexperienced investigator. The brigade commander stated that he would have allowed access. The problem does not appear systemic. The Army recommended addressing the issue through future doctrinal publications and through training. We concur. In addition, USACIDC further reviewed the investigation and determined that the metal object removed from the body was covered with fibrous tissue and had been in the body for quite some time. With that information, we agree that the metal object was likely not associated with any potential abuse during detention, and its preservation as evidence not warranted.

Case No. 13

Summary: A soldier alleged that he witnessed several counterintelligence (CI) agents strike, pull hair, and force into asphyxiation numerous Iraqi detainees, as well as point loaded weapons at detainees' heads and tell them that they would be killed if they did not talk. The final ROI reflected that the investigation did not identify any witnesses to the alleged abuses. It moreover reflected that the complainant committed the offenses of Aiding the Enemy, False Official Statements, and Unauthorized Wear of Military Insignia.

Assessment: Our review of the investigative file disclosed that the complainant identified three CI agents as having committed the alleged abuses. The subsequent investigation consisted of interviewing, under rights advisement, the alleged perpetrators (all of whom denied wrongdoing in sworn statements), and nine other individuals who would have been in a position to know about or observe the alleged abuses. All denied knowledge of any detainee maltreatment. Only one alleged detainee victim was identified by name. The investigation determined that this detainee had been released. No apparent attempt was made to locate him for an interview. Each alleged perpetrator, as well as the complainant, declined a polygraph examination. During the investigation, considerable evidence was collected that cast doubt on the *truthfulness* of the complainant's assertions.

Although the investigative interviews conducted to validate the complainant's claims were thorough and, assuming their accuracy, apparently resolved the complaint, the investigation would have been more complete had it included locating and reviewing the CI documents created contemporaneously with the interrogations. This could have resulted in identifying the alleged victims for subsequent contact and interview. Medical records should also have been reviewed, and assigned medical personnel should have been interviewed to determine if detainees injured as described had been treated. The complainant also alleged that abuses against four detainees were witnessed by several soldiers from the "MP company" and "Motar company,"[45] and an Iraqi linguist who were sharing the Same building. While MI and MP soldiers were interviewed, as well as one linguist, there is no indication that anyone from the "Motar company" was interviewed.

Because this particular case received substantial attention for other reasons, including alleged reprisal actions against the complainant, we recommend additional investigative steps.

Recommendation 7. The Commander, USACIDC, reopen this investigation and attempt to review contemporaneous counterintelligence and medical records, and, if indicated and/or possible, identify and interview potential victims.

Management Comments and OIG DoD Response. The Army responded that they believed they accomplished the intent of this recommendation through USACIDC re-

[45] Likely a misspelling of "mortar."

interview of the complainant and review of the case file. That review found "inconsistencies in the complaint and the apparent lack of any other testimonial, documentary, or medical evidence supporting an allegation of abuse . . . ." While the complaint may lack credibility, we also note that the investigation focused primarily on interviews of the complainant and persons who were either likely perpetrators of the alleged abuse or those close to the perpetrators. To be thorough, we believe that independent sources should have been pursued, such as contemporaneous CI and medical records, interviews of detached personnel, and, finally, identification and interviews of alleged victims if deemed appropriate given the results of the previous actions. We did not find evidence of such investigative steps in the case file.

1 We recommend that USACIDC reconsider its position and review the appropriate CI records, if they still exist, to determine which detainees were interrogated during the period indicated in the complaint. After identifying names of detainees, agents should determine if the complaint can be corroborated through a review of medical or other potentially relevant records. After having checked such independent sources, a decision could then be made to close or continue the investigation.

Case No. 14

Summary: The investigation was initiated in June 2004 when HQ USACIDC obtained an excerpt from an ICRC report, dated February 2004 and tasked the responsible USACIDC field unit to investigate alleged abuses identified in the report. The ICRC alleged that at least 25 detainees were mistreated while temporarily being held by Coalition Forces at the Al-Baghdadi Air Base, *Iraq,* prior to their transfer to Abu Ghraib. The allegations included frequent beatings, sleep deprivation, handcuffing detainees from behind and requiring them to kneel for extended periods of time, making a detainee stand naked in front of an air conditioner while cold water was poured on him, and allowing a dog to bite *this* same detainee in the thigh.

Assessment: *Our* review disclosed that the case agent created an investigative plan that included fully identifying, locating and interviewing the alleged victims and obtaining a copy of the complete ICRC report, which was accomplished. The investigative effort came to a halt, however, when the SJA, Multinational Forces – *Iraq* (MNF-I), advised that no contact should be made with the ICRC due to "the sensitive relationship" between ICRC and Coalition Forces. Unable to identify a victim through the ICRC, USACIDC closed the investigation.

Despite the apparent inability to contact ICRC and identify specific detainees involved in the alleged abuse, and the time required for the USACIDC field unit to obtain the complete ICRC report, USACIDC could have pursued various investigative leads and attempted to resolve the abuse allegations. Specifically, USACIDC could have visited the Air Base to identify the relevant and responsible unit(s), interviewed U.S. personnel (medical, military police, administrative), reviewed medical and arrest records, and

identified detainees held at the Air Base during the identified time frame. USACIDC could also have reviewed records and conducted interviews at the gaining detention facility, Abu Ghraib. Pursuing these investigative leads might have identified the detainees involved and enabled USACIDC to resolve the allegations.

Recommendation 8. The Commander, U.S. Central Command, establish a policy that requires theater command recipients of ICRC reports to promptly notify the appropriate MCIO when ICRC reports containing allegations of crimes involving detainees are received

Management Comments and OIG, DoD Response. The Army noted that on July 14, 2004, the Secretary of Defense promulgated policy entitled, "Handling of Reports from the International Committee of the Red Cross." that requires all DoD military or civilian officials receiving ICRC reports to transmit them within 24 hours to the USD(P) with information copies to the Director, Joint Staff; the Assistant Secretary of Defense for Public Affairs; the General Counsel of DoD; and the DoD Executive *Secretary.* It also requires the transmittal of ICRC reports received by officials within a combatant command area of operation to the commander of the combatant command. The policy requires the USD(P) to develop a course of action within 72 hours of receipt. The Army recommended that, in accordance with DoDI 5505.3, the development of any such course of action include the referral of complaints of abuse to the appropriate MCIO.

We discussed the Army's recommendation with the DoD Office of General Counsel. They believed that ICRC reports containing allegations of criminal activity received by local commanders may be shared directly with assigned criminal investigators. Since the intent of our recommendation was to get reports of alleged crimes in the hands of investigators more quickly, we modified our recommendation accordingly.

Appendix A. Acronyms

AFIP	Armed Forces Institute of Pathology
AFME	Armed Forces Medical Examiner
AFOSI	Air Force Office of Special Investigations
AR	Army Regulation
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BG	Brigadier General
CDR	Commander
CI	Counterintelligence
CID	U.S. Army Criminal Investigation Command
CIDR	CID Regulation
CJCS	Chairman of the Joint Chiefs of Staff
CJSOTF	Combined Joint Special Operations Task Force
DIG	Deputy Inspector General
DIG-P&O	Deputy IG for Policy and Oversight
DoD	Department of Defense
DoDD	DoD Directive
EPOW	Enemy Prisoner of War
EPW	Enemy Prisoner of War
GEN	General
GTMO	Guantanamo (Naval Base Guantanamo Bay, Cuba)
HQDA	Headquarters, Department of the Army
ICRC	International Committee of the Red Cross
IG	Inspector General
IG DoD	Inspector General of the Department of Defense
IPO	Office of Investigative Policy and Oversight
LTG	Lieutenant General
MCIO	Military Criminal Investigative Organization
MG	Major General
MI	Military Intelligence
MNF-I	Multi-National Forces-Iraq
MP	Military Police
MTF	Military Treatment Facility
MWD	Military Working Dog
NCIS	Naval Criminal Investigative Service
OEF	Operation Enduing Freedom
OIF	Operation Iraqi Freedom
OIG	Office of Inspector General
OIPO	Office of Investigative Policy and Oversight
OPORD	Operations Order
PCIE	President's Council on Integrity and Efficiency
QRF	Quick Response/Reaction Force
RCM	Rule for Court Martial

ROE	Rules of Engagement
ROI	Report of Investigation
RUF	Rules for the Use of Force
SA	Special Agent
SECDEF	Secretary of Defense
SF	Special Forces
SIR	Serious Incident Report
SJA	Staff Judge Advocate
SROE	Standing Rules of Engagement
UCMJ	Uniform Code of Military Justice
USACIDC	U.S. Army Criminal Investigation Command
VADM	Vice Admiral

Appendix B. Scope and Methodology

This oversight review covered 50 closed criminal investigations of allegations that U.S. military personnel abused prisoners, detainees, or persons under the control of U.S. forces. At the time this review commenced, USACIDC had opened 93 investigations involving allegations of detainee abuse. Forty eight of the 50 investigations were conduced by the United States Army Criminal Investigation Command, and two were conducted by the Naval Criminal Investigative Service, a ratio consistent with total case openings. Nineteen of the investigations involved detainee deaths (13 cases involved deaths due to natural causes,[46] 4 were alleged homicides,[47] 1 was accidental, and 1 was later determined through investigation to be a false allegation)[48], 21 involved alleged assaults, 6 were alleged thefts of detainee property or money, and 4 involved other matters.

