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HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

USFOR-A-CDR

MEMORANDUM FOR RECORD

MAY 21 2010

SUBJECT: AR 15-6 Investigation, 21 February 2010 U.S. Air-to-Ground Engagement in the Vicinity of Shahidi Hassas, Uruzgan District, Afghanistan

1. I have reviewed the AR 15-6 Investigation into the 21 February 2010 U.S. air-to-ground engagement in the vicinity of Shahidi Hassas, Uruzgan District, Afghanistan. I approve the Investigating Officer's (IO's) findings and I approve recommendations as follows:

a. Joint Forces Command (JFCOM):

(1) This investigation is to be referred to JFCOM for review and full implementation of all of the recommendations regarding changes in home station training. However, at a minimum, consideration should be given to the development of predeployment training at home station and combat training centers to ensure that Command Posts are put through a rigorous series of COIN training and challenging scenarios.

(2) Additionally request JFCOM develop a seminar taught by former Battalion/Brigade/Division level Commanders/Command Sergeants Majors, using case studies and vignettes that educate and train leaders on "Leading COIN Formations." Develop a required professional reading list of books, periodicals, articles and investigations that bring to light the complexities and leadership responsibilities of leaders at all levels of COIN operations.

(3) Review war-fighting terminology for use in a COIN environment. Request JFCOM review and publish standard definitions for doctrinal terms and frequently used non-doctrinal terms throughout the CJOA. Incorporate these terms in predeployment training CTC and MTT training plans.

(4) Incorporate CIVCAS reporting requirements in predeployment training plans.

b. IJC and USFOR-A J7: This report will be referred to the ISAF Joint Command (IJC) and the USFOR-A J7 for implementation of in country training recommendations. Specifically, the J-7 will work with the IJC to:

(1) Develop a mobile training team to travel throughout the CJOA to evaluate and train units' Command Posts on COIN Operations as well as to develop a seminar to educate and train leaders on leading COIN formations. Further, this training should ensure full development and training on the targeting process, responsibilities and engagement criteria at all levels in accordance with the Rules of Engagement and Tactical Directives.

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USFOR-A-CDR

SUBJECT: AR 15-6 Investigation, 21 February 2010 U.S. Air-to-Ground Engagement in the Vicinity of Shahidi Hassas, Uruzgan District, Afghanistan

(2) Ensure that deployed US and coalition units update and develop new vignettes to meet the requirements of the AOR and continue COIN training as outlined above on a sustainment basis while deployed.

(3) Incorporate CIVCAS reporting requirements in sustainment training.

c. United States Air Force:

(1) This investigation, findings and recommendations will be forwarded to Headquarters Air Force to consider appointing Air Combat Command as the lead MAJCOM to quickly codify command level guidance on Distributed Common Ground System/Remote Piloted Vehicle tactics, techniques and procedures (TTPs) and conflict resolution in an Air Force Tactics Techniques and Procedures manual.

(2) It is requested that the Wing Commander for the 432nd Air Expeditionary Wing Commander convene a Commander's Directed Investigation (CDI) to determine the actions and assessments of the (b)(1)1.4a Predator crew in this incident.


d. IJC and USFOR-A, J3:

(1) Draft and issue a FRAGO to ensure that all unit SOP's incorporate a battle drill so that when a potential target is identified for an air-to-ground strike, the battle drill includes planning for (b)(1)1.4a, (b)(1)1.4c after the strike.

(2) Draft and issue a FRAGO to standardize the procedures used by ISR platforms when maintaining Full Motion Video coverage of a strike site until an (b)(1)1.4a, (b)(1)1.4c element can arrive.

e. SOTF (b)(1)1.4a and CJSOTF-A: Retrain on the Tactical Directive and develop standard operating procedures to address CIVCAS reporting.

2. Recommendations regarding disciplinary actions will be reviewed and considered for implementation as per my discretion.


STANLEY A. MCCHRYSTAL
General, U.S. Army
Commander
United States Forces-Afghanistan/
International Security Assistance
Force, Afghanistan

REPORT OF PROCEEDINGS BY INVESTIGATING OFFICER/BOARD OF OFFICERS

For use of this form, see AR 15-6; the proponent agency is OTJAG.

IF MORE SPACE IS REQUIRED IN FILLING OUT ANY PORTION OF THIS FORM, ATTACH ADDITIONAL SHEETS

SECTION I - APPOINTMENT

Appointed by General Stanley M. McChrystal
(Appointing authority)

on 22 February 2010 (Date)
(Attach inclosure 1: Letter of appointment or summary of oral appointment data.) (See para 3-15, AR 15-6.)

SECTION II - SESSIONS

The (investigation) (board) commenced at Kandahar Airfield, Afghanistan at 1300
(Place) (Time)

on 22 February 2010 (Date)
(If a formal board met for more than one session, check here . Indicate in an inclosure the time each session began and ended, the place, persons present and absent, and explanation of absences, if any.) The following persons (members, respondents, counsel) were present: (After each name, indicate capacity, e.g., President, Recorder, Member, Legal Advisor.)

- Major General Timothy McHale, USA, Investigating Officer
- Colonel (b)(3), (b)(6) USA, Ground Combat Subject Matter Expert/Advisor
- Colonel (b)(3), (b)(6) USA, Aviation Subject Matter Expert/Advisor
- Colonel (b)(3), (b)(6) USA, Aviation Subject Matter Expert/Advisor
- Lieutenant Colonel (b)(3), (b)(6) USA, Lead Legal Advisor
- Lieutenant Colonel (b)(3), (b)(6) USA, Ground Liaison Subject Matter Expert
- Lieutenant Colonel (b)(3), (b)(6) USA, Special Operations Advisor
- Major (b)(3), (b)(6) USA, Assistant Legal Advisor
- Master Sergeant (b)(3), (b)(6) USAF, Senior Paralegal
- Sergeant (b)(3), (b)(6) Paralegal
- Specialist (b)(3), (b)(6) Paralegal

The following persons (members, respondents, counsel) were absent: (Include brief explanation of each absence.) (See paras 5-2 and 5-8a, AR 15-6.)

N/A

The (investigating officer) (board) finished gathering/hearing evidence at 1300 on 18 March 2010
(Time) (Date)

and completed findings and recommendations at _____ on _____
(Time) (Date)

SECTION III - CHECKLIST FOR PROCEEDINGS

A. COMPLETE IN ALL CASES		YES	NO ^{1/}	NA ^{2/}
¹	Inclosures (para 3-15, AR 15-6) Are the following inclosed and numbered consecutively with Roman numerals: (Attached in order listed)			
	a. The letter of appointment or a summary of oral appointment data?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Copy of notice to respondent, if any?(See item 9, below)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	c. Other correspondence with respondent or counsel, if any?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	d. All other written communications to or from the appointing authority?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Privacy Act Statements (Certificate, if statement provided orally)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Explanation by the investigating officer or board of any unusual delays, difficulties, irregularities, or other problems encountered (e.g., absence of material witnesses)?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	g. Information as to sessions of a formal board not included on page 1 of this report?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	h. Any other significant papers (other than evidence) relating to administrative aspects of the investigation or board?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

FOOTNOTES: ^{1/} Explain all negative answers on an attached sheet.

^{2/} Use of the N/A column constitutes a positive representation that the circumstances described in the question did not occur in this investigation or board.

		YES	NO ^{1/}	NA ^{2/}
2	Exhibits (para 3-16, AR 15-6)			
	a. Are all items offered (whether or not received) or considered as evidence individually numbered or lettered as exhibits and attached to this report?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Is an index of all exhibits offered to or considered by investigating officer or board attached before the first exhibit?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Has the testimony/statement of each witness been recorded verbatim or been reduced to written form and attached as an exhibit?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Are copies, descriptions, or depictions (if substituted for real or documentary evidence) properly authenticated and is the location of the original evidence indicated?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Are descriptions or diagrams included of locations visited by the investigating officer or board (para 3-6b, AR 15-6)?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Is each written stipulation attached as an exhibit and is each oral stipulation either reduced to writing and made an exhibit or recorded in a verbatim record?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	g. If official notice of any matter was taken over the objection of a respondent or counsel, is a statement of the matter of which official notice was taken attached as an exhibit (para 3-16d, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3	Was a quorum present when the board voted on findings and recommendations (paras 4-1 and 5-2b, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
B. COMPLETE ONLY FOR FORMAL BOARD PROCEEDINGS (Chapter 5, AR 15-6)				
4	At the initial session, did the recorder read, or determine that all participants had read, the letter of appointment (para 5-3b, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	
5	Was a quorum present at every session of the board (para 5-2b, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	
6	Was each absence of any member properly excused (para 5-2a, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Were members, witnesses, reporter, and interpreter sworn, if required (para 3-1, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	If any members who voted on findings or recommendations were not present when the board received some evidence, does the inclosure describe how they familiarized themselves with that evidence (para 5-2d, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. COMPLETE ONLY IF RESPONDENT WAS DESIGNATED (Section II, Chapter 5, AR 15-6)				
9	Notice to respondents (para 5-5, AR 15-6):			
	a. Is the method and date of delivery to the respondent indicated on each letter of notification?	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Was the date of delivery at least five working days prior to the first session of the board?	<input type="checkbox"/>	<input type="checkbox"/>	
	c. Does each letter of notification indicate —	<input type="checkbox"/>	<input type="checkbox"/>	
	(1) the date, hour, and place of the first session of the board concerning that respondent?	<input type="checkbox"/>	<input type="checkbox"/>	
	(2) the matter to be investigated, including specific allegations against the respondent, if any?	<input type="checkbox"/>	<input type="checkbox"/>	
	(3) the respondent's rights with regard to counsel?	<input type="checkbox"/>	<input type="checkbox"/>	
	(4) the name and address of each witness expected to be called by the recorder?	<input type="checkbox"/>	<input type="checkbox"/>	
	(5) the respondent's rights to be present, present evidence, and call witnesses?	<input type="checkbox"/>	<input type="checkbox"/>	
	d. Was the respondent provided a copy of all unclassified documents in the case file?	<input type="checkbox"/>	<input type="checkbox"/>	
	e. If there were relevant classified materials, were the respondent and his counsel given access and an opportunity to examine them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	If any respondent was designated after the proceedings began (or otherwise was absent during part of the proceedings):			
	a. Was he properly notified (para 5-5, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Was record of proceedings and evidence received in his absence made available for examination by him and his counsel (para 5-4c, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Counsel (para 5-6, AR 15-6):			
	a. Was each respondent represented by counsel?	<input type="checkbox"/>	<input type="checkbox"/>	
	Name and business address of counsel:			
	(If counsel is a lawyer, check here <input type="checkbox"/>)			
	b. Was respondent's counsel present at all open sessions of the board relating to that respondent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. If military counsel was requested but not made available, is a copy (or, if oral, a summary) of the request and the action taken on it included in the report (para 5-6b, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	If the respondent challenged the legal advisor or any voting member for lack of impartiality (para 5-7, AR 15-6):			
	a. Was the challenge properly denied and by the appropriate officer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Did each member successfully challenged cease to participate in the proceedings?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Was the respondent given an opportunity to (para 5-8a, AR 15-6):			
	a. Be present with his counsel at all open sessions of the board which deal with any matter which concerns that respondent?	<input type="checkbox"/>	<input type="checkbox"/>	
	b. Examine and object to the introduction of real and documentary evidence, including written statements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Object to the testimony of witnesses and cross-examine witnesses other than his own?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Call witnesses and otherwise introduce evidence?	<input type="checkbox"/>	<input type="checkbox"/>	
	e. Testify as a witness?	<input type="checkbox"/>	<input type="checkbox"/>	
	f. Make or have his counsel make a final statement or argument (para 5-9, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	
14	If requested, did the recorder assist the respondent in obtaining evidence in possession of the Government and in arranging for the presence of witnesses (para 5-8b, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Are all of the respondent's requests and objections which were denied indicated in the report of proceedings or in an inclosure or exhibit to it (para 5-11, AR 15-6)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FOOTNOTES: ^{1/} Explain all negative answers on an attached sheet. ^{2/} Use of the N/A column constitutes a positive representation that the circumstances described in the question did not occur in this investigation or board.				