The DIG-P&O established a Criminal Investigative Task Force (Task Force) to perform the review. The Task Force was comprised of one criminal investigator augmentee from each MCIO under the leadership of criminal investigators and analysts from OIPO. The Task Force researched the DoD, Military Department, and MCIO policies and procedures for opening, conducting, and closing the types of criminal investigations under review, as well as the Quality Standards for Investigations established by the President's Council on Integrity and Efficiency (PCIE). From these documents, the Task Force developed a master protocol of investigative procedures that served as a standard for measuring timeliness and thoroughness. The protocol included: (1) general procedures that were common requirements for all investigators plus procedures specific to a particular MCIO; and (2) investigative steps specific to certain crimes (e.g., photographing wounds, sketching crime scenes, requesting an autopsy in death cases, etc.). The protocol was then converted into a database. When each case file was reviewed, the reviewing Task Force members entered pertinent data into the database, which was later sorted and used to identify the degree to which each case met or did not meet timeliness and thoroughness requirements. Finally, since it was believed immediate action in some cases could be taken to remedy identified discrepancies, a comprehensive database report, including draft findings, was provided to USACIDC while the review was ongoing.

[46] Although deaths by [illegible] and NCIS began investigating all detainee deaths after abuse allegations became [illegible] USACIDC

[41] One case [illegible] two death

[48] See Appendix D, Glossary, for definition of [illegible] of death."

Appendix C. Background

U.S. and Coalition Forces began holding detainees when military operations commenced in Afghanistan on October 7,2001. The numbers of holding facilities and detainees increased after military operations commenced in Iraq on March 19, 2003. U.S. and Coalition forces remain in Afghamstan and Iraq, and operations at detention and holding facilities continue. As of May 2005, the U.S. contingent of MNF-I operated 3 theater-level internment facilities in Iraq, 2 theater-level holding facilities and 20 Forward Operating Bases in Afghanistan,[49] and one holding facility at GTMO. U.S. military and civilian forces have detained more than 70,000 individuals since military operations began in Afghanistan in October 2001.[50]

Various principles of international law and treaties, including the Geneva Conventions, as applicable, govern the treatment accorded to detainees taken during war and other armed hostilities. Overall, they are intended to ensure that detainees taken during armed hostilities are treated humanely.

The DoD programs governing detainee treatment and abuse reporting are prescribed in DoD Directive (DoDD) 2311.01E, "DoD Law of War Program," May 9,2006 (which replaced DoDD 5100.77, December 9, 1998), and DoDD 2310.1, "DoD Program for Enemy Prisoners of War (EPOW) and Other Detainees," August 18,1994. The Secretary of the Army is Executive Agent for these DoD programs. Military Department guidance can be found in multi-Service joint policy AR 190-8.[51]

DoD Law of War Program

The law of war encompasses all international law for the conduct of hostilities binding on the United States or its individual citizens, including treaties and international agreements to which the United States is a party, and applicable customary international law."[52] The DoD policy is intended to ensure (among other things) ". . . [h]umane and efficient care and full accountability for all persons captured or detained by the U.S. Military Services throughout the range of military operations."[53] To this end, DoDD 2311.01E defines a reportable incident as, ". . . [a] possible, suspected, or alleged violation of the law of war," and requires that:

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[49] Information from the Office of the Deputy Assistant Secretary of Defense (Detainee Affairs) on June 22, 2005.

[50] Ibid.

[51] The joint policy combines AR 190-8, OPNAVINST 3461.6, AFJI 31-304, and MC03461.1.

[52] DoDD 2311.01E, May 9, 2006.

[53] DoD Directive 2310.

> All reportable incidents committed by or against U.S. personnel, enemy persons, or any *other* individual are reported promptly, investigated thoroughly, and, where *appropriate*, remedied by corrective action.[54]

As Executive Agent responsible for reportable incidents, the Secretary of the *Army* ". . . act[s] for the Secretary of Defense in developing and coordinating plans and policies for, and in supervising the execution of, the investigation of reportable incidents."[55]

DoD Program for EPOWs and Other Detainees

DoDD 2310.1 implements the international law of war, both customary and codified, including the Geneva Conventions, for EPOWs, including the sick or wounded, retained personnel, civilian internees, and other detained personnel. The program objectives include ensuring:

> "Obligations and responsibilities of the U.S. Government are observed and enforced by the U.S. Military Services. . . throughout the range of military operations, and
>
> "Humane and efficient care and full accountability for all persons captured or detained by the U.S. Military Services throughout the range of *military* operations."[56]

DoDD 2310.1 requires commanders of the Unified Combatant Commands to ensure that suspected or alleged violations of the Geneva Conventions, which includes the Geneva Convention Relative to the Treatment of Prisoners of War, and other violations of the international law of war are promptly reported to the appropriate authorities and investigated in accordance with DoD Directives 5100.77 and 2311.01E.

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[54] DoDD 2311.01E, Paragraph. 4.4.
[55] DoDD 5100.77, Paragraph *5.6.*
[56] DoDD 2310.1, Paragraphs 3.2 and 4.4.

Appendix D. Prior DoD Coverage

The following reports addressed various aspects of detainee abuse, from the perspectives of command and control, intelligence, and detention operations, for example. None involved reviews of criminal investigations.

1. *Assessment of DoD Counterterrorism Interrogation & Detention Operations in Iraq (Miller Report.)*

Investigating Officer:	MG Miller
Appointing Authority:	SECDEF
Date of Comuletion:	9 Sep 03

2. *Office of the Provost Marshal General of the Army – Assessment of Detention and Corrections Operations in Iraq (Ryder Report)*

Investigating Officer:	MG Ryder
Appointing Authority:	LTG Sanchez
Date of Comuletion:	6 Nov 03

3. *AR 15-6 Investigation of the 800th Military Police Brigade (Taguba Report.)*

Investigating Officer:	MG Taguba
Appointing Authority:	LTG Sanchez
Date of Comuletion:	Mar 04 (Briefed to SECDEF 6 May 04)

4. *Department of the Army Inspector General: Detainee Operations Inspections (DAIG Report)*

Investigating Officer:	The Army Inspector General
Appointing Authority:	Acting Secretary of the Army (Hon R. L. Brownlee)
Date of Comuletion:	21 July 04

5. *Army Regulation 15-6 Investigation of the Abu Ghraib Prison and the 205th MI Brigade (Fay Report - and/or Fay/Jones Report -and/or Kern Report.)*

Investigating Officer:	LTG Jones and MG Fay
Appointing Authority:	GEN Kern
Date of Comuletion:	6 Aug 04

6. *Treatment of Enemy Combatants Detained at Naval Station Guantanamo Bay, Cuba. and Naval Consolidated Brig Charleston. (First Navy IG Review)*

Investigating Officer:	VADM Church
Appointing Authority:	SECDEF
Date of Comuletion:	10 May 04

7. *Schlesinger: Final report of the Independent Panel to Review DoD Detention Operations (Schlesinger Report.)*

Investigating Officer:	Schlesinger Panel

Appointing Authority: SECDEF
Date of Comvletion: 24 Aug 04

8. *CJSOTF Abuse (Formica Report)*
Investigating Officer: BG Formica
Appointing Authority: LTG Sanchez
Date of Cornvletion: 13 Nov 04

9. *Detention Operations and Facilities in Afghanistan (Jacoby Report)*
Investigating Officer: MG Jacoby
Appointing Authority: Commander, CFC-A
Date of Cornuletion: 26 June 04

10. *Detention Operations and Detainee Interrogation Techniques (Church Report)*
Investigating Officer: VADM Church
Appointing Authority: SECDEF
Date of Cornvletion: 7 Mar 2005

11. *U.S. Army Surgeon General Assessment of Detainee Medical Operations for OEF, GTMO, and OIF (Kiley Report)*
Investigating Officer: MG Martinez-Lopez
Appointing Authority: LTG Kiley
Date of Comvletion: 13 Apr *05*

12. Report *Army Regulation 15-6 Investigation of Detainee Operations in GTMO (Furlow/Schmidt Report)*
Investigating Officers: BG Furlow and LTG Schmidt
Appointing Authority: GEN Craddock, CDR, SOUTHCOM
Date of Comvletion: 1 Apr 05

Appendix E. Glossary

Armed Forces Institute of Pathology (AFIP) - a tri-service agency of the DoD specializing in pathology consultation, education and research.

Armed Forces Medical Examiner (AFME) - The Office of the Armed Forces Medical Examiner (OAFME) is a component of the Armed Forces Institute of Pathology *(AFIP),* located at the *AFIP* Annex, Rockville, Maryland. Regional and Associate Medical Examiners, appointed by the Armed Forces Medical Examiner with concurrence of the respective service Surgeon General, **are** located at designated military medical treatment facilities within the United States and overseas. The *OAFME* is staffed **24** hours a day. The missions of the *AFME* include consultation, education, and research, consistent with the missions of the **AFIP.**

According to established policy, the AFME will be notified expeditiously by the casualty branch, **safety** center, or investigative agency of the death of any service member on active duty or active duty for training and of any individual, regardless of **status,** who dies on a military installation, vessel, or aircraft or while enrolled in the Personnel Reliability **Program.** Upon determination by the AFME that a medicolegal investigation is necessary, the notifying activity is responsible for advising appropriate command authority that AFME personnel will arrive to participate in the investigation.

The *AFME* has authority to order medicolegal investigations, including an autopsy of the decedent for any service member on active duty or member of the Reserve Components on active duty for training whose death **occurs** in an area where the Federal Government **has** exclusive jurisdictional authority, and if circumstances surrounding the death **are** suspicious, unexpected, or unexplained. At locations with a military MTF, the *AFME* will provide consultative services to the MTF and/or local operational commander(s) in determining the necessity and/or extent of medicolegal investigation. Final determination on the necessity and extent of medicolegal investigations rests with the Armed Forces Medical Examiner **as** specified in the DOD Directive. **Where** no medical or command authority is present, the *AFME* will determine the **need** or extent *or* medicolegal investigation. All deaths with medicolegal significance will have a medicolegal investigation, to include an autopsy.

In **areas** where the *AFME* In any case where DOD has exclusive jurisdiction, the military MTF medical examiner will issue a death certificate. All copies of death certificates will be certified by the military MTF.

Attended death - is a death that occurs as a result of **natural** causes wherein the deceased was either hospitalized during at least a 24-hour period preceding death or under the continuing care of a physician immediately preceding the death.

Autopsy - a post mortem medical examination **as** a part of the medicolegal investigation *requiring* the systematic examination, external and internal, of the body to assist in determining the cause, manner, and circumstances of death.

Cause of death - that disease, injury, or injuries that resulted in the death.

Defense Criminal Investigative Organizations – *group* comprised of the Defense Criminal Investigative Service (DCIS), the Army Criminal Investigation Command (USACIDC), the Naval Criminal Investigative Service (NCIS), and the Air Force Office of Special Investigations (AFOSI).

Detainee - A term used to refer to any person captured or otherwise detained by an armed force.

Enemy Prisoner of War - A detained person as defined in Articles 4 and 5 of the Geneva Convention Relative to the Treatment of Prisoners of War of August 12,1949.

Felony - A criminal offense punishable by death or confinement for more than one year.

Law of **War -** That part of international law that regulates the conduct of armed hostilities. It is often called the law of armed conflict. The law of war encompasses all international law for the conduct of hostilities binding on the United States or its individual citizens, including treaties and international agreements to which the United States is a party, and applicable customary international law. (DoD Directive 5100.77, DoD Law Of War Program, 9 December 1998).

Manner of death - the legal classification of death, whether it be natural, suicide, homicide, accident or undetermined.

Military Criminal Investigative Organization – one of the group comprised of the United States Army Criminal Investigation Command (USACIDC), the Naval Criminal Investigative Service (NCIS), and the Air Force Office of Special Investigations (AFOSI)

Military Treatment Facility (MTF) – Medical facility operated by the U.S. Armed Forces.

Medicolegal – Of, or relating to, both medicine and law.

Military exigency – an emergency situation requiring prompt or immediate action to obtain and record facts.

Non-Judicial Punishment – punishment under Article 15 of the Uniform Code of Military Justice (UCMJ). For the purpose of this report, such punishment is reserved for minor offenses and may not be imposed if the member demands trial by court-martial.

Offense - An act committed in violation of a law or directive prohibiting it, or omitted in Violation of a law or directive ordering it, and punishable by death, imprisonment, or the imposition of certain fines or restrictions. The term offense includes any felony or misdemeanor, but not a violation of a law or directive that is administrative in nature.

Persons Under U.S. Control - Any person under the direct control and protection of US forces. *Also,* Person in Custody.

Reportable Incident - A possible, suspected, or alleged violation of the Law of War.

Report of **Investigation (ROI)** - Includes all reports used to convey investigative details or the status of investigations (e.g., initial, status, final supplemental, *etc.).*

Retained Personnel - Enemy personnel who come within any of the categories below are eligible to be certified as retained personnel.

a. Medical personnel exclusively engaged in the: (1) Search for collection, transport, or treatment of the wounded or sick; (2) Prevention of disease; and/or (3) Staff administration of medical units and establishments exclusively.
b. Chaplains attached to enemy armed forces.
c. Staff of national Red Cross societies and other voluntary aid societies duly recognized and authorized by their governments. The staffs of such societies must be subject to military laws and regulations.

Subject - A person, corporation, or other legal entity or organization, about which credible information exists that would cause a trained investigator to presume that the person, corporation, or *other* legal entity committed a criminal offense. (See, DoD Directive 5505.7, "Titling and Indexing Subjects of Criminal Investigations in the Department of Defense," January 7,2003)

Appendix F. Secretary of Defense Policy Memorandum on Conducting Autopsies

SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

JUN 9 2004

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
UNDER SECRETARIES OF DEFENSE
COMMANDERS OF THE COMBATANT COMMANDS
ASSISTANT SECRETARIES OF DEFENSE
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, OPERATIONAL TEST AND EVALUATION
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
ASSISTANTS TO THE SECRETARY OF DEFENSE
DIRECTOR, ADMINISTRATION AND MANAGEMENT
DIRECTOR, PROGRAM ANALYSIS AND EVALUATION
DIRECTOR, NET ASSESSMENT
DIRECTOR, FORCE TRANSFORMATION
DIRECTORS OF THE DEFENSE AGENCIES
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the United States

References: (a) DoD Directive 2310.1, "DoD Program for Enemy Prisoners of War (EPOW) and other Detainees," August 18, 1994
(b) DoD Directive 5100.77 "DoD Law of War Program," December 9, 1998
(c) [illegible] INST 3461.6, AFJI 31-304, MCO 3 [illegible] of [illegible], Retained Personnel, Civilian Internees and Other Detainees," 1 October 1997
(d) 10 U.S.C. 1471, Formula
(e) DoD Directive 5154.24, "Armed Forces Institute of Pathology," October 3, 2001
(f) DoD Instruction 5154.30, "Armed Forces Institute of Pathology Operations," March 18, 2003

This memorandum reiterates and clarifies procedures for investigating deaths of detainees in the custody of the Armed Forces, including the requirement for an autopsy.