SECTION IV - FINDINGS (para 3-10, AR 15-6)

The *(investigating officer) (board)* , having carefully considered the evidence, finds:

Please See Attached:

Tab A: Findings

SECTION V - RECOMMENDATIONS (para 3-11, AR 15-6)

In view of the above findings, the *(investigating officer) (board)* recommends:

Please See Attached:

Tab B: Administrative Recommendations

Tab C: Command Accountability Recommendations

Tab D: Chronology of Investigative Events

Tab E: Table of Contents

SECTION VI - AUTHENTICATION (para 3-17, AR 15-6)

THIS REPORT OF PROCEEDINGS IS COMPLETE AND ACCURATE. (If any voting member or the recorder fails to sign here or in Section VII below, indicate the reason in the space where his signature should appear.)

(Recorder)

TIMOTHY P. McHALE

(Investigating Officer) (President)

(Member)

(Member)

(Member)

(Member)

SECTION VII - MINORITY REPORT (para 3-13, AR 15-6)

To the extent indicated in Inclosure _____, the undersigned do(es) not concur in the findings and recommendations of the board. (In the inclosure, identify by number each finding and/or recommendation in which the dissenting member(s) do(es) not concur. State the reasons for disagreement. Additional/substitute findings and/or recommendations may be included in the inclosure.)

(Member)

(Member)

SECTION VIII - ACTION BY APPOINTING AUTHORITY (para 2-3, AR 15-6)

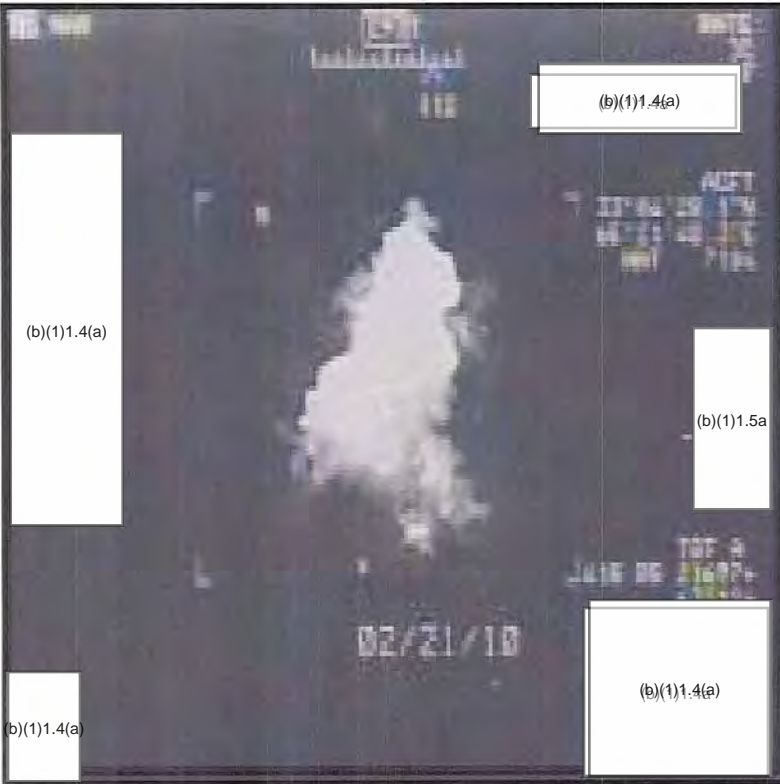
The findings and recommendations of the (investigating officer) (board) are (approved) (disapproved) (approved with following exceptions/substitutions). (If the appointing authority returns the proceedings to the investigating officer or board for further proceedings or corrective action, attach that correspondence (or a summary, if oral) as a numbered inclosure.)

STANLEY M. McCHRYSTAL, General, USA

Page 7 redacted for the following reason:

(b)(1)1.4a, (b)(1)1.4g, (b)(3), (b)(6), (b)(2)

21 FEB 2010 CIVCAS IN URUZGAN PROVINCE



Page 9 redacted for the following reason:

(b)(2), (b)(3), (b)(6)

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Re-graded Unclassified when Separated From Classified Enclosure



HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

13 APR 2010

USFOR-A DCDR-S

MEMORANDUM FOR Commander, United States Forces-Afghanistan/International Security Assistance Force, Afghanistan

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

1. Enclosed is the completed AR15-6 investigation report relating to the 21 February 2010 civilian casualty incident in Uruzgan Province.
2. In the course of this investigation, I have traveled to Kandahar Air Field (KAF) to interview witnesses from SOTF (b)(1)1.4a and TF (b)(1)1.4a to Tarin Kowt to meet members of the ODA team, to Bagram Air Field (BAF) to interview members of the CJSOTF-A as well as to Kabul to meet and interview witnesses. I have also traveled to FOB (b)(1)1.4a to meet with local Afghans and community leaders and I have interviewed members of the local Afghan Security Group, the local Afghan Police and members of the local Afghan National Army in order to obtain the atmospherics of the community where the incident occurred. In addition, I have reviewed briefing slides, intelligence reports, Command Post logs, operations orders and plans, imagery, situation reports both before and after the incident, medical records, personnel reports, battle damage assessments, Predator video as well as OH-58D gun camera video in order to gain a complete and accurate assessment of how this incident occurred and what were the series of errors which caused this to occur. In addition, I conducted a series of personal interviews with the injured Afghans in order to have a first-hand account of what happened on 21 February 2010 in Uruzgan Province.
3. At your invitation, the United States Air Force and US Army Special Operations Command sent teams to review the investigation's findings and recommendations. I have considered the input of both teams and have adopted most of their recommended changes. I have enclosed a memorandum explaining any recommendations from these teams that I did not incorporate into the report.

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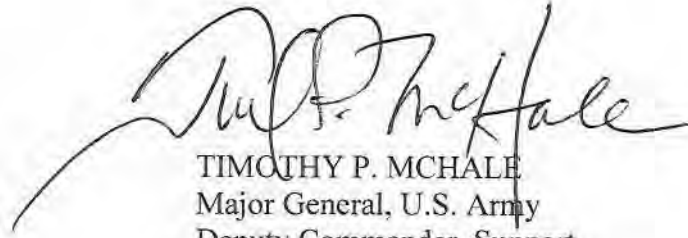
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4. Using the questions contained in your appointment memorandum dated 22 February 2010, I have enclosed findings at TAB A. My recommendations for avoiding incidents of similar nature are at TAB B. My recommendations regarding command accountability are at TAB C.



TIMOTHY P. MCHALE
Major General, U.S. Army
Deputy Commander, Support
U.S. Forces - Afghanistan

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HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

USFOR-A DCDR-S

13 APR 2010

MEMORANDUM FOR Commander, United States Forces-Afghanistan/International Security Assistance Force, Afghanistan

SUBJECT: Executive Summary for AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

1. On 21 February 2010, up to twenty three (23) local nationals were killed and twelve others injured when the convoy they were travelling in was mistaken for an insurgent force and engaged with air-to-ground fire. The tragic loss of life was compounded by a failure of the commands involved to timely report the incident. The strike occurred because the ground force commander lacked a clear understanding of who was in the vehicles, the location, direction of travel and the likely course of action of the vehicles. This lack of understanding resulted from poorly functioning command posts at SOTF (b)(1)1.4b and CJSOTF-A which failed to provide the ground force commander with the evidence and analysis that the vehicles were not a hostile threat and the inaccurate and unprofessional reporting of the Predator crew operating out of Creech, AFB Nevada which deprived the ground force commander of vital information.
2. Three vehicles carrying over thirty civilians were mistaken for an insurgent convoy and engaged with Hellfire missiles and 2.75" aerial rockets. The ground force commander was executing a combined combat operation in the village of Khod. He believed the vehicles, approximately 12 kilometers away, contained a group of insurgents attempting to execute a flanking maneuver to reinforce insurgents operating near the village.
3. Movements of the vehicles appeared to match calls heard over (b)(1)1.4(a) radio for insurgents to mass for an attack on the combined US and Afghan forces near Khod. The vehicles were first spotted at approximately 0500D (local time). None of the women were spotted in or near the vehicles during the three and a half hours the vehicles movements were tracked. Two children were spotted near the vehicles, but inaccurate reporting from the crew of the unmanned Predator aircraft to the forces on the ground led the Operational Detachment Alpha (ODA) to believe that the vehicles contained only armed military aged males. Information that the convoy was anything other than an attacking force was ignored or downplayed by the Predator crew. In addition, the operations centers at SOTF (b)(1)1.4b and CJSOTF-A failed to analyze the readily available information and communicate effectively with the ODA Commander.
4. The ODA Commander conducting Battle Damage Assessment (BDA) counted fifteen (15) to sixteen (16) men killed at the site. During follow-up operations, local elders identified twenty three men killed and solatia payments were made to their families. Additionally, eight (8) men, one (1) woman and three (3) children were injured in the engagement and are receiving care from US or Coalition medical personnel. The ODA commander immediately released the remains of the deceased to local Afghan

USFOR-A DCDR-S


SUBJECT: Executive Summary for AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

Police and community leaders at the strike site and the ODA team evacuated the wounded for medical care.

5. Initial observations of the vehicles appeared to indicate a threat force. Adult men were observed gathering in and around the vehicle, moving tactically and appearing to provide security during stops. The movement of the vehicles matched pre-mission intelligence and the (b)(1)1.4(a) radio traffic. The ODA Commander displayed tactical patience in letting the situation develop for several hours before the engagement. The time bought by that patience was wasted because of the Predator crew's inaccurate reporting and the failure of both command posts to properly analyze the situation and provide control, insights, analysis, or options to the ODA commander. Once the more experienced SOTF (b)(1)1.4 Day Battle Captain came on shift, the situation was analyzed and he took appropriate steps to assist in developing alternative engagement scenarios with the SOTF (b)(1)1.4 Commander. Unfortunately, these alternatives had not yet been implemented before the engagement occurred.

6. Immediately after the engagement SOTF (b)(1)1.4 and CJSOTF-A had ample evidence of a possible CIVCAS incident but failed to report it. Both commands sought to confirm the existence of CIVCAS rather than reporting suspected CIVCAS as required. The OH-58Ds which fired the missiles and rockets, ceased their engagement when they spotted bright clothing and suspected women were present. Despite the reports sent by the OH-58Ds, the Full Motion Video (FMV) from the Predator showing women and children on the objective site and reports from the Predator over the Internet Relay Chat (mIRC), neither SOTF (b)(1)1.4 or CJSOTF-A reported suspected CIVCAS. Even after receiving a First Impression Report from the aviation unit which conducted the strike and performed the MEDEVAC, CJSOTF-A refused to report CIVCAS as the information contradicted initial reports from the (b)(1)1.4a, (b)(1)1.4c and did not come from a CJSOTF-A unit. SOTF (b)(1)1.4 and CJSOTF-A finally reported the CIVCAS nearly twelve (12) hours after the strike when the SOTF (b)(1)1.4 surgeon reported the casualties in the hospital.

7. Using the questions contained in your appointment memorandum dated 22 February 2010, I have enclosed findings at TAB A. My administrative recommendations for avoiding incidents of a similar nature in the future are at TAB B. In addition, these findings include suggestions regarding command accountability at TAB C.



TIMOTHY P. MCHALE
Major General, U.S. Army
Deputy Commander, Support
U.S. Forces - Afghanistan



HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

USFOR-A CDR

22 February 2010

MEMORANDUM FOR MG Timothy P. McHale, DCDR-S, United States Forces
Afghanistan, New Kabul Compound, APO AE 09356.