References (a), (b) and (c) establish policy and procedure for investigations of possible violations of protections afforded enemy prisoners of war, retained personnel, civilian internees, and other detainees, including procedures in cases of deaths of such

persons. References (d), (e), and (f) provide that the Office of the Armed Forces Medical Examiner has primary jurisdiction and authority within DoD to determine the cause and manner of death in any DoD death investigation. This jurisdiction may be exercised as part of DoD death investigations of enemy prisoners of war, retained personnel, civilian internees, and other detainees in the custody of the Armed Forces of the United States.

In the case of a death of such an individual, the commander of the facility (or if the death did not occur in a facility, the commander of the unit that exercised custody over the individual) shall immediately report the death to the responsible investigative agency; Army Criminal Investigation Division, Navy Criminal Investigative Service, or Air Force Office of Special Investigations. This investigative agency shall contact the Office of the Armed Forces Medical Examiner (AFME). The AFME will determine whether an autopsy will be performed. The regional combatant commander shall notify the Secretary of Defense, through the Chairman, Joint Chiefs of Staff, of all deaths occurring in US armed forces custody.

Upon declaration of death, the remains will be placed in a clean body bag and secured awaiting instructions from the appropriate investigating agency. The remains will not be washed and all items on or in the body will be left undisturbed except for weapons, ammunition and other items that pose a threat to the living. The body will not be released from United States custody without written authorization from the investigative agency concerned or the Armed Forces Medical Examiner.

In summary, in the case of death of any individual described above, while in custody of the Armed Forces of the United States, it is presumed that an autopsy shall be performed, unless an alternative determination is made by the Armed Forces Medical Examiner. Determination of the cause and manner of death in these cases will be the sole responsibility of the AFME or other physician designated by the AFME.

Points of contact for procedures under this memorandum are: AFME, CDR Mallak, (301) 319-0000. DSN 285-0000, Mallak@AFIP.OSD.Mil; ARMY CID, SA Birt, (703) 806-0299, DSN 456-0299, Angela.Birt@Belvoir.Army.Mil; NCIS, SA Carruth, (202) 433-9254, DSN 288-9254, TCCarruth@NCIS.Navy.Mil; OSI, SA Poorman (240) 875-1073, DSN 858-1073 James.Poorman@ogn.af.mil.

This memorandum is effective immediately.

Appendix G. 800th Military Police Brigade Rules of Engagement

ANNEX B

800TH Military Police Brigade Rules of Engagement for operations in Iraq.

Nothing in these rules of engagement limits your inherent authority and obligation to take all necessary and appropriate action to defend yourself, your unit, and other US Forces.

Hostile Forces: Until there has been a declared cessation of hostilities, Iraqi Military and Paramilitary forces are considered hostile and may be attacked provided there is a positive identification of a legitimate military target, and the target has not surrendered or is otherwise out of battle due to sickness or wounds. Do not target, except in self-defense, civilians, protected sites (i.e. hospitals, places of worship, schools, cultural institutions), or civilian infrastructure. If you must fire on these objects then engage in order to disable or disrupt, not destroy – if possible.

2. **Hostile Actors**: You may engage in other persons who commit hostile acts or show hostile intent with the minimum force necessary to counter the hostile act or demonstrated hostile intent and to protect US Forces.

   Hostile Act: An Attack or other use of force against US Forces or a use of force that directly precludes / impedes the mission / duties of US Forces.

   Hostile Intent: The threat of imminent use of force against US Forces or the threat of force to preclude / impede the mission / duties of US Forces

3. **Authorized Use of Force**: You may use force, up to and including deadly force, against hostile actors:
   A. In self-defense
   B. In defense of your unit, or other US Forces
   C. To prevent the theft, damage, or destruction of firearms, ammunitions, explosives, or other property designated by your Commander as vital to National Security. (Protect other property with less than Deadly Force)

Rules for Escalating Use of Force

Nothing in these rules of engagement limits your inherent authority and obligation to take all necessary and appropriate action to defend yourself, your unit, and other US Forces.

4. **Escalating Use of Force**: Generally, within the compound, non-lethal force is sufficient. When possible, use the following degrees of force against hostile actor:
   A. **SHOUT**: verbal warnings to HALT or "KIFF" (pronounced "COUGH")
   B. **SHOVE**: physically restrain, block access, or detain.
   C. **SHOW**: your weapon and demonstrate intent to use it.
   D. **SHOOT**: to remove the threat of death/serious bodily injury or to preclude designated property
      IF YOU MUST FIRE:
      1. Fire only Aimed shots. **NO WARNING SHOTS**
      2. Fire no more rounds than necessary
      3. Fire with due regard for safety
      4. Take reasonable efforts not to destroy property
      5. Stop firing as soon as the situation permits

5. **Crowds**: Control civilian crowds, mobs, or rioters interfering with US Forces with the minimum necessary force. When circumstances permit, attempt the following steps to control crowds:
   A. Repeated warning to HALT OR "KIFF" (pronounced "COUGH")
   B. Show of force, including riot control formation.
   C. Blocking of access, or other reasonable use of force necessary under the circumstances, and proportional to the threat.

6. **Detainees**: If a detainee attempt to escape the guard must SHOUT HALT (KIFF) 3 times. If the attempt to escape is from a fenced-in enclosure, the detainee will not be fired upon unless the person has actually cleared the outside compound wire and is continuing their efforts to escape.

7. Treat All persons with Dignity and Respect

THE ABOVE ROE IS IN EFFECT AS OF 24 JUNE 2003 AND SUPERCEDES ALL PRIOR 800TH MP BDE ROE

Appendix H. ROE/RUF Training Slides

Situation 1

- While on guard duty at your detention facility, a crowd of about 20 detainees gather together, shouting demands for better food. The unarmed crowd is starting to grow and is getting more aggressive, but has not moved toward the wire.
- What do the ROE/RUF allow you to do?

Response

- You may apply graduated force to disperse the crowd.
- The following degrees of graduated response should be **used:**
  SHOUT. Verbal warnings to halt/stop three times.
  SHOVE. Physically **restrain,** block access, or detain.
  SHOW. Show your weapon and demonstrate the intent to use it.
  SHOOT. To remove the threat of death/serious bodily injury.
- No hostile intent or hostile act, so you cannot use deadly force.
- Riot Control Means (RCM) and non-lethal munitions **are** the preferred means of a graduated **response**
- Detention Facility Commander may order use of Riot Control **Agents** (RCA) **as** the last, non-lethal **resort.**

Situation 2

- You are escorting a 6'3", 300lb. male detainee to be interrogated. The detainee is in flexicuffs. All of a sudden, he breaks out of the flexicuffs. You are not within the detainee's reach yet and he **has** not made any move towards you.
- You have a M9 pistol and a M26 Taser that you have been trained to use.
- What should you do under the RUF?

Response

- Use a graduated response.
- Use non-lethal munitions as the situation permits.
- Engage with the M26 Taser.
- If, for some reason, the Taser **does** not work, be prepared to escalate to deadly force in self defense if the detainee shows hostile intent or a hostile act.

Situation 3

- While manning a guard tower, you notice a detainee has made it past the outer wire and is escaping. The detainee is still only 60 meters from your position.
- You are armed with a M-16 rifle, with a FN303 less-than-lethal weapon system mounted under the barrel.
- What can you do under the RUF?

Response

- Deadly force against an escapee is an extreme measure.
- Deadly force cannot be used against an escapee except as a last resort when no other means are available to apprehend the escapee.
  - M 16? Not when other means are available.
  - FN 303 Range is up to 100 meters. Escapee is within range, so non-lethal option is available.
- Engage target with FN 303.

Situation 4

- Same facts as previous situation.
- You've fired the FN **303** but missed.
- Escapee is continuing to run and is almost out of FN **303** range, but is still within range of your **M16.**
- **A** QRF with **up** armored humvees is on standby and could easily reach the escapee.
- **What** can you do under the RUF?

Response

- Engage the **FN 303** again?
  - Almost out **of** range. Could take another shot.
- Engage the M16?
  - Not when other means are still available.
- QRF is still available to chase and detain escapee.
- Cannot use deadly force under the **RUF** when other means **are** available.

Situation 5

- **A** full scale not is on hand. You've fired **RCM** bean bags into the crowd. Still, the rioting detainees are threatening to break through the wire and into your positions. Your commander has ordered the use of **CS** gas. **After** a few whiffs of the CS, the detainees *start* to disperse.
- One determined detainee has made it through the wire and is running towards you. He has a shiv raised above his head. You have a not baton and a fully loaded M4 carbine.
- Whatcanyoudo?

Response

- By running at you with a weapon, the detainee **has** demonstrated hostile intent.
- Deadly force is authorized in self defense.
- If you fire, remember:
  - Fire only aimed shots.
  - Fire no more rounds than necessary.
  - Fire with due regard for innocent bystanders.
  - Take reasonable efforts not to destroy property.
  - Stop firing **as** soon **as** the situation permits.

Appendix I. Management Comments

DEPARTMENT OF THE ARMY
OFFICE OF THE PROVOST MARSHAL GENERAL
2800 ARMY PENTAGON
WASHINGTON DC 20310-2800

REPLY TO ATTENTION OF

DAPM-ZC

APR 2 1 2006

MEMORANDUM FOR Deputy Inspector General for Policy and Oversight, Office of the Department of Defense Inspector General

SUBJECT: Draft Report on Review of Criminal Investigations of Alleged Detainee Abuse (Project No. PPD2005-D005), 24 Feb 06, and Revised Executive Summary, 30 Mar 06 (IPO2004C0005)

1. The Department of the Army appreciates the opportunity to review and comment on the draft subject report and revised executive summary (EXSUM). The Secretary of the Army and the Commander, U.S. Army Criminal Investigation Command (USACIDC) are committed to ensuring thorough, fair, and timely investigations of all criminal allegations. In furtherance of that objective, we value the findings and recommendations of the Department of Defense Inspector General (DoDIG) as they contribute to identifying concerns that may be systemic to Department of Defense detainee operations as well as to assessing and improving specific USACIDC reports of investigation relating to detainee abuse.

2. We note that the content of the 24 Feb 06 draft DoDIG report, most significantly with regard to the recommendations, differs from the content of the revised EXSUM, dated 30 Mar 06. Accordingly, we recommend the 24 Feb 06 report be revised to comport with the revised EXSUM. The Army requests the opportunity to review and comment on the revised report.

3. Enclosed please find the Army's response to assist the DoDIG in preparing the revised report. Given our understanding that the report will be revised to comport with the revised EXSUM of 30 Mar 06, our comments are focused on the specific recommendations set forth in that EXSUM.

4. Please contact MAJ Mark A. Jackson, Chief of OPMG Strategic Initiatives, at 703-692-6985, mark.a.jackson@us.army.mil.

DONALD J. RYDER
Major General, USA
Provost Marshal General

End
as

HQDA DAPM
Response to DODIG Draft Report on Review of Criminal Investigations of Alleged Detainee Abuse

The Department of the Army submits the following interim comments to the DoDIG Draft *Report on Review of Criminal Investigations of Alleged Detainee Abuse* (Project No. PPD2005-D005), 24 Feb 06, and Revised Executive Summary, 30 Mar 06, to assist the DoDIG in preparing the final report.

In May 2004, the USACIDC established a task force of agents at its Fort Belvoir, Virginia headquarters, to assist in the quality control review of detainee abuse investigations being forwarded to the U.S. Army Crime Records Center for filing. In July 2004, the USACIDC welcomed to its headquarters members of a DoDIG task force chartered "to evaluate the thoroughness and timeliness of criminal investigations into allegations of detainee abuse." Nearly simultaneously, these two task forces performed quality assurance reviews of the first sets of case files issuing from USACIDC agents in Iraq and Afghanistan, documenting investigations into allegations of detainee abuse.

We believe it important that the DoDIG report emphasize the unusual operational circumstances attending USACIDC's investigation of the detainee abuse allegations at issue. As the report notes, USACIDC conducted these investigations in midst of ongoing combat and counter-insurgency operations. This environment often limited identification of and access to witnesses and documentary evidence. Additionally, following the public disclosure of allegations of abuse at Abu Ghraib prison in Iraq, the number of detainee abuse allegations reported to USACIDC surged significantly in a short period of time. As the DoDIG report accurately notes, in May 04, the Provost Marshal General of the Army – also the Commander, USACIDC – announced that USACIDC would investigate all abuse allegations involving detainees under the control of U.S. Army personnel or in facilities controlled by U.S. Army personnel. This change in policy expanded USACIDC investigative responsibility beyond the general felony crime threshold established by Army Regulation (AR) 195-2, *Army Criminal Investigation Activities*, 30 Oct 85. In addition to the 600-plus allegations of detainee abuse referenced above, the same small community of CID investigators concurrently investigated more than 2600 other non-detainee related cases. Together, these factors significantly challenged the capabilities of USACIDC investigative resources.

It long has been and remains standard procedure for senior USACIDC headquarters agents to review sensitive investigations ongoing in the field and to provide advice and expert assistance to field agents regarding additional investigative measures and actions required to ensure the sufficiency of those investigations. In the cases at issue in this DoDIG report, the overwhelming number of detainee abuse investigations undertaken within a short period of time, coupled with technical difficulties that limited communications between USACIDC headquarters and theater investigative agents, curtailed the ability of headquarters USACIDC to provide real-time, in-process, quality assurance review, advice, and assistance to agents in the field. In short, in the cases at issue, DoDIG task force personnel and the USACIDC quality assurance team, both were in the unusual position of reviewing cases for the first time. We appreciate the DoDIG report's focus on USACIDC's continuous efforts, simultaneous with the DoDIG review, to identify and correct deficiencies in investigations. In many cases, USACIDC and DoDIG identified deficiencies concurrently. When not precluded by circumstances in the war zone, USACIDC field elements were directed to address, and did correct, those shortcomings.

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We believe the DoDIG report may benefit from some discussion as to the substantial role that the Under Secretary of Defense for Policy (USD(P), and its sub-element, the Deputy Assistant Secretary (Detainee Affairs), have undertaken in the oversight of detainee operations policy. Further, the report should acknowledge the tremendous progress made across DoD over the last two years toward improving the full spectrum of detainee operations.

Given our understanding that the earlier version of the complete report will be revised to comport with the revised EXSUM of 30 Mar 06, we have focused the following comments on the specific recommendations set forth in that EXSUM:

Recommendation (a). The Army recommends that this recommendation set forth in the revised EXSUM be revised to read: "Command emphasis on the requirement for expeditious referral of matters involving detainee deaths, serious bodily injury, thefts of property valued at more than $1000 [current dollar threshold standard for larceny], and other serious matters to *the appropriate Military Criminal Investigative Organization (MCIO).*" Specifically –

The DoDIG report appears to imply that failure to refer certain criminal allegations to the appropriate MCIO for investigation may be a systemic problem, at both home stations and in deployed environments. That given, the Department of the Army concurs in this finding, noting that USACIDC's ability to conduct a thorough, fair, and timely investigation may be adversely impacted by any delay in the report of an allegation. The Department of the Army recommends that remediation of delays in reporting criminal allegations to the appropriate MCIO cannot and should not be limited to matters involving allegations of detainee abuse. We note that DoD Instruction 5505.3, *Initiation of Investigations by Military Criminal Investigative Organizations*, 21 Jun 02, emphasizes the mandate of commanders at all levels to "ensure that criminal allegations or suspected criminal allegations involving persons affiliated with the DOD or any property or programs under their control or authority are referred to the appropriate MCIO or law enforcement organization." AR 195-2 implements DoDI 5505.3 and specifically applies this reporting requirement to the Army. The Department of the Army will emphasize, in its professional military education and Army school system courses, a commander's duty and responsibility to report criminal allegations to the appropriate MCIO or other law enforcement organization.