SUBJECT: Appointment as Investigating Officer

1. MG McHale, you are hereby appointed as an investigating officer pursuant to Army Regulation (AR) 15-6 to conduct an informal investigation into the circumstances surrounding the air-to-ground fire incident in the vicinity of Shadid-e Hasas, Uruzgan District on 21 February 2010 that allegedly resulted in the death of 12-15 local Afghan nationals and caused injuries to others.
2. You will investigate this incident thoroughly addressing the facts/circumstances surrounding the incident. Your investigation should include interviews of all individuals directly involved or who may have knowledge of the incident. You should determine if any inappropriate or criminal conduct took place and whether non-judicial punishment or court-martial is appropriate. Your investigation will address the following matters using a question and answer format in your findings and recommendations:
 - a. What were the facts and circumstances surrounding the incident (5 Ws)?
 - b. Please describe in specific detail the circumstances of how the incident took place.
 - c. What was the mission of the Operational Detachment Alpha (ODA) and partnered Afghan units at the time of the incident?
 - d. What was the mission of the OH-58's unit?
 - e. Was the use of force in accordance with the Rules of Engagement (ROE)?
 - f. Did the U.S. properly identify hostile intent/hostile actions before employing force? If so, what were the facts that were used to establish hostile act/intent? If not, why not?
 - g. What were the acts that led to the strike? Were the escalation of force (EOF) procedures for targeting followed? Who determined that the vans exhibited hostile intent?
 - h. Was Positive Target Identification (PID) established? If so what facts provided the PID?
 - i. Did the occupants of the vans present an imminent threat to any U.S. or coalition forces, or civilians? Who made the determination that it was necessary to engage the vans?
 - j. What warnings were given to the Afghan Nationals, if any? If none, were any appropriate to utilize?

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DRONES / CENTCOM / 000076

USFOR-A CDR

SUBJECT: Appointment Order - Investigating Officer Pursuant to Army Regulation (AR) 15-6, *Procedures for Investigation Officers and Boards of Officers*, 2 October 2006

k. What efforts were made to mitigate the risk of death or injury to other non-combatants during this firing? Is there anything more that could have been done to prevent this incident from happening?

l. What intelligence, if any, did the firing unit receive that may have led them to believe the vans were hostile?

m. How many Afghan Nationals injured in this incident? Where were those injured located during the incident, how were they injured, and by whom? What is the extent of their injuries? What medical treatment was given to the injured local nationals? Were MEDEVAC procedures used, and if not, why were they not used? Were the procedures that were used timely and appropriate under the circumstances? What steps were taken to ensure follow-on medical care?

n. How many Afghan Nationals were killed in the incident? What are the names of the individuals that were killed and what are the names of the individuals wounded? Is there any evidence that any of the individuals killed or wounded were associated with Anti-Afghan Forces?

o. Were solatia or CERP condolence payments? If not, would such payments be appropriate? What actions have the chain of command taken with regard to contacting or caring for the wounded? What actions have the chain of command taken to mitigate the negative impact of this incident with local community leaders?

p. What recommendations concerning improvements, if any, to coalition force tactics, techniques, and procedures will help avoid this type of incident in the future?

q. Was a post strike battle damage assessment (BDA) done? If not, why not? If so, was it conducted within two hours of the strike? If not, how long after the strike was it conducted? Who conducted the BDA? Was the site under surveillance from the time of the strike until the BDA was completed?

r. What were the community leaders' impressions and opinions of the strike?

s. Were initial reports of the incident accurate? If not, was there an attempt to intentionally mislead the chain of command? At what point did the unit on the ground suspect that the incident might have involved CIVCAS? How long did it take the unit to report that suspicion to its higher headquarters? Did any headquarters fail to timely notify its next higher headquarters?

t. Any other matters you deem relevant.

3. Use Chapter 3, AR 15-6, to guide your investigation. You will take sworn statements from all witnesses using DA Form 2823. Your authority to administer oaths is the Uniform Code of Military Justice, Article 136(b) (4). If, during the course of your investigation, you come to suspect that an individual may have committed a violation of the Uniform Code of Military Justice or federal law, you must advise them of their rights under the Uniform Code of Military Justice, Article 31(b), or the Fifth Amendment, as appropriate. Use DA Form 3881 for this purpose. Additionally, you should provide witnesses with Privacy Act

USFOR-A CDR

SUBJECT: Appointment Order - Investigating Officer Pursuant to Army Regulation (AR) 15-6, *Procedures for Investigation Officers and Boards of Officers*, 2 October 2006

statements before soliciting personal information, such as social security numbers. Your legal advisor can assist you with these matters.

4. No military or civilian witness can be ordered to give testimony that may incriminate them. However, you may order a military witness to provide a statement if you believe they have relevant information which would not incriminate the witness.


5. Your findings must be supported by a preponderance of the evidence, and your recommendations must be legally consistent with the findings. Submit your findings and recommendations on a separate memo and state "see attached memo" on the DA Form 1574.

6. Before you begin your investigation, you must receive a briefing from MAJ (b)(3), (b)(6) (b)(3), (b)(6) USFOR-A, Judge Advocate, who has been appointed as your legal advisor. He can be reached at (b)(3), (b)(6) SVOIP (b)(2). You must consult with your legal advisor regarding all aspects of this investigation, including developing an investigation plan, determining whether witnesses need to be advised of their rights under the UCMJ, Article 31 (or the Fifth Amendment), and preparing findings and recommendations. In addition, LTC (b)(3), (b)(6) CFSOCC-A, SVOIP (b)(2) is available as a liaison for the CFSOCC-A and will assist in any way necessary. COL (b)(3), (b)(6) (b)(3), (b)(6) USARCEN Support Element, SVOIP (b)(2) is assigned to the investigative team and is available to assist in any way necessary.

7. Your final investigation should include, at least, the DA Form 1574; Findings and Recommendations Memorandum; Appointment Memorandum; Chronology of your Investigation; Index of Exhibits; and applicable Exhibits (sworn statements, photos, story board, lessons learned, etc.) labeled and in order.

8. This investigation constitutes your primary duty until completed. It will take precedence over all other duties. You have fourteen (14) days from the date of this appointment to complete your investigation. The investigation, including all completed documents, will then be forwarded to the USFOR-A Legal Office for a legal review. You will then route the investigation to me for approval. If an extension is required, then forward your request through MAJ (b)(3), (b)(6)

9. The point of contact for this memorandum is LTC (b)(3), (b)(6) at DSN (b)(2) (b)(2) VOSIP (b)(2) (b)(3), (b)(6) or (b)(3), (b)(6)


STANLEY A. McCHRISTAL
General, U.S. Army
Commander
United States Forces – Afghanistan
International Security Assistance
Force, Afghanistan



HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

USFOR-A-SJA

MEMORANDUM FOR Commander, United States Forces-Afghanistan

SUBJECT: Investigation of Air-to-Ground Fire Incident, Uruzgan District
21 February 2010

1. On behalf of MG McHale, we would request an extension of time to complete the investigation pursuant to Army Regulation (AR) 15-6 into the circumstances surrounding the air-to-ground fire incident in the vicinity of Shadid-e Hasas, Uruzgan District on 21 February 2010, which allegedly resulted in the death of approximately sixteen local Afghan nationals and caused injuries to others.
2. The investigation has been extremely thorough and to date we have interviewed over fifty-four witnesses. Additional time is necessary to draft summaries of their statements and to interview at least one more witness. We would request an extension of up to and including March 24, 2010.
3. The point of contact for this memorandum is the assistant Legal Advisor, MAJ (b)(3), (b)(6) (b)(3), (b)(6) at (b)(2)

(b)(3), (b)(6)

LTC, JA, U.S. Army
Deputy Staff Judge Advocate

000017

DRONES / CENTCOM / 000079



HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

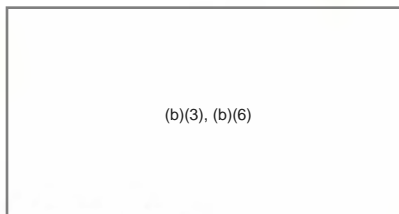
USFOR-A-CDR

MEMORANDUM FOR Deputy Commander - Support, United States Forces-Afghanistan,
ATTN: Major General McHale, APO AE 09356.

SUBJECT: Investigation of Air-to-Ground Fire Incident, Uruzgan District
21 February 2010

Your request for an extension is approved. Submit your completed report of investigation no later than 24 March 2010.

FOR THE COMMANDER:



Colonel, JA
Staff Judge Advocate
United States Forces – Afghanistan



HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

USFOR-A-CDR

1 April 2010

MEMORANDUM FOR Deputy Commander - Support, United States Forces-Afghanistan,
ATTN: Major General McHale, APO AE 09356.

SUBJECT: Investigation of Air-to-Ground Fire Incident, Uruzgan District
21 February 2010

Your request for an extension is approved. Submit your completed report of investigation no
later than 24 April 2010.

FOR THE COMMANDER:



Colonel, JA
Staff Judge Advocate
United States Forces – Afghanistan

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DRONES / CENTCOM / 000081

BOOK 1

21 FEBRUARY 2010 – URUZGAN PROVINCE CIVCAS

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HEADQUARTERS
UNITED STATES FORCES - AFGHANISTAN
KABUL, AFGHANISTAN
APO AE 09356

18 APR 2010

USFOR-A-DCDR-S

MEMORANDUM FOR Commander, United States Forces-Afghanistan/International Security Assistance Force, Afghanistan

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

1. (U) As per the appointment dated 22 February 2010, I have conducted an investigation pursuant to Army Regulation (AR) 15-6 into the circumstances surrounding the air-to-ground engagement incident in the vicinity of Shahidi Hassas, Uruzgan District on 21 February 2010 that resulted in the death of up to twenty three (23) local Afghan nationals and caused injuries to 12 others.

2. ~~(S)~~ Using the questions contained in your appointment memorandum dated 22 February 2010, I present my findings and recommendations as follows:

a. ~~(S)~~ What were the facts and circumstances surrounding the incident (5 Ws)?

(b)(1)1.4a, (b)(1)1.4c, (b)(1)1.4g

(2) (U) The Predator crew made or changed key assessments to the ODA CDR that influenced the decision to destroy the vehicles. The Predator crew has neither the training nor the tactical expertise to make these assessments. First, at 0517D, the Predator crew described the actions of the passengers of the vehicles as "tactical maneuvering." At that point the Screeners, located in Hurlburt Field, Florida described the movement as adult

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DRONES / CENTCOM / 000083

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

males, standing or sitting. (b)(1)1.4a Log, Book 5, Exhibit X, page 2). At the time of the strike "tactical maneuver" is listed by the ODA Joint Tactical Air Controller (JTAC), as one of the elements making the vehicles a proper target. (b)(1)1.4a Log, Book 5, Exhibit T, page 57). Second, at 0710D, the Screeners assess that the vehicles are evading the area, but the Predator crew disagrees saying "might be flanking as well." (b)(1)1.4a Log, Book 5, Exhibit X, page 11). The assessment that the vehicles may be evading is never passed to the ODA, instead the Predator Pilot passes "convoy possibly flanking to the west." (b)(1)1.4a Log, Book 5 Exhibit W, Page 2). Third, the Predator pilot describes a scuffle near one of the vehicles as the "potential use of human shields" with no Screener concurrence and no basis for that assessment. (b)(1)1.4a Log, Book 5, Exhibit T, page 16). Finally, and most importantly, the Screeners in Hurlburt Field, Florida identified children as being members of the convoy but later changed that assessment to adolescents. The Predator crew reported the "adolescents" to the ODA as teenagers and ultimately the Predator crew made no mention of children, adolescents, or teenagers when handing the target off to the OH-58Ds. (Kiowa Radio Traffic, Book 2, Exhibit CC).

(3) (U) While the ODA was dependent on the Predator crew for information regarding the target, the command posts at SOTF (b)(1)1.4a and CJSOTF-A were not. Both SOTF- (b)(1)1.4a and CJSOTF-A have access to the Predator Full Motion Video (FMV) and the Internet Relay Chat (mIRC). (CPT (b)(3), (b)(6) Book 4, Exhibit 9; MAJ (b)(3), (b)(6) Book 3, Exhibit 19). Both command posts had information concerning children beginning at 0537, when the Screeners in Hurlburt Field first identified two children at the rear of the SUV. (b)(1)1.4a Log, Book 5, Exhibit X, page 29). Despite the fact that the CJSOTF-A J2 Operations NCO was aware of reports of children in the convoy he did not pass that information to the JOC chief and the JOC chief apparently failed to read the mIRC chat that was displayed in the TOC. (PO (b)(3), (b)(6) Book 4, Exhibit 4 page 5). The CJSOTF-A night JOC chief was not aware of children in the convoy. (MAJ (b)(3), (b)(6) Book 4, Exhibit 21, page 5). Although the JOC Director woke COL (b)(3), (b)(6), the CJSOTF-A CDR, no one informed COL (b)(3), (b)(6) of the presence of children in the convoy. (COL (b)(3), (b)(6) Book 3, Exhibit 4 page 5).

(4) (U) Conversely, the SOTF (b)(1)1.4a night Battle Captain, CPT (b)(3), (b)(6) was aware of reports of children in the convoy and of weapons being identified. (CPT (b)(3), (b)(6) Book 4, Exhibit 26, page 5). None of the SOTF (b)(1)1.4a Field Grade Officer leadership was awake between the ODA's infill until LTC (b)(3), (b)(6) was woken up approximately twenty minutes prior to the strike. (LTC (b)(3), (b)(6) Book 4, Exhibit 2 page 31). CPT (b)(3), (b)(6) took no action to wake anyone up during this operation. (CPT (b)(3), (b)(6) Book 4, Exhibit 26, page 3). Despite his awareness of the presence of children in a potential target, CPT (b)(3), (b)(6) provided no guidance to the ODA CDR. (CPT (b)(3), (b)(6) Book 3, Exhibit 24 page 21).

(5) (U) The ODA CDR, CPT (b)(3), (b)(6) decision to engage the vehicles was within the Rules of Engagement based on the information he had available. CPT (b)(3), (b)(6) initially displayed tactical patience in letting the target develop for several hours. However, his decision to strike the target violated the intent of the Tactical Directive by failing to scrutinize and limit the use of force in a situation where there was no urgent need to engage the vehicles. CPT (b)(3), (b)(6) engaged the vehicles over twelve kilometers from his forces when there was no immediate threat to his forces.

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

b. (U) Please describe in specific detail the circumstances of how the incident took place.

(1) (U) At 0245D on 21 February 2010, ODA 3124, augmented with 30 Afghan National Police (ANP) and 20 Afghan National Army (ANA) soldiers, conducted an air infiltration from Fire Base (b)(1)1.4a (frequently referred to by previous name, FOB Cobra) to Objective Khod. The intent of the mission was to conduct a daylight cordon and search of Objective Khod no earlier than 210605DFEB10 in order to disrupt insurgent infrastructure operating in western Uruzgan Province and increase popular support of the Government of the Islamic Republic of Afghanistan (GIROA) and the International Security and Assistance Force (ISAF). Objective Khod is a village in Shahidi Hassas district of Uruzgan Province. An AC-130 and an MQ-1 Predator were in support. The Predator pilot, call sign (b)(1)1.4a and the Predator crew operated out of Creech Air Force Base, Nevada and the Screeners operated out of Hurlburt Field, Florida.

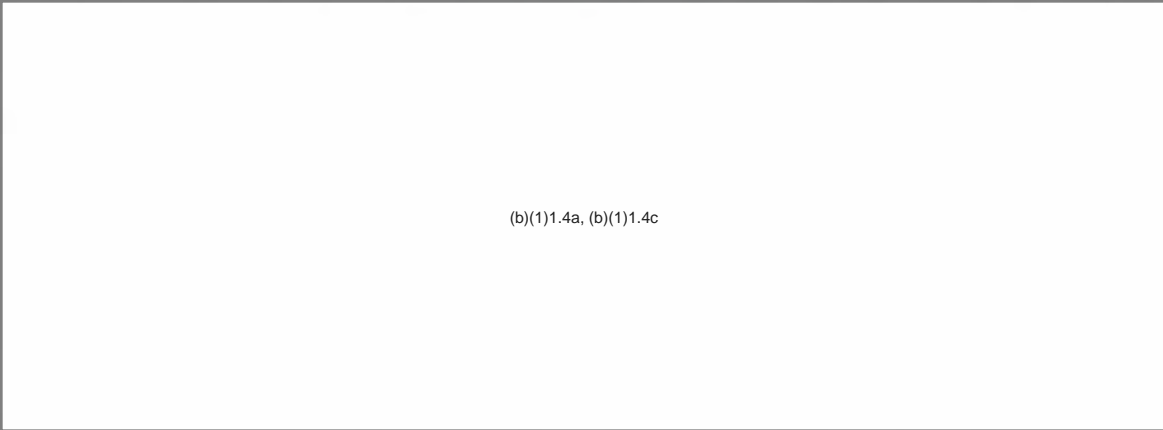
(b)(1)1.4a, (b)(1)1.4c, (b)(3), (b)(6)

(3) (U) At 0533D, the Screeners from Hurlburt Field Florida first identified a possible weapon with the MAMs in the convoy. There are additional reports of weapons at 0622D, 0730D, and 0734D. Throughout the over three and a half hours the vehicles were observed, only three weapons were positively identified. This information was passed to the Predator Pilot located in Creech AFB, Nevada, (b)(1)1.4a who, in turn, passed this information to the ODA JTAC (Joint Tactical Air Controller; Technical Sergeant (b)(3), (b)(6) also known as call sign, (b)(1)1.4a.

(4) (U) At 0538D, 0540D, and 0547D, the Screener identified a child or two children in the vicinity of the SUV. However, when queried at 0738D by the ODA JTAC about earlier reports of children, the Predator crew discusses with the Screeners, and the Screeners change the assessment to "adolescents." Although there was no agreed to definition of "adolescents," the Predator pilot reports to the JTAC "We're thinking early teens.... adolescents." (b)(1)1.4a log, Book 5, Exhibit X, Pages 5, 6, and 12).

(b)(1)1.4a, (b)(1)1.4c

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province



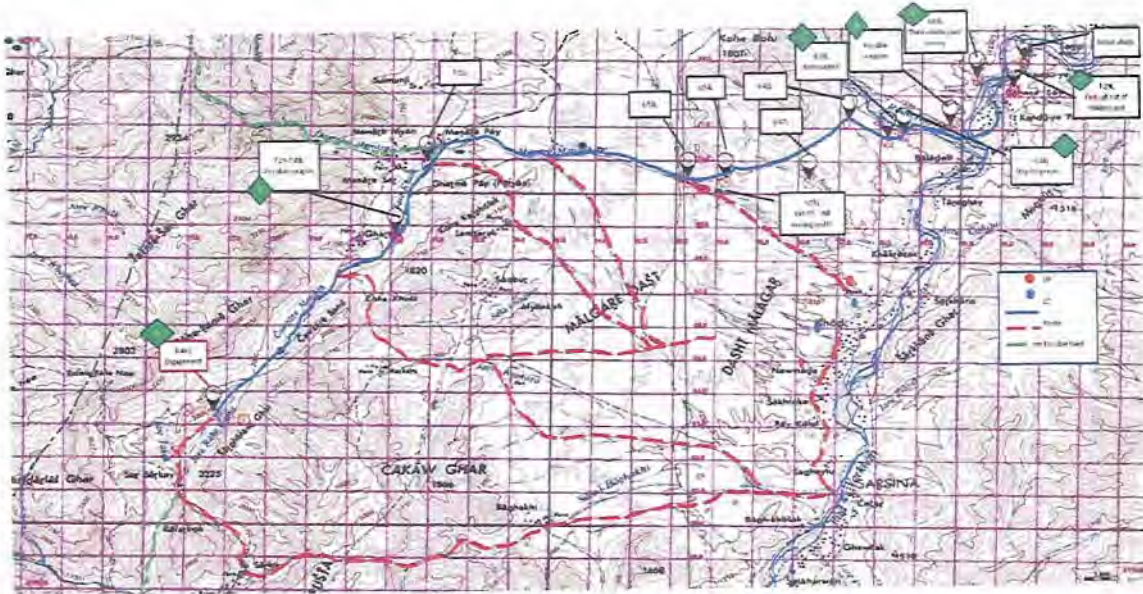
(b)(1)1.4a, (b)(1)1.4c

(7) (U) The first missile struck the first vehicle in the convoy with a catastrophic kill. The second Hellfire struck the third vehicle in the convoy as the occupants were exiting the vehicle, having stopped after seeing the first vehicle hit. A pilot from each of the helicopters (CW2 (b)(3), (b)(6) Book 3, Exhibit 3 and CW2 (b)(3), (b)(6) Book 4, Exhibit 25) confirmed that the occupants of the third vehicle looked like they exited holding weapons and were crouching in a defensive firing position before the second missile struck. (Kiowa Radio Traffic, Book 2, Exhibit CC; see also CW2 (b)(3), (b)(6) Book 3, Exhibit 3 and CW2 (b)(3), (b)(6) Book 4, Exhibit 25). The third missile struck immediately in front of the middle vehicle, disabling it. After the occupants of the second vehicle exited, the rockets were fired at the people running from the scene referred to as “squirters”; however, the rockets did not hit any of the targets. (Kiowa Radio Traffic, Book 2, Exhibit CC). As they were coming around to re-engage, the pilots observed the “squirters” had brightly colored clothing and looked like females. (Kiowa Radio Traffic, Book 2, Exhibit CC). The females appeared to be waving a scarf or a part of the burqas. (Kiowa Radio Traffic, Book 2, Exhibit CC). The OH-58Ds immediately ceased engagement, and reported the possible presence of females to the JTAC. (Kiowa Radio Traffic, Book 2, Exhibit CC). At 0911, the Predator Screener reports, “At least 3 females and 1 possible child near the 2nd vehicle.” (b)(1)1.4a Log, Book 5, Exhibit X). At 0916, Screener reports, “One adult female observed holding child.” (b)(1)1.4a Log, Book 5, Exhibit X).



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SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province



(8) (U) Concurrent to the ODA CDR directing the OH-58D engagement, the SOTF-
(b)(1)1.4 Operations Center was monitoring the situation via the internet relay chat (mIRC), as well
as watching the Predator full motion video (FMV). The night Battle Captain for the JOC,
CPT (b)(3), (b)(6) was monitoring the situation from 0330 – 0800D, when he then turned over
the situation to the day Battle Captain, CPT (b)(3), (b)(6). CPT (b)(3), (b)(6) saw the situation developing
and reviewed the mIRC chat and determined that before a strike would take place, the Judge
Advocate, (JA) CPT (b)(3), (b)(6), needed to be consulted. Shortly thereafter the SOTF-
(b)(1)1.4 CDR, LTC (b)(3), (b)(6) was awakened because of a phone call from the CJSOTF-A CDR, COL (b)(3), (b)(6).
After consultation between the JA, Battle Captain and Commander, they elected to coordinate
an air-vehicle interdiction (AVI) team with an adjacent unit to stop the vehicles and to detain
the occupants. (CPT (b)(3), (b)(6), Book 4, Exhibit 9; CPT (b)(3), (b)(6) Book 3, Exhibit 7; LTC (b)(3), (b)(6)
Book 4, Exhibit 2). Before that decision could be disseminated to the ODA or (b)(1)1.4a the
OH-58Ds had engaged the target. (CPT (b)(3), (b)(6) Book 4, Exhibit 9; CPT (b)(3), (b)(6) Book 3,
Exhibit 7; LTC (b)(3), (b)(6) Book 4, Exhibit 2).

(b)(1)1.4(a), (b)(3), (b)(6)

(10) (U) Upon receiving the report of possible women in the engagement area from
the OH-58D crew, at 0915D the ODA CDR reported to the SOTF-
(b)(1)1.4 CDR that they had a “possible incident”. According to the ODA CDR, the SOTF-
(b)(1)1.4 CDR replied, “Don’t second-guess yourself. We’ll figure it out later.” (CPT (b)(3), (b)(6) Book 3, Exhibit 24). The SOTF-
(b)(1)1.4a CDR does not recall the exact words but confirmed the basic message was conveyed. (LTC
(b)(3), (b)(6) Book 4, Exhibit 2).

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

(11) (U) At 1254D, three and a half hours after the strike, the ODA team conducted sensitive site exploitation (SSE) of the engagement area. The team immediately coordinated MEDEVAC for the twelve injured personnel in the engagement area, as well as host nation support for removal of the fifteen-sixteen killed in the attack, calling the ANP Chief in Kajaran. (CPT (b)(3), (b)(6) Book 3, Exhibit 24; TSgt (b)(3), (b)(6) Book 4, Exhibit 22). At one point during the (b)(1)1.4a the ODA CDR submitted a BDA report to the SOTF (b)(1)1.4a Battle Captain. While he states the report included three vehicles destroyed, fifteen KIAs, three women uninjured, three children uninjured, one woman injured, and one child injured," the SOTF (b)(1)1.4a Log has all minus the report of one woman injured and one child injured. LTC (b)(3), (b)(6) confirms that the information regarding the injured woman and child was passed from CPT (b)(3), (b)(6) (LTC (b)(3), (b)(6) Book 4, Exhibit 2).