We expect that the planned revision of DoD Directive 2310.1, *The DoD Detainee Program*, will redesignate the Secretary of the Army as the DoD Executive Agent for the administration of detainee operations policy. It is further expected that in that role he will revise and reissue AR 190-8, *Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees*, 01 Oct 97, and other detainee policy and doctrinal publications. We fully expect all such new publications within the purview of the Army to emphasize the responsibility of commanders to report expeditiously allegations of detainee abuse to the appropriate MCIO or other law enforcement organization

Recommendation (b): The DoDIG revised EXSUM recommends "... continued emphasis on the Secretary of Defense memorandum clarifying autopsy policy." The Army concurs in this recommendation. Specifically –

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All cases reviewed for the DoDIG report were completed prior to the promulgation of the Secretary of Defense policy, *Procedures for Investigation into the Deaths of Detainee in the Custody of the Armed Forces of the United States*, 09 Jun 04. As acknowledged by the DoDIG report, in nearly all cases assessed in which autopsies were not conducted, the remains were removed from U.S. control before notifying criminal investigators, negating the opportunity to conduct an autopsy and to benefit from the information such a procedure might yield. It appears that policies in effect prior to 09 Jun 04 may have been confusing as to the obligation to report a detainee death, particularly when the death appeared to have resulted from natural causes, and as to the requirement for the involvement of trained medical examiners in post-mortem processes. The Army agrees with the DoDIG conclusion that the Secretary of Defense policy of 09 Jun 04 resolved any existing uncertainty as to the response required in cases of detainee death. The policy requires the MCIO to contact the Office of the Armed Forces Medical Examiner (AFME), creates a presumption that an autopsy will be conducted (unless an alternative determination is made by the AFME), and reserves to the AFME, or other physician designated by the AFME, the responsibility to determine the cause and manner of death.

Revised detainee operations policy and doctrine, including a Special Text 4-02.46 and new field manual for medical support to detainee operations, will incorporate and appropriately emphasize the tenets of the current policy. Further, the Army will emphasize the policy as appropriate in its professional military education, Army school system courses, in Army training specifically focused on preparing leaders and Soldiers to conduct detainee operations, and in the training of USACIDC agents. Of particular note, the Surgeon General of the Army has developed the Detainee Operations Distance Learning Course (https://mhslearn.satx.disa.mil), an on-line scenario-based course intended to provide pre-deployment training for healthcare personnel of all Military Departments who will be involved in detainee operations. This course gives particular attention to seven aspects of detainee healthcare: (1) medical records; (2) treatment purposes; (3) medical information; (4) reporting possible violations; (5) training; (6) scope of care; and (7) procedures for the management of deceased detainees and their property. The course incorporates the Secretary of Defense detainee death investigation and autopsy policy.

Recommendation (c): The DoDIG revised EXSUM recommends "... a review of the implementation of the rules for the use of deadly force against detainees and increased focus on those rules in pertinent criminal investigations." With regard to the first element of this recommendation, the Department of the Army defers to the appropriate Combatant Commander and subordinate operational commanders, within whose purview such responsibility and authority lie. With regard to that part of the recommendation advocating increased focus on rules for the use of deadly force in criminal investigations to which such rules are pertinent, the Department of the Army concurs. Specifically –

We note that the USACIDC quality assurance team, working concurrently with members of the DoDIG task force to review for the first time the investigations upon which the findings in this DoDIG report are based, independently ascertained that certain case files were insufficient in that they did not incorporate copies of the applicable rules for the use of deadly force against detainees. The USACIDC returned all cases to which such rules were deemed pertinent to the field for correction. USACIDC has undertaken the wholesale revision of USACIDC Regulation 195-1, *Criminal Investigation Operational Procedures*, 01 Jan 05, which provides guidance to agents regarding standards for conducting criminal investigations. With a view to correcting any systemic deficiency identified DoDIG, the revised regulation will specifically mandate that, when relevant to

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Response to DODIG Draft Report on Review of Criminal Investigations of Alleged Detainee Abuse

the case under investigation, agents obtain and include in the USACIDC case file, a copy of applicable rules of engagement or rules for the use of force. Further, agents will be specifically charged to determine and document any other supplementary verbal orders relevant to the use of force. Consideration and analysis of any such rules and supplementary verbal orders, as well as the degree of compliance therewith, will necessarily remain a key element in rendering investigative findings. These principles also will be emphasized in the training of USACIDC agents.

- **Recommendation (d).** The DoDIG revised EXSUM recommends "... increased investigative emphasis on medical records and prior medical care in cases involving detainee deaths from various medical conditions." The Department of the Army concurs with this recommendation to the extent that such records are available, noting that when indicated by autopsy results or other indicia in a particular case, or when otherwise appropriate, investigative agents should review medical history documents and/or obtain them for inclusion in the investigative report. Specifically --

  The report indicates that the Commander, USACIDC, should require a medical records review in all detainee death cases to determine if relevant historical entries were made and follow-up care provided. It is important to be mindful that the operational situation will affect the level of medical care provided to detainees and the extent to which detainee medical records are created and maintained. The geographic location of a detainee; the relative austerity or robustness of medical resources, to include facilities, personnel, and supplies; and the availability of diagnostic tools are the same factors which, among others, would similarly affect the level of care afforded members of the U.S. Armed Forces. Army health care providers are charged to create and maintain medical records on all detainees in accordance with AR 190-8 and AR 40-66, *Army Medical Record Administration and Health Care Documentation*, 20 Jul 04. The requirement to create and maintain accurate and complete detainee medical records was emphasized by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) in the memorandum, *Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States*, 3 Jun 05.

  The ASD(HA) memorandum further underscored the policy long set forth in AR 190-8, that to the extent practicable, the medical treatment of detainees should be guided by professional judgments and standards similar to those that would be applied to personnel of the U.S. Armed Forces. As appropriate, USACIDC agents refer concerns about the quality of medical care, not of a criminal nature, to the servicing medical commander for quality review in accordance with AR 40-68, *Clinical Quality Management*, 26 Feb 04. If criminal activity were suspected, the criminal investigation process must be completed before final action is taken under the medical quality review process.

  Specific guidance to USACIDC agents describing those investigative circumstances under which the collection and review of detainee medical records is mandated and/or desirable, as well as the benefits of interviewing witnesses, including laypersons, who may possess relevant observations or other information pertaining to the health of a detainee, will be included in the revision to USACIDC Regulation 195-1 and in the training of USACIDC agents. The Surgeon General's Detainee Operations Distance Learning Course, referenced above, addresses medical treatment standards and record keeping practices applicable to detainee operations.

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- **Recommendation (e).** The DoDIG revised EXSUM recommends "... several other case specific investigative actions." Although the revised EXSUM does not address these case specific investigative actions, we presume they are the same as those set forth in the DoDIG report, dated 24 Feb 06, originally provided to use for review. Specifically –

  Original Report Recommendation (e7). That the Commander, USACIDC, initiate a review of Report of Investigation (ROI) 0050-04-CID259-80155 to (a) ensure the brigade commander's refusal to grant USACIDC agents access to the facility has been addressed and corrected, and (b) review the propriety of the direction to dispose of potential evidence. We believe the USACIDC already has accomplished the intent of this recommendation.

  Comments concerning recommendation (e7). USACIDC agents coordinated with the officer who was the Commander of the 89th Military Police Brigade, the unit at issue, at the time of the incident. The Brigade Commander asserted that at no time did he deny USACIDC agents access to the facility, that he was unaware until questioned after-the-fact that agents had been denied access by any person under his command, and had the matter been raised to his attention, it is unquestioned he would have granted the agents access. This miscommunication appears to have been the result of the ill-considered decision of a young and inexperienced officer on the staff of the 89th Military Police Brigade, coupled with the failure of young and inexperienced USACIDC agents to raise the access request to an appropriately higher level in the chain of command. The Army notes the proscriptions set forth in DoDI 5505.3 that "[c]ommanders ... shall not impede an investigation or the use of investigative techniques that an MCIO consider necessary and that are permissible under law or regulation" and the requirement that MCIO Commanders "report promptly through their chain of command to the Secretary of the Military Department concerned the facts in all situations where attempts are made to impede and investigation or the use of investigative techniques." The Army believes this issue, of potential DoD-wide systemic concern, can best be addressed through emphasis in future policy and doctrinal publications, in professional military education and Army school system courses, in Army training specifically focused on preparing leaders and Soldiers to conduct detainee operations, and in the training of USACIDC agents.