(12) (U) At 1425D, TF (b)(1)1.4a (unit which had conducted the MEDEVAC) submitted a CIVCAS First Impression Report (FIR) to TF Pegasus. The TF (b)(1)1.4a CDR then forwarded the FIR to SOTF (b)(1)1.4a who forwarded to CJSOTF-A. MAJ (b)(3), (b)(6), the CJSOTF-A JOC Chief, brought the FIR to COL (b)(3), (b)(6) attention at approximately 1430D but COL (b)(3), (b)(6) refused to even read the report because "it was not from my element and I have boots on the ground" (COL (b)(3), (b)(6) Book 3, Exhibit 4). No further reporting was submitted higher until 2015D when the SOTF (b)(1)1.4a Surgeon sent an email report to the SOTF- (b)(1)1.4a Battle Captain verifying CIVCAS based on his discussion with the Dutch Forward Surgical Team (FST) on the MEDEVAC patients they had received. (SOTF (b)(1)1.4a Surgeon, Book 2, Exhibit AA).

c. (U) What was the mission of the Operational Detachment Alpha (ODA) and partnered Afghan units at the time of the incident?

(1) (U) The 2nd Company, 1st Battalion, 4 Brigade of the 205th and ANP assisted by ODA 3124 were to conduct a daylight cordon and search of Objective Khod (village in Shahidi Hassas District) in order to disrupt insurgent infrastructure operating in Western Uruzgan Province and increase popular support of GIROA and ISAF. (Pre-CONOP, Book 5, Exhibit I)

(2) (U) Key tasks for this operation were to disrupt the enemy in Western Uruzgan, deny enemy safe haven and freedom of movement while avoiding collateral damage. The task organization for this mission was 20 ANA soldiers from the 205 Corps, 30 ANP personnel, and ODA 3124 task organized with other coalition capabilities for a total of 67 Coalition personnel.

d. (U) What was the mission of the OH-58Ds' unit?

(1) (U) The OH-58Ds from A troop 1/17 Cav (call signs (b)(1)1.4a), attached to TF (b)(1)1.4a, 82d Aviation Brigade, were launched at 0615D to respond to a troops in contact (TIC) request. The OH-58D Warriors were on a close air support mission to ODA 3124. The aircraft took approximately 15 minutes after notification to traverse their route and approached the high ground to the southeast of FOB (b)(1)1.4a. Upon arrival at their "hold short" location, they started hearing the radio traffic on the (b)(1)1.4a FIRES Net. The aircrews monitored transmissions of the ODA CDR speaking with 2 x F15's call signs, (b)(1)1.4a. Two additional elements were on the Net; ODA 3124 JTAC (TSgt (b)(3), (b)(6)) on scene, call sign (b)(1)1.4a and the ready reaction force JTAC located at FOB (b)(1)1.4a, (b)(1)1.4a

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

Before entering the Net, the OH-58Ds let communications traffic clear and then contacted (b)(1)1.4a, who was relaying communications to JAG 25 to the north at OBJ Khod. (b)(1)1.4a initially had the aircraft hold, in the vicinity of FOB Tinsley, 15-20 KM south of the ODA CDR; with the intent of holding the aircraft out of range of enemy visual and audio detection. After approximately 15 minutes, both aircraft landed within FOB (b)(1)1.4a to conserve fuel. The aircraft departed for refuel at the Forward Arming and Refueling Point (FARP) in Tarin Kowt then returned approximately 40 minutes later. Upon their return to FOB Tinsley they again checked in with the JTAC (b)(1)1.4a

(2) (U) Around 0840-0845D (b)(1)1.4a requested the aerial scout weapons team move to a grid that was plotted by (b)(1)1.4a. This plot location was vicinity of the three vehicle convoy that was later engaged. The OH-58Ds identified the target vehicles by picking up visual description and confirmation of the vehicles moving south from the assigned grid location. (b)(1)1.4a confirmed vehicles identification. The OH-58Ds then contacted (b)(1)1.4a (b)(1)1.4a confirmed PID as validated by (b)(1)1.4a and passed the ODA CDR's intent to engage those vehicles. Aircraft 1 (b)(1)1.4a engaged and struck the first vehicle with a Hellfire missile while aircraft 2 (b)(1)1.4a struck the trail vehicle with a single Hellfire missile. The aircraft then returned to target and Aircraft 2 (b)(1)1.4a then engaged but near-missed the middle vehicle with a Hellfire. Both aircraft returned once again and engaged the fleeing vehicle occupants with 2.75" HE folding fin aerial rockets. The helicopter pilots then observed personnel fleeing the vehicles with brightly colored clothing. Suspecting that these were women, the helicopters ceased the engagement.

e. (U) Was the use of force in accordance with the Rules of Engagement (ROE)?

(1) (U) United States Forces in Afghanistan, such as ODA (b)(1)1.4a which are not designated NATO OPCON to ISAF operate under CJCS Standing ROE (CJCSI 3121.01B, 13 JUN 05), CENTCOM theater specific ROE (CENTCOM 081600ZNOV95) and OEF ROE Serial I MOD 002. See USFOR-A FRAGO 10-078. The vehicles were engaged under self-defense rules outlined in CJCS Standing ROE. In accordance with the SROE, unit commanders always retain the inherent right and obligation to exercise unit self-defense in response to a hostile act or demonstrated hostile intent. A hostile intent is the threat of imminent use of force against the United States, US forces or other designated persons or property. The determination of whether the use of force against US forces is imminent will be based on an assessment of all facts and circumstances known to US forces at the time and may be made at any level. Imminent does not necessarily mean immediate or instantaneous. As part of the determination of hostile intent, a soldier or commander must determine, with a reasonable degree of certainty, that the person or object represent a legitimate military target. This is referred to as Positive Target Identification or PID. CENTCOM ROE dictates that PID must be established and maintained or re-established prior to engagement, however, PID requirements do not remove or detract from a commander's responsibility and authority to take reasonable action in response to hostile acts or demonstrated hostile intent. (CENTCOM PID Policy, Book, Exhibit C)

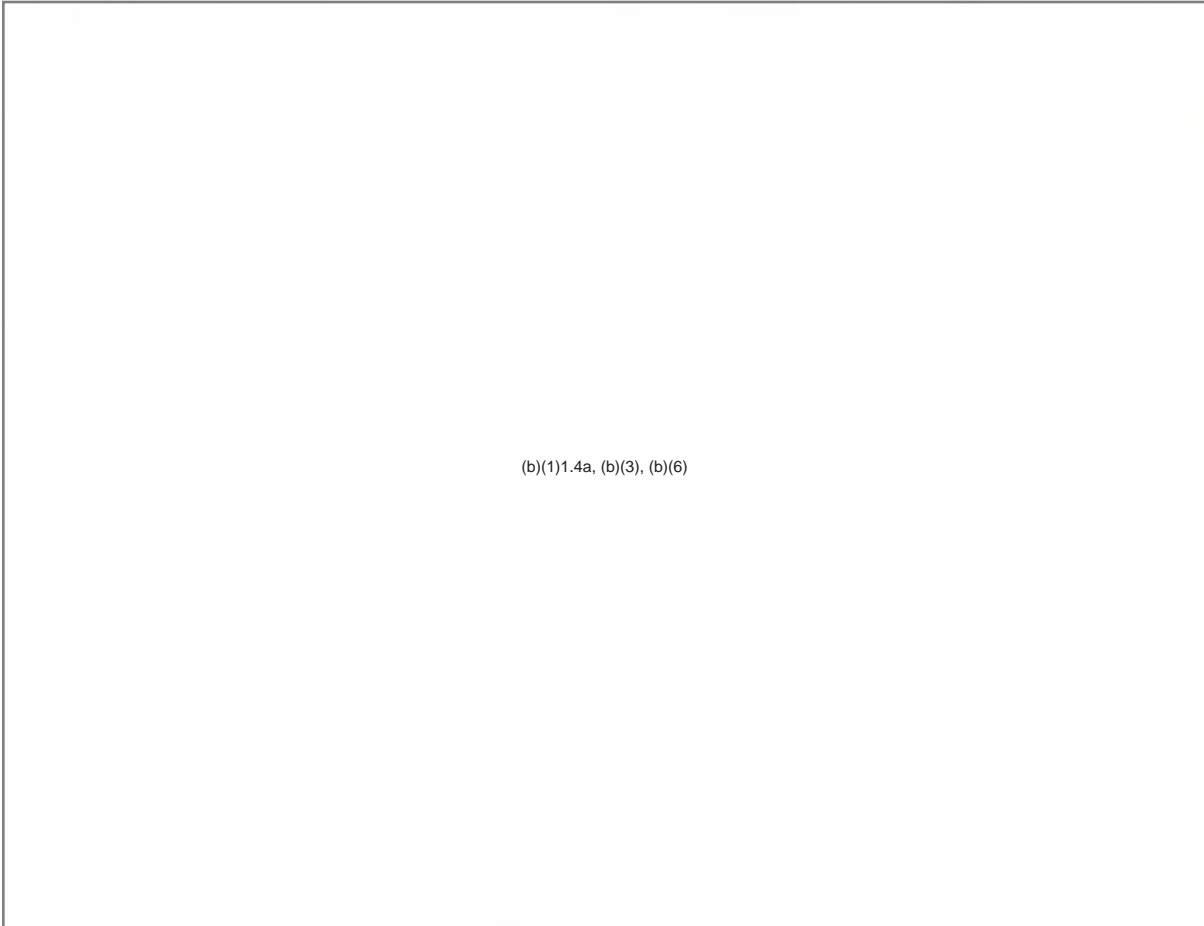
(2) (U) As discussed more fully below, a reasonable determination as to each of these criteria was developed early on in the engagement but additional information was gained that should have led a reasonable person to question each of these determinations. At the time the vehicles were struck, the Commands had sufficient information to conclude that the vehicles were not demonstrating a hostile intent and did not represent an imminent threat.

SUBJECT: AR 15-6 Investigation, 21 February 2010 CIVCAS incident in Uruzgan Province

Neither the command posts within any of the tactical commands, nor the Predator crew, relayed the facts accurately to the ground commander which would have provided him the necessary information to make an informed decision.

(3) (U) The ODA CDR acted in a reasonable belief that each of the criteria for a self-defense engagement existed. During his initial interview, the ODA CDR, CPT (b)(3), (b)(6) indicated that there were two reasons for his decision to engage. CPT (b)(3), (b)(6) stated that he engaged because he believed the vehicles were attempting to flank his force and thus represented an imminent threat to his force and that he considered the possibility that the vehicles were the personal security detail for a high value individual (HVI) and were attempting to flee. The latter determination would have required a collateral damage estimate and approval from a strike approval authority. I find by a preponderance of the evidence that the ODA CDR engaged primarily based on a belief that the vehicles represented an imminent threat to the forces under his command. Key information that would have led to a reevaluation of that determination was not accurately conveyed to the ODA CDR and were not noticed or acted upon by the operations centers at the SOTF (b)(1) and CJSOTF-A levels.

f. ~~(S)~~ Did the U.S. properly identify hostile intent/hostile actions before employing force? If so, what were the facts that were used to establish hostile act/intent? If not, why not?



(b)(1)1.4a, (b)(3), (b)(6)

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(3) (U) While the initial determination of hostile intent by the ODA CDR/JTAC was reasonable, subsequent information should have led to a reexamination of that decision. The vehicles began approximately five kilometers from the objective and moved West and South until they were engaged approximately twelve (12) kilometers from the Village of Khod. While the movement away could have been consistent with the perceived flanking maneuver, the movement was also consistent with civilians moving through the area. At the time they were struck, the vehicles had passed the most likely avenues of approach back to OBJ Khod. The Screeners in Florida were only able to identify three weapons in over three and a half hours of observation. At 0539D, 0540D, and 0547D, the Screener identified a child or two children in the vicinity of the SUV. However, when later queried by the ODA JTAC about whether we are talking “teenagers or toddlers” (b)(1)1.4a Log, Book 5, Exhibit X) the Predator crew goes back to the Screeners, who clarify that the children are “adolescents.” Although the Screener stated during questioning that to her an adolescent is seven to twelve years old (b)(3), (b)(6) Book 4, Exhibit 14), the Predator operator assumes she means a teenager and passes teenager to the JTAC. (b)(1)1.4a Log, Book 5, Exhibit X). Additionally, despite several queries from the JTAC regarding the demographics of the vehicle occupants, the Predator crew never informs the JTAC and ODA CDR that they have not observed the occupants of the third vehicle joining the convoy and thus had never positively identified the age and gender of the occupants.

(4) (U) The movement away from the objective, the bypassing several routes back to the Khod objective area, the low number of weapons positively identified, the failure to identify the occupants of the final vehicle and the observation of children, perhaps as young as seven years-old should have caused a reevaluation of the target. Both the SOTF (b)(1)1.4a Command Post and the CJSOTF-A JOC possessed all the information necessary to make that reevaluation, but failed to piece the information together in a timely manner. I find that the ODA CDR acted reasonably based on the challenges he was dealing with and the information available to him. However, leaders at both command posts, with the ability to focus on the target and review chat logs, should have re-examined whether the vehicles were exhibiting hostile intent prior to engaging the target.

g. ~~(S)~~ What were the acts that led to the strike? Were the escalation of force (EOF) procedures for targeting followed? Who determined that the vehicles exhibited hostile intent?

(b)(1)1.4a, (b)(3), (b)(6)

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(b)(1)1.4a, (b)(3), (b)(6)

(3) (U) Ineffective SOTR (b)(1)1.4a Operations Center.

(a) (U) The SOTR (b)(1)1.4a Operations Center was not fully engaged in the fight as they did not have any active situational awareness of the operation or the possible vehicle interdiction. CPT (b)(3), (b)(6) the night Battle Captain, stated that his role was more passive than active. As such, the operations center was only monitoring the situation as it developed versus providing command and control. Combined with this passive role, the ODA commander was not required to provide regular reports to the Operations Center, but instead, the ODA CDR was expected to manage all tasks as well as conduct the mission.

(b) (U) Captain (b)(3), (b)(6) the SOTR (b)(1)1.4a Battle Captain during the time leading up to the engagement, was not trained on proper procedures or management of engagements for the team. He had only been assigned as a Battle Captain for a little less than three weeks at the time of the engagement, and had not been fully trained on the SOP's for what happens in situations such as the one that developed on 21 February 2010. Immediately after the shift change, the day Battle Captain, CPT (b)(3), (b)(6) called for the Judge Advocate, CPT (b)(3), (b)(6) and began to develop situational awareness.

(c) (U) The inexperience of CPT (b)(3), (b)(6) led to his lack of understanding of his role and may have contributed to his lack of effort to fully be engaged in the fight from a command and control perspective. This was a critical oversight by his more senior leaders as well as the non-commissioned officers who worked with him. The SOTR (b)(1)1.4a S3, MAJ (b)(3), (b)(6) stated that CPT (b)(3), (b)(6) skills as a Battle Captain were "rudimentary." In essence, his chain of command put the most junior, least trained person in a position of responsibility without proper support and training during ongoing operations.

(d) (U) All three experienced Field Grade Officers, LTC (b)(3), (b)(6) (CDR), MAJ (b)(3), (b)(6) (XO), and MAJ (b)(3), (b)(6) (S3) were on the same battle rhythm or daily cycle so that all three were asleep during the critical hours of operations. While each expressed that they were working 16-18 hours per day, when the missions were being executed, there were no senior leaders available for consultation as all were asleep between the hours of approximately 0200 and 0730. (LTC (b)(3), (b)(6) Book 4, Exhibit 2; MAJ (b)(3), (b)(6) Book 3, Exhibit 25)

(e) (U) The SOTR (b)(1)1.4a Operations Center lacked Commander's Critical Information Requirements linked to Battle Drill execution. CPT (b)(3), (b)(6) and the other personnel on duty the night and early morning of the actions did not execute the battle drills as set forth by (b)(3), (b)(6) The day Battle Captain, CPT (b)(3), (b)(6) did execute the battle drills upon his assessment of the situation by immediately consulting with the Judge Advocate, CPT (b)(3), (b)(6) assigned to the SOTR (b)(1)1.4a CPT (b)(3), (b)(6) believed the vehicles to be a hostile force representing a threat to the ground force but questioned whether striking the target would be consistent with the tactical directive. (CPT (b)(3), (b)(6) Book 4, Exhibit 9) CPT (b)(3), (b)(6)

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assessment was made in less than 30 minutes from his entry onto the JOC floor. CPT (b)(3), (b)(6) assessment was that the vehicles represented an imminent threat, as that term is defined in the SROE, but not an immediate threat; therefore, based on the Tactical Directive he recommended a non-lethal response. (CPT (b)(3), (b)(6) Book 3, Exhibit 7) The SOTI (b)(1)1.4a CDR, LTC (b)(3), (b)(6) was not awakened until the Command Post received a call from the CJSOTF-A CDR, COL (b)(3), (b)(6). Colonel (b)(3), (b)(6) did not order a lethal strike on the vehicle, but said "we got PID but this element is moving to reinforce. I don't want to wait until they are on top of our guys or the village where now we risk the potential of CIVCAS and reinforcement in containment of our guys." (COL (b)(3), (b)(6) Book 3, Exhibit 4). While COL (b)(3), (b)(6) explained that he was merely indicating that if the target was to be engaged, it should be engaged away from the village of Khod; he took no steps to determine where the vehicles were currently located, the direction they were travelling, or what route the vehicles could take to reach the objective. (COL (b)(3), (b)(6) Book 3, Exhibit p. 6,7). (b)(3), (b)(6) interpreted this as guidance to put lethal fires on the target. (LTC (b)(3), (b)(6) Book 4, Exhibit 2, p. 18). Despite the guidance, LTC (b)(3), (b)(6) previewed the tactical situation and received (b)(3), (b)(6) advice and decided to engage using non-lethal force. LTC (b)(3), (b)(6) decision was reached in less than 20 minutes from his being awakened up by CPT (b)(3), (b)(6). However, these assessments and employment of non-lethal forces could have occurred at any time in the almost four hours that the vehicles had been watched by the prior shift.

(b)(1)1.4a

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(b)(1)1.4a, (b)(3), (b)(6)

1 (U) No one agreed on the definition of an adolescent. The Screener, SrA (b)(3), (b)(6), when asked "Is adolescent a different call out then child or children?" responded "I think it varies from Screener to Screener. One Screener may be more comfortable with calling out adolescent. It is very difficult to tell. I personally believe an adolescent is a child, an adolescent being a non-hostile person." (SrA (b)(3), (b)(6) Book 4, Exhibit 15). He stated he believed an adolescent to be 9-14 years-old (SrA (b)(3), (b)(6) Book 4, Exhibit 15). SrA (b)(3), (b)(6) the primary Screener at the time, said she believed an adolescent to be 7-13 years-old, and "in a war situation they're considered dangerous." (b)(3), (b)(6) Book 3, Exhibit 14, Page 5)

2 Despite lacking a common definition for "adolescent" the Screeners changed their initial call at 0837D, stating the "*2 children were assessed to be adolescents (sic) and they were last seen in the dark toned w/ white top SUV." (b)(1)1.4a Log, Book 5, Exhibit X). The * indicates a corrected assessment. (SrA (b)(3), (b)(6) Book 4, Exhibit 15). Ultimately, the distinction between children, adolescents and MAMs disappeared. The Predator crew immediately before the strike was ordered, only identified military capable war-fighting age males as being on the convoy. (Kiowa Radio Traffic, Book 2, Exhibit CC). During the target handoff between the Predator and the OH-58Ds, the Predator confirmed that they had PID'd a minimum 3 weapons, 21 MAMs and have not lost PID they are continuing to observe these vehicles as well. (Kiowa Radio Traffic, Book 2, Exhibit CC).

(e) Additionally, on several occasions the Predator crew identified weapons on their own, independent of the screener's assessment. At 0511D the Predator pilot makes a radio call to (b)(1)1.4a and says "we are eyes on the first vehicle; observing to try and PID on the pax in the open" and then on internal intercom he says to the crew "I bet; DGS (Distributed Ground Station) is not calling anything for us, right?" They prompted the screeners in mIRC to let them know if they PID any weapons, but at 0518D, the screeners reported that they could not confirm any weapons. At 0529D the Predator pilot states to the crew "does it look like he is hold'n something across his chest. It's what they've been doing here lately, they wrap their *expletive* up in their man dresses so you can't PID it." Then on the radio to (b)(1)1.4a he says "looks like the dismounted pax on the hilux pickup on the east side is carrying something, but we cannot PID what it is at this time but he is carrying something." After the Predator crew prompted them twice in mIRC, the screeners call out a possible weapon and then ask the crew to white hot to get a better look. The response from

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the sensor operator is "white hot is not going to give us anything better, that truck would make a beautiful target." The Predator pilot then at 0534D made this radio call "All players, all Players from (b)(1)1.4a from our DGS the MAM that just mounted the back of the hilux had a possible weapon, read back possible rifle." During their post strike review, the screeners determined that this was not a weapon. At 0624D the screeners called out a weapon, this was the only time that the Screeners called out a weapon without being prompted by the Predator crew. At 0655D, the Predator pilot called (b)(1)1.4a on the radio and told him that the Screeners called out two weapons. The Screeners had not made any call outs of weapons. At 0741 the Predator pilot calls (b)(1)1.4a and says " There's about 6 guys riding in the back of the highlux, so they don't have a lot of room. Potentially could carry a personal weapon on themselves." Again, no call out from the screeners, this is his own opinion.

(f) (U) The Predator crew used the term "PID" to mean positive identification of an object rather than as used in the Rules of Engagement to mean positive identification of a target. For example, at 0512D, (b)(1)1.4a states, "We are eyes on a vehicle, personnel in the open, definite tactical movement, cannot PID weapons at this time, how copy?" (b)(1)1.4a Log, Book 5, Exhibit X). The Predator Safety Observer, Capt (b)(3), (b)(6) described PID as "Positive identification. A reasonable certainty, whatever you think it to or what you're calling it out to be and you continue to maintain PID." Positive identification of weapons is neither required nor sufficient for PID. During the target handover with the OH-58Ds PID of weapons is passed rather than a true positive identification of the vehicles as a legitimate military target. At 0845D, (b)(1)1.4a (call sign of OH-58Ds) confirms visual contact of 3 vehicles with (b)(1)1.4a (call sign of Predator), and confirms PID of weapons. (Kiowa Radio Traffic, Book 2, Exhibit CC).

(g) (U) The Predator crew possessed a desire to engage inconsistent with evolving target actions. The pervasive theme throughout several interviews with the Predator team, and seen throughout the internal crew dialogue was the desire to go kinetic. The Captain who was supposed to act as a safety observer stated that there was a "Top Gun" mentality amongst the Predator crews. (CPT (b)(3), (b)(6) Book 4, Exhibit 20, p. 9). The Predator crews sitting safely in Creech AFB, Nevada should be a dispassionate check on forces facing a dangerous situation. Instead, the most mature voice on the radio was the JTAC, TSgt (b)(3), (b)(6) who was in harm's way on the ground.

1 Early on the AC 130 and the ODA CDR indicate a desire to destroy the vehicles based on the information available. At 0514D, the ODA JTAC passes to the Predator crew that the "ODA CDR's intent is to destroy the vehicles and the personnel." (b)(1)1.4a Log Chat, Book 5, Exhibit T, Page 7).

2 Early on when the Predator crew is talking about engaging the target based on a possible weapons sighting, TSgt (b)(3), (b)(6) responds "we notice that but you know how it is with ROEs, so we have to be careful with those, ROE's." In contrast the Predator crew acted almost juvenile in their desire to engage the targets. When the Screeners first identified children, the Predator Sensor responds "bull sh*t, where?" The Predator Pilot than follows with "at least one child... Really? assisting the MAM, uh, that means he's guilty//Yeah review that (expletive deleted)...why didn't he say possible child, why are they so quick to call (expletive deleted) kids but not to call (expletive deleted) a rifle." (b)(1)1.4a audio log, Book 5, Exhibit T). At 0539D, The Predator sensor operator says on internal comms "I really doubt that children call, man I really (expletive deleted) hate that." at 0557D he states,

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"I want this pickup truck full of dudes," and at 0832D he say one guy fires the laser. Everybody else, buddy lazes for everybody else. And they all just go ... and if they all fired roughly simultaneously... and it rains freakin' Hellfires all over them, that would be bad ass, But... we're not killers, we are ISR (b)(1)1.4a audio log, Book 5, Exhibit T).