  As to the disposition of "potential evidence," we note the autopsy finding that the metal fragment removed from the deceased was covered with fibrous tissue and had obviously been imbedded in his body for some time. There is no evidence to suggest that the detainee acquired the metal fragment in the course of capture or while otherwise in the custody and control of U.S. personnel. Due to the forensic pathologist's determination that the deceased had died of natural causes from a heart attack, the metal fragment was appropriately determined to be only an artifact, not related to any criminal investigation. In accordance with AR 195-5, *Evidence Procedures*, 28 Nov 05, items of potential evidence determined to have no evidentiary value may be disposed of before they are released to the evidence custodian.

  Original Report Recommendation (e8). The Commander, USACIDC, reopen ROI 0139-03-CID469-60206 and attempt to identify and interview each alleged abuse victim, review the alleged victim's medical records, and determine whether additional action is warranted before closing.

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Comments concerning recommendation (e8). We believe the USACIDC already has accomplished the intent of this recommendation. The complainant referenced by DoDIG, who is the centerpiece of the investigation, was again contacted by USACIDC agents on 13 Mar 06. . Subsequent to this interview, a USACIDC quality assurance review deemed this investigation sufficient given the significant substantive inconsistencies in the complainant's statements, coupled with the apparent lack of any other testimonial, documentary, or medical evidence supporting an allegation of abuse, as well as the absence of other potential leads.

Original Report Recommendation (e9). The Commander, USACIDC, establish a process whereby field investigative units receive International Committee of the Red Cross (ICRC) reports in a timely fashion and take action to investigate identified alleged abuses to the extent possible. The Department of the Army non-concurs with this recommendation.

Comments concerning recommendation (e9). We note that on 14 Jul 04, the Secretary of Defense promulgated detailed policy entitled, *Handling of Reports from the International Committee of the Red Cross*. That policy requires that all ICRC reports received by a military or civilian official of the Department of Defense at any level shall, within 24 hours, be transmitted to the USD(P), with information copies to the Director, Joint Staff; the Assistant Secretary of Defense for Public Affairs; the General Counsel of DoD; and the DoD Executive Secretary. ICRC reports received by officials within a combatant command area of operation shall also be transmitted simultaneously to the commander of the combatant command. The USD(P) shall, within 72 hours of receipt, develop of a course of action. The Army recommends that the development of any such course of action include the referral of complaints of abuse to the appropriate MCIO, in accordance with DoDI 5505.3.

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON. DC 20301-1200

HEALTH AFFAIRS

MAR 3 0 2006

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Findings of Report on Review of Criminal Investigations of Alleged Detainee Abuse

Findings and recommendations of the above report were reviewed for issues that pertain to Health Affairs.

Six of 50 investigations conducted by the U.S. Army Criminal Investigation Command (USACIC) and the Naval Criminal Investigative Service (NCIS) were not thorough because an autopsy was not conducted. I concur with the DoD IG recommendation that the Secretary of the Army, the Commander, U.S. Central Command, and the Military Criminal Investigative Organizations take steps to ensure that the policy outlined in the June 9, 2004, Secretary of Defense memorandum requiring autopsies in detainee death cases is fully implemented and enforced.

Five of 50 investigations were not thorough because a detainee's medical care prior to death was either not sufficiently investigated by USACIC or not documented by medical personnel. I concur with the DoD IG recommendation that the Commander, United States Army Criminal Investigation Command require a medical records review in all detainee death cases to determine if relevant historical entries were made and follow-up medical care was provided, ensuring that discrepancies are further investigated.

My points of contact for this issue are Col Robert Ireland (functional) at (703) 681-1703 and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-3492, ext. 4065

for William Winkenwerder, Jr., MD

UNCLASSIFIED
UNITED STATES CENTRAL COMMAND
OFFICE OF THE CHIEF OF STAFF
7115 SOUTH BOUNDARY BOULEVARD
MACDILL AIR FORCE BASE, FLORIDA 33621-5101

CCDC-COS 14 Apr 06

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL, 400 Army Navy Drive, Arlington, VA 222202-4704

SUBJECT: USCENTCOM Reply to 24 **Feb** 06 WD IG Draft **Report,** Subject: Review of **Criminal** Investigations **of Alleged Detainee Abuse, Project No. 2004C005**

REF A: M D IG, Memo, OTG **1 Mar** 06, **Subject: Report** on Review **of Criminal** Investigations **of** Alleged Detainee **Abuse** (Project **No. PPD2005-D005)**

REF B: DOD **IG, Draft Report,** DTD 24 **Feb 06, Subject: Review of** Criminal Investigations *of* **Alleged Detainee Abuse,** Project **No. 2004C005**

1. **USCENTCOM has reviewed** the subject draft **report and submits the** following responses *to* the applicable **findings** and recommendations.

2. Finding A: **"Army commanders frequently** did not expeditiously **refer** apparent criminal matters to USACIDC."

a. Non-concur with **comment**

(1) **In a majority** of situations, commanders **operating** within **Operation** Enduring Freedom and Operation **Iraqi** Freedom referred **cases** to **USACIDC** within appropriate **time limits** given the nature and **pace of** operations; the **areas** in which **operations and the suspected** criminal matter **took** placet **the available resources** rithin the theaters **of** operations **for** both the **commanders and** USACIDC) **and the** level **of** threat **and hostilities.**

(2) Recommend restating **the finding as "Commanders** should consider expeditious referral **of** apparent criminal **matters to** USACIDC that **are** within USACIDC's **purview as** found in Army Regulation (AR) **195-2, Annex** B, Table B-1."

(3) **Commanders** at **a11** levels **have the** inherent authority and **a** responsibility **to** make preliminary inquires into suspected **criminal** offenses. **This** authority **and** responsibility is codified in Manual **For** Courts-Martial published **by** Executive **Order 13262** specifically **at** Rule for Courts-Martial **(RCM)** 303. **RCM** 303 states "Upon receipt of information **that a member** *of* the command is accused *or* **suspected of** committing an offense or offenses triable **by** court-martial, *the* **immediate commander shall**

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(emphasis added) make or cause to be made a preliminary inquiry into the charges or suspected offenses." The discussion section following the rule, which is not binding but instructional, states that "The preliminary inquiry is usually informal. It may be an examination of the charges and an investigative report or other summary of expected evidence. In other cases a more extensive investigation may be necessary....[I]n serious or complex cases the commander should consider (emphasis added) whether to seek the assistance of law enforcement personnel in conducting any inquiry or further investigation. The inquiry should gather all reasonably available evidence bearing on guilt or innocence and any evidence relating to aggravation, extenuation, or mitigation."

3. Recommendation 1: "That the Secretary of tho Army and the Commander, U.S. Central Command stress to commanders the nand to expeditiously refer Army matters involving apparent war crimes or felonies to the United States Army Criminal Investigation Division Command (USACIDC) in accordance with Army Regulation 195-2 and that commands refrain from investigating such matters without prior law enforcement coordination."

a. Concur in part and non-concur in part with comment

(1) Concur with USCENTCOM or ita subordinate unit. stressing the need for commanders to consult with USACIDC in suspected criminal matters and referring suspected violations of the law Of armed conflict to the appropriate Service investigative commands for investigation.

(a) USCENTCOM and ita major subordinate commands (CFC-A, CJTF-76, and MNF-I) have stressed in both OEF and OIP the need to consult with USACIDC representatives regarding criminal matters. (e.g., legal annexes, detention operations orders and annexes, and policies.)

(2) Won-concur with referring a11 felonies, as defined in the report (e.g. offenses allowing confinement for 1 or more years) to USACIDC.

(a) Commander's authority and discretion to investigate allegations of detainee abuse should not be limited by making a referral to USACIDC mandatory. Based on criminal case dispositions regarding detainee abuse allegations since 2004, the moat frequent charge io under Article 93, Uniform Code for Military Justice (UCMJ), "Cruelty and maltreatment." The elements of this article are "(1) That a certain person was subject to the orders of the accused; and (2) That the accused was cruel toward, oppressed, or maltreated that parson." As indicated by the elements. subjective analysis of facta and circumstances is required to determine if it should or can be charged as an offense. Furthermore, making false allegations of

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detainee abuse to tie up resources and to gain more favorable treatment is a Tactic, Technique, and Procedure (TTP) of the enemy. Commanders are vested with the Authority, have the necessary means (e.g., commander's inquiries and AR 15-6), and should have thm discretion to decide which cases are referred to USACIDC. Additionally, all felonies are not within USACIDC purview to investigate in accordance with AR 195-2 at Table B-1. (e.g. assaults under certain conditions).