3 At 0513D (b)(1)1.4a asks if there are any tubes or cylindrical object carried by the individuals getting off the truck. The Predator crew passed that to the Screeners who made no note of seeing anything. The Predator crew continued to discuss internally and at one point, one of the individuals indicated that the only place the mortar could be was in the back of the SUV, which would give them a chance to shoot. "[H]ope we get to shoot the truck with all the dudes in it//Yea the only way I could see like a mortar or something would be like in that last SUV cause there's not a lot of people in it, vs. the truck//see anything in the back of that truck ..." The response to this chatter was "[W]hen we first put eyes on this group they were loading a duffle bag size object in the back of the SUV." (b)(1)1.4a Log, Book 5, Exhibit X).

(5) (U) Lack of understanding of the Tactical Directive. The US Standing Rules of Engagement allow for engagement in self-defense whenever a force represents an imminent threat. There is no requirement that the threat be immediate and engagement can be initiated at any level of command. (CJCS 3121.01B, 13 JUN 05). Throughout the command and staff at all levels, with the exception of LTC (b)(3), (b)(6) once a target was identified as an imminent threat, planning began for a kinetic strike. (COL (b)(3), (b)(6) Book 3, Exhibit 4). However, COMISAF/COMUSFOR-A's guidance in the Tactical Directive is to limit civilian casualties by avoiding lethal force when possible. (Tactical Directive, Book 2, Exhibit D). Virtually everyone we spoke with recognized the need to strike away from compounds or other areas which could lead to collateral damage, but LTC (b)(3), (b)(6) was the only commander to express a desire for non-lethal force. (LTC (b)(3), (b)(6) Book 4, Exhibit 2).

(6) (U) Poor target hand-off between Predator and the OH-58D crew also led to the strike. When the OH 58's came on station and were identifying the potential target, the Predator crew did not mention children or adolescents at the target site. Instead, the Predator crew only identified PID of military age males, weapons and tactical maneuvering, as well as, the location of the target. Once the OH-58D crew engaged and individuals with bright colored clothing (possible females) were seen, they broke off of the engagement as this conflicted with the PID that they were told.

(b)(1)1.4a, (b)(3), (b)(6)

(a) (U) The ODA CDR was overly tasked with all of the duties and responsibilities outside of conducting mission on the objectives due to SOTF (b)(1)1.4a and CJSOTF-A C2 nodes not providing C2 support. He was responsible for the OH-58Ds, AC-130 Intel, and Predator analysis as well as the close fight in the vicinity of objective KHOD. As the Ground Force Commander, his first priority is to move towards the objective and execute the mission, with minimal danger to the men under his command. The objective for Operation Noble Justice was an open bazaar to cordon and search, as well as, to detain multiple people for questioning. He had one team in the bazaar and two over-watch elements

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on the high ground which he was coordinating, as well as moving through the town. All of these elements plus analyzing information from the AC 130 and the Predator, and coordination of close air support including the movement of the OH-58Ds was an oversaturation of responsibilities. This is especially true as he was forced to monitor the vehicle's movement, as well as, the helicopters' movements in areas that were several kilometers outside of the immediate objective area.

(b)(1)1.4a, (b)(3), (b)(6), (b)(1)1.4g, (b)(1)1.4c

(c) (U) The ODA CDR exhibited good initial situational awareness and/or situational understanding but was unable to properly develop and refine the target or determine threat intent. He was unable to refine the target due to the myriad of tasks being executed; synchronize the USAF aircraft, integrated the AC130, integrate the intelligence platform from the AC130 into the ground picture, synchronized the kinetic capability of the Predator, integrate the intelligence capability of the Predator, integrate and synchronize the OH58Ds, while fighting the close fight. Simply stated, no command and control headquarters above the ODA provided any input or support.

h. ~~(S)~~ Was Positive Target Identification (PID) established? If so what facts provided the PID?

(b)(1)1.4a, (b)(1)1.4c

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(b)(1)1.4a, (b)(1)1.4g, (b)(1)1.4c, (b)(3), (b)(6)

(3) (U) While the initial determination of PID by the ODA CDR was reasonable, subsequent information should have led to a reexamination of that PID declaration. The Screeners in Florida were only able to identify three weapons over the entire three and a half hours of monitoring the vehicles. Additionally, two children or adolescents were observed. As discussed above, the Screeners could not determine that these were, in fact teenagers. [redacted] (b)(3), (b)(6) Book 4, Exhibit 14, page 4). When the final vehicle entered the convoy [redacted] (b)(1)1.4a assessed their hostility with the statement "guilty by association." [redacted] (b)(1)1.4a Log, Book 5, Exhibit X). The Predator never passed suspected or confirmed children or adolescents when describing the occupants of the vehicles to the OH-58D crews. (Kiowa Radio Traffic, Book 2, Exhibit CC). The inattentiveness of the SOTF [redacted] (b)(1)1.4a and CJSOTF-A Operations Centers and the slanted presentation of information by the Predator pilot led to a failure to reexamine the PID determination. I find that the ODA CDR acted reasonably based on the information available. However, leaders at both operations centers, with the ability to focus on the target and review chat logs, should have reexamined the PID determination prior

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to engaging the target. At a minimum, the presence of children required a proportionality analysis to determine the lawfulness of the target.

i. ~~(S)~~ Did the occupants of the vans present an imminent threat to any U.S. or coalition forces, or civilians? Who made the determination that it was necessary to engage the vans?

(b)(1)1.4a, (b)(1)1.4c

(2) (U) As with PID, the initial determination of an imminent threat by the ODA CDR was reasonable, but subsequent information should have led to a reexamination of that determination by the operations centers monitoring. The vehicles began approximately five (5) kilometers north of the objective and moved west and south until they were engaged approximately twelve (12) kilometers from the Village of Khod. While the movement away could have been consistent with the perceived flanking maneuver, the movement was also consistent with civilians moving through the area. At the time they were struck, the vehicles had passed the most likely avenues of approach back to OBJ Khod. The Screeners in Florida were only able to identify three weapons in over three and a half hours of observation. At 0539D, 0540D, and 0542D, the Predator Screener identified a child or two children in the vicinity of the SUV. However, when queried by the ODA JTAC about whether we are talking “toddlers or teens” the Predator crew goes back to the Screeners, who clarify that the children are “adolescents.” Although the Screener stated during questioning that to her an adolescent is 7-13 years old, the Predator operator assumes she means a teenager and passes teenager to the JTAC. Additionally, despite several queries from the JTAC regarding the demographics of the vehicle occupants, the Predator crew never informs the JTAC and ODA CDR that they have never observed the occupants of the third vehicle to join the convoy.

(3) (U) The movement away from the objective, the bypassing of the most likely routes back to the objective, and the low number of weapons positively identified should have led to a reevaluation of the imminence of the threat. Additionally the presence of children, while not ruling out that the force represented an imminent threat, was evidence that the force was most likely not, in fact, moving to reinforce insurgents near the objective. Both the SOTF (U) Command Post and the CJSOTF-A JOC possessed all the information necessary to make that reevaluation but failed to piece the information together in a timely manner. I find that the ODA CDR acted reasonably based on the information available. However, leaders at both operations centers, with the ability to focus on the target and review chat logs, should have reexamined the determination of hostile intent prior to engaging the target. Unfortunately, in this situation neither Ops Center was actively engaged in the operation.

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j. (U) What warnings were given to the Afghan Nationals, if any? If none, were any appropriate to utilize?

(U) No warnings were given to the Afghan Nationals before they were engaged. The lack of warnings is consistent with US self-defense rules where an entity exhibiting a hostile intent represents an imminent threat to a US or designated coalition force. Consistent with COMISAF/COMUSFOR-A Tactical Directive lesser means of force could have been employed. Once the SOTF (b)(1), (b)(4) CDR and Judge Advocate reviewed the target, they quickly concluded that an Aerial Vehicle Interdiction Team was the preferred course of action. The failure of the SOTF (b)(1), (b)(4) Operations Center to comprehend the tactical situation prevented the SOTF-12 CDR from being engaged in sufficient time to implement this course of action.

k. (U) What efforts were made to mitigate the risk of death or injury to other non-combatants during this firing? Is there anything more that could have been done to prevent this incident from happening?

(1) (U) Location: The engagement occurred in a location that was away from other non-combatants. As such, there would have been minimal, if any, risk of death or injury to other non-combatants.

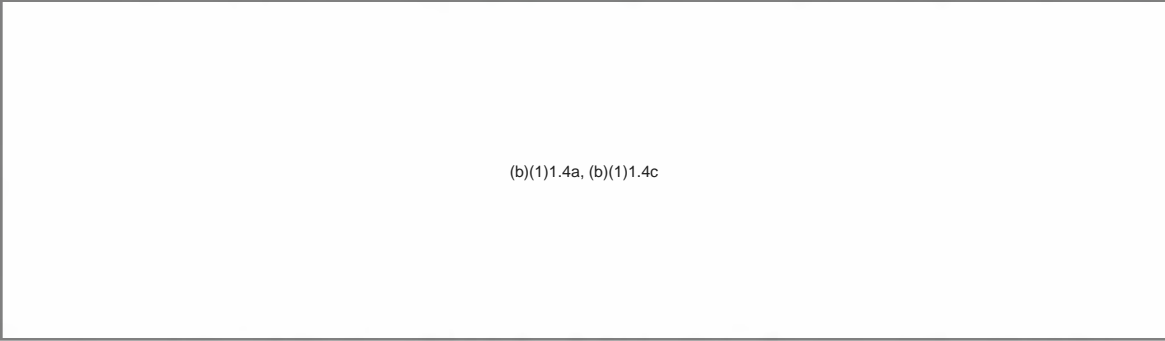
(2) (U) Targeting of Vehicles: All echelons of command were aware of the requirement to avoid a strike near a compound or other built up area. The breakdown occurred in the failure to mitigate the risk that the convoy themselves had non-combatants. The reports of "adolescents," even if they were teenagers old enough to fight, should have caused a recognition that there were non-combatants in the convoy. Throughout the encounter, all parties involved assumed that all adult males were legitimate targets and even teenagers old enough to fight were legitimate targets. For example, when asked his definition of an adolescent, TSgt (b)(3), (b)(6) replied "My definition is someone that is 15 years old, a young adult.... They are not 15 years old by American standards. I've seen them be fairly cold blooded on the battle field and I know that the insurgent forces have a lot of young men working for them, supporting the Taliban." (TSgt (b)(3), (b)(6) Book 4, Exhibit 22). While perhaps true, that does not render all fifteen year olds combatants. Even after the strike, adult males were reported as enemy killed in action despite the fact that no weapons or explosives were found. (LTC (b)(3), (b)(6) Book 4, Exhibit 2).

(3) (U) Actions that could have been done to prevent this incident from happening are contained in the recommendations section.

l. ~~(S//REL REL FVEY)~~ What intelligence, if any, did the firing unit receive that may have led them to believe the vans were hostile?