(3) Non-concur with requiring commanders to refrain from investigating criminal matters without prior law enforcement coordination.

(a) Given the nature and pace of combat operations: the areas in which operations and the suspected criminal matter takes place; the available resources within the theaters of operations for both the commanders and USACIDC; and the level of threat and hostilities it is not prudent to hold up a commander's preliminary inquiry dum to lack of prior coordination with USACIDC. Recommend re-stating the recommendation as, 'Consultation with USACIDC representatives is required as soon as practicable when commanders are notified of suspected offenses."

4. Finding B: "Not using autopsies to assist in determining cause and manner of death resulted in insufficient accounting in some death cases."

a. Concur.

5. Recommendation *2:* "That *the* Secretary of the Army, the Commander U.S. Central Command, and the Military criminal Investigative Organizations take steps to ensure that the policy outlined in the June 9, 2004, Secretary *of* Defense Memorandum requiring autopsies in detainee death cases is fully implemented and enforced."

a. Concur *with* comment

) USCENTCOM its MSC subordinate commands enforce thm SECDEF policy SCEMTC has issued fragmentary orders requiring and CFC-A, through its executive agent for detention operations CJTF-76, and MNF-I require autopsies to be performed in all cases where a detainee dies in detention.

6. Finding C: "(1) Investigations concerning the potential use of excessive force against detainees did not adequately focus on the Rules of Engagement (ROE) concerning use of force against

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detainees; and (2) ROE applied at the local level varied from written directives."

a. Partially concur with part (1 with comment:

(1) Recommend substituting RUF for ROE in part (1) above. The issue in part (1) concerns tho Rules *for* the Use of Force (RUF) not the Rules of Engagement (ROE). Tho ROC are mission specific and developed in coordination with JS/OSD; RUF fall within tho revised Standing Rules *of* Engagement (SROE). Additionally, Service investigative agencies have made determinations of "justifiable homicide" which indicate that the RUF were considered *in* the investigation.

b. Concur with part (2) with comment

(1) The Rules of Engagement (ROE) and Rules for the Use of force (RUF) are reviewed and updated through modifications, requests for supplemental measures and changes an tho conditions require. All levels of command have the ability and responsibility to recommend updates. Also, subordinate commanders may issue additional rules and instructions that provide definitive guidance and that remains compatible with the ROE and RUF.

7. Recommendation 4: "That the Secretary of the Army and the Commander, U.S. Central Command review tho rules of engagement and tho rules for the use *of* deadly force from the top down to ensure clarity and consistency, and to ensure they are thoroughly taught and applied."

a. concur in part and non-concur in part with comment.

(1) Concur in part with reviewing the rules for the use *of* deadly force.

(a) Rules for the Use of Force (RUF) are reviewed and updated through modifications, requests *for* supplemental rules and changes as the conditions require. All levels of command in detention operations already have tho ability and responsibility to review tho RUF as it applies to their specific operations. request supplemental measures, and to recommend updates. Within the USCENTCOM area *of* operations, U.S. Army Central Command (ARCENT) can review all RUF regarding detention operations. Also, subordinate commanders may issue additional rules and instruction that provides definitive

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guidance and that remains compatible with RUF established by higher headquarters. Mditfonally, there may be differences in guard forces at different facilities depending on uhat alternatives are available to the guard force at each location (e.g., um: kind6 of lesa-than-lethal alternatives do they have) and tho nature of the detainees.

(b) The Rules for the Use of Force (RUF) fall within tho revised Standing Rules of Engagement but the U.S. Army, as executive agent for detainee operations, along with the other Services, have more oversight responsibility of deadly force policy formation than USCENTCOM, which operates more at the strategic level.

(2) Non-concur with ensuring the ROE/RUF are thoroughly tawht by USCENTCOM so they can be applied. Training is a Service responsibility. U.S. forces are only operationally controlled by USCENTCOM. Recommend inclusion of a11 Services in tho re ——— dationas detention facility guard force personnel may come frm any of them,

3. My POC for this matter is LTC John Logans, USCENTCOM/CCJA, DSN 312-651-6422.

[redacted] J. AUSTIN III
Major General, USA

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DEPARTMENT OF THE ARMY
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APR 25 2006

SAIG-ZX

MEMORANDUM FOR Deputy Inspector General for Policy and Oversight, Office of the Department of Defense Inspector General

SUBJECT: DAIG Response to DODIG Draft Report – Review of Criminal Investigations of Alleged Detainee Abuse (Project No. PPD2005-D005)

1. Reference Department of Defense Inspector General memorandum dated 01 Mar 06 *and attachment* DODIG Draft Report – Review of Criminal Investigations of Alleged Detainee Abuse (Project No. PPD2005-D005)

2. Department of the Army Office of The Inspector General has reviewed the above and provides the following input:

- Noted w/comment: Page 1, background, last sentence..."While we recognize that some investigative shortcomings may stem from the hostile nature of the environment, we believe that the problem areas that we have identified reflect systemic deficiencies." Statement is ambiguous—believe "hostile nature of the environment" they are referring to is war, but could be misconstrued as agencies not working together, or facilities.

3. Point of contact is COL Keith Blowe, Executive Officer, at DSN 225-1502, COMM (703) 695-1502, keith.blowe@ignet.army.mil.

ALAN W. THRASHER
Major General, USA
Deputy The Inspector General

DEPARTMENT OF DEFENSE
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-6000

REPLY TO ATTENTION OF

AFIP-CME

16 August 2006

From: Mallak, Craig T. CDR
Sent: Wednesday, March 29, 2006 11:12 AM
To: *OIG DOD*
Subject: Report on Review of Criminal Investigations of Alleged Detainee Abuse

1. We never had a permanent presence in Iraq or Afghanistan. We would respond, usually within 24 hours of the death of an EPW. With only seven of us, it didn't and doesn't make sense to have a medical team (doc, investigator, and photographer) in country on an extended basis for one, maybe two cases a month. There is also no administrative or lab capability in country to complete the case in country. We hand carry back the specimens that need to be analyzed here in Rockville. Also, with over 100 US cases per month coming through Dover and other case throughout the US and world, we needed everyone stationed right here in Rockville. Most deployments to Iraq and Afghanistan lasted 5-7 days, with a record turn around of 72 hours from the time a team left Dover to the time they returned to Dover to do an EPW case in Iraq. We now have all cases, including the EPW's come to Dover, where we can do the job correctly and still turn the case around in less than 24 hours from the time they arrive in at Dover. The remains are then returned to Iraq and the family. Trying to do first world forensics in a tent in Baghdad caused problems when we went to court. We are putting the final touches on a permanent facility in Iraq and if the numbers of US causalities drop off, we'll be going back to Iraq on an as needed basis to do these cases.

2. We have an up to date spreadsheet of all EPW deaths we have investigated, now over 80, and if you would like a copy of the report, let me know.

3. In your glossary, page 37, you stated we provided consultation to the local commander about whether an autopsy needs to be performed. We don't provide consultation to the local commander whether an autopsy is required. We make the call and have to live with that decision. The local commander, under the circumstances listed in 10 USC 1471 can order an autopsy if we decline to engage. We never decline if they fit the criteria listed in the federal law.

4. The second to last paragraph on page 37 seems to have two sentences run together.

5. And to date, amazingly, there have been no EPW deaths at the detainee camp in Cuba. But, we do have a plan in place to handle those cases.

Please let me know if I may be of further assistance.

for Craig T. Mallak
CDR, MC, USN
Armed Forces Medical Examiner

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Appendix J. Report Distribution

Office of the Secretary of Defense

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Senate Committee on Governmental Affairs
House Committee on Armed Services
House Subcommittee on National **Security,** Veterans *Affairs,* **and** International Relations, Committee on Government Reform

*Recipient of draft report.

Evaluation Team Members

The Policy and Programs Directorate, Office of the Assistant Inspector for Investigative Policy and Oversight, Office of the Deputy Inspector General for Inspections and Policy, Office of the Inspector General of the Department of Defense, prepared this report. Office of the Inspector General personnel who contributed to this report are listed below.

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