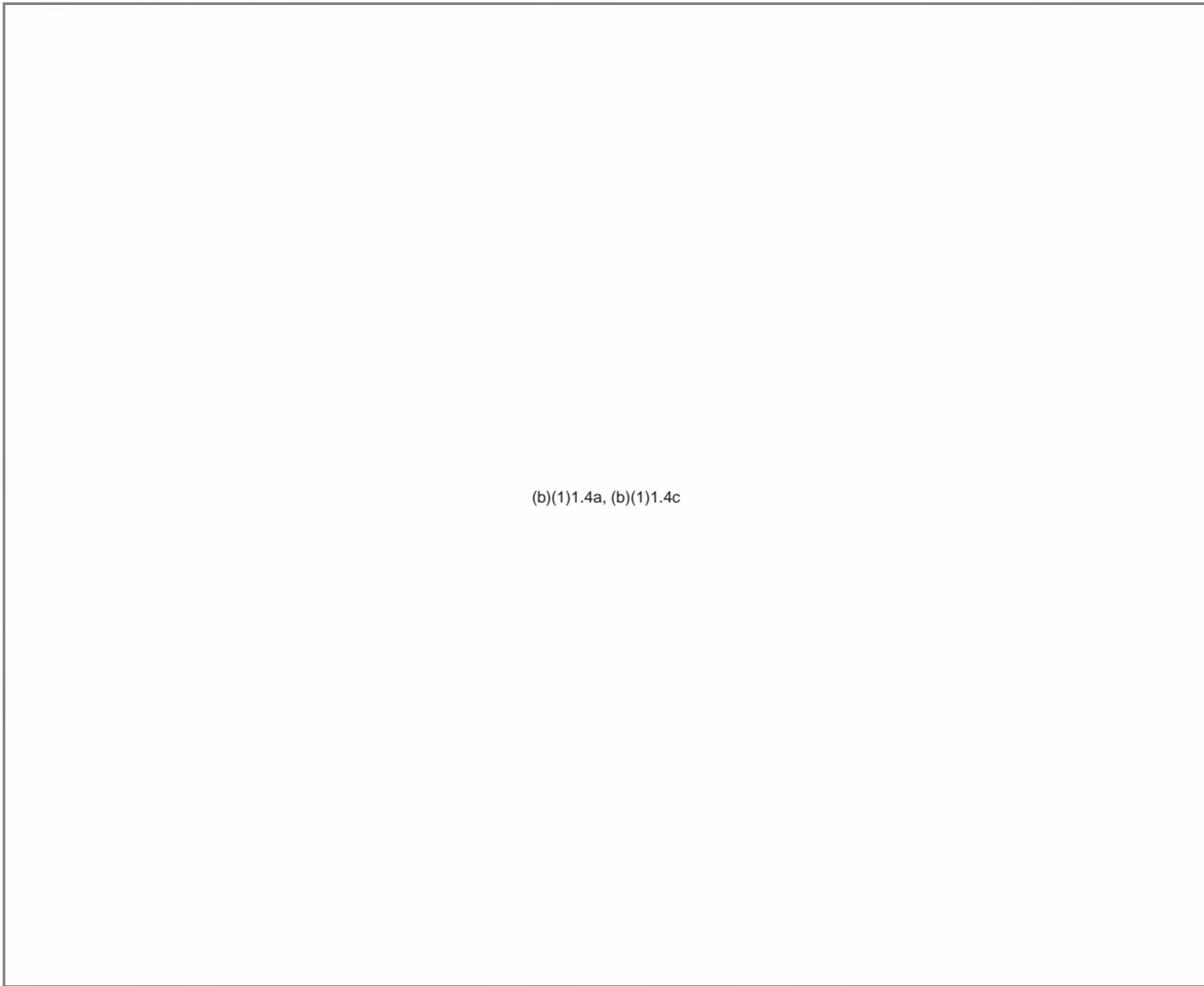
(b)(1)1.4a, (b)(1)1.4c

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(b)(1)1.4a, (b)(1)1.4c

(b) (U) Example: CJSOTF-A J2 OPS Team, PO (b)(3), (b)(6) was monitoring the mIRC Chat at CJSOTF-A HQ, but did not speak directly to the Battle Captain or JOC Chief or have a directive or training to do so when they saw mIRC chat discussing the possibility of children. (MAJ (b)(3), (b)(6) Book 4, Exhibit 21, page 9). When asked if he has to report certain things to the Battle Captain if they happen, PO (b)(3), (b)(6) responded "no." (PO (b)(3), (b)(6) Book 4, Exhibit 4).



(b)(1)1.4a, (b)(1)1.4c

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m. ~~(FOUO)~~ How many Afghan Nationals were injured in this incident? Where were those injured located during the incident, how were they injured, and by whom? What is the extent of their injuries? What medical treatment was given to the injured local nationals? Were MEDEVAC procedures used, and if not, why were they not used? Were the procedures that were used timely and appropriate under the circumstances? What steps were taken to ensure follow-on medical care?

(1) (U) There were twelve Afghan Nationals injured in the incident, 8 adult males, one woman and three children (estimated ages 5, 12 and 14).

(a) ~~(FOUO)~~ Where were those injured located during the incident, how were they injured, and by whom?

1 ~~(FOUO)~~ In the first vehicle there were three injured, no women or children. They were (b)(6) s/o (son of) (b)(6) (patient #2199), (b)(6) s/o (b)(6) (#2204) and (b)(6) s/o (b)(6) (#4225). These three were injured from the first Hellfire missile fired from (b)(1)1.4a

2 ~~(FOUO)~~ In the second vehicle there were four injured, including the woman and young child. They were (b)(6) s/o (b)(6) (# 2202), (b)(6) (#2201) (b)(6) (female) (#2200) and (b)(6) (5 year old boy)(#2203) These 4 were injured from the third Hellfire missile, the second fired by (b)(1)1.4a

3 ~~(FOUO)~~ In the third vehicle there were 4 injured, (b)(6) (b)(6) (#4224), (b)(6) s/o (b)(6) (driver) (#4226), (b)(6) s/o (b)(6) (#4227) and (b)(6) s/o (b)(6) (#4228). These 4 were injured from the second Hellfire missile, the first fired by (b)(1)1.4a

4 ~~(FOUO)~~ The final injured individual was (b)(6) (#4223) . It is not known which vehicle he was in at the time of the incident.

(b) ~~(FOUO)~~ The following chart shows the patients, the initial injuries, treatments and preliminary status :

CURRENTLY AT TK LN HOSPITAL- REQUIRE 30 MORE DAYS OF TREATMENT		
(b)(6) Patient #2200 50 y/o female	Severe Facial Trauma Right Leg Fracture, Left Pilon Fx Compartment Syndrome	Treatments to date: Initial facial surgery, fasciotomy, external fixation of right leg fracture, wounds cleaned and closed -18 MAR 10: Continues to do well, treatment is not complete, has regular follow up appointments with FST.
(b)(6) Patient #4224 28 y/o male	Left leg fracture Severe multiple fractures of left foot, Right leg laceration and soft tissue injuries	Treatments to date: Treatment of right leg soft tissue injuries, external fixation of left leg and foot, wounds cleaned and closed -18 MAR 10: Continues to do well, treatment is not complete, has regular follow up appointments with FST.

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(b)(6) Patient #4225, mid 20's male	Right leg amputation Left lower leg fracture Pulmonary Embolism- 25Feb	Treatments to date: Right leg amputation through knee, external fixation of left lower leg fracture, wounds cleaned and closed, IVC filter placement -18 MAR 10: Continues to do well, treatment is not complete, has regular follow up appointments with FST.
CURRENTLY AT TK LN HOSPITAL- TREATMENT COMPLETE- AWAITING TRANSPORTATION HOME		
(b)(6) Patient #2199 25 y/o male Ward Bed 5	Face and neck trauma Pneumothorax Multiple chest shrapnel Right arm shrapnel injury	Treatments to date: Chest surgery, removal of shrapnel, chest tube, tracheostomy, wounds cleaned and closed, wound vacuum -18 MAR 10: Had follow up appointment with TK FST, treatment complete and awaiting transport back to home village. ODB working transportation. Patient is eager to return home.
(b)(6) #2201 26 y/o male	Multiple shrapnel wounds Right wrist injury	Treatments to date: wounds cleaned and closed, wrist splint -18 MAR 10: Had follow up appointment with TK FST, treatment complete and awaiting transport back to home village. ODB working transportation. Patient is eager to return home.
(b)(6) Patient #2204 25 y/o male	Multiple shrapnel wounds Facial Trauma	Treatments to date: Wounds cleaned and closed. -18 MAR 10: Had follow up appointment with TK FST, treatment complete and awaiting transport back to home village. ODB working transportation. Patient is eager to return home.
(b)(6) Patient #4226 28 y/o male	Compartment Syndrome Left leg fracture	Treatments to date: Fasciotomy, internal fixation of fracture, wounds cleaned and closed -18 MAR 10: Had follow up appointment with TK FST, treatment complete and awaiting transport back to home village. ODB working transportation. Patient is eager to return home.
(b)(6) Patient #4223 20's y/o male	Facial burns and lacerations Inhalation injury Fractured thumb	Treatments to date: Wounds cleaned and closed. -18 MAR 10: Had follow up appointment with TK FST, treatment complete and awaiting transport back to home village. ODB working transportation. Patient is eager to return home.
(b)(6) Patient #2203 5 y/o male	Left lower leg amputation Multiple shrapnel injuries	Treatments to date: Amputation at left ankle, wounds cleaned and closed -18 MAR 10: Had follow up appointment with TK FST, treatment complete and awaiting transport back to home village. ODB working transportation. Patient is eager to return home. Patient's family declined assistance with prosthetic limb. They want to return home and will make own arrangements for prosthetic. Family was counseled on this, they understand options, but choose to make their own way to Kabul in the future. They understand that ICRC will assist with prosthetic in Kabul when they are ready.
(b)(6) Patient #2202 22 y/o male	Gluteal trauma Right ankle fracture Left leg amputation	Treatments to date: Left below the knee amputation, wounds cleaned and closed -18 MAR 10: Had follow up appointment with TK FST, treatment complete and awaiting transport back to home village. ODB working transportation. Patient is eager to return home. Patient declined assistance with prosthetic limb. He wants to return home and will make own arrangements for prosthetic. Patient was counseled on this, understands

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		options, but chooses to make own way to Kabul in the future. He understands that ICRC will assist with prosthetic in Kabul when he is ready.
TREATMENT COMPLETE- RETURNED HOME		
(b)(6) Patient #4227 14 y/o male	Left lower limb shrapnel	Treatments to date: Wounds cleaned and closed. 8 MAR 10: All treatments complete, returned home to village.
(b)(6) Patient #4228 12 y/o male	Lower leg fractures Tendon rupture Multiple lacerations	Treatments to date: Wounds cleaned and closed, both legs splinted 8 MAR 10: All treatments complete, returned home to village.

As of 01 APR 10 eight of twelve patients along with 5 family members have been transported to Kabul. Four patients elected not to travel to Kabul. ISAF transported the patients and their families to TK where an ANA fixed wing aircraft transported them to Kabul. Dr. (b)(6) is the local TK Doctor who coordinated for their care. The patients are in the Sardar Mohammed Daud Khan Hospital in Kabul. Dr. (b)(6) stated that some of the patients will be going to India for treatment and others will stay in Kabul for an extended time. Dr. (b)(6) is working directly for President Karzi and is taking his job very seriously. Dr. (b)(6) also stated that it is his responsibility to coordinate all the moving pieces with GIRA. USAID will assist with transportation back to TK. No timeline is set for return since medical care may vary for each patient.

(c) (U) Were MEDEVAC procedures used, and if not, why were they not used?

(U) Yes, all twelve individuals were MEDEVACed from the strike site. Six were taken to the US FST and six were taken to the Dutch Role II hospital.

(d) (U) Were the procedures that were used timely and appropriate under the circumstances?

(U) There was almost a four hour delay between the engagement and any US forces arriving "boots on the ground" at the strike site. Once they arrived and established security the team immediately administered first aid and called for MEDEVAC. The almost four hour delay before having anyone on the ground to conduct 1.4a, (b)(6) and care for the wounded was not in accordance with the Tactical Directive of 1 July 2009 which indicates that a Battle Damage Assessment be conducted within two hours following the employment of any air-to-ground or indirect fires, to include self-defense. Once the team did arrive on the ground, they acted quickly and cared for and evacuated the injured.

(2) (U) What steps were taken to ensure follow-on medical care?

(a) (U) The remaining patients are being cared for by the local TK hospital and will continue follow up care with the TK FST until their wounds are fully healed (approximately 6 weeks). The FST will also help coordinate prosthetics for the three (3) amputees though USAID and ICRC prosthetic lab in Kabul (also done in 6 weeks). The AOB medic is serving as patient advocate and helping coordinate transport to and from

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appointments. All patients will be taken back to their village when all medical requirements are met. All injured/treated have communicated with family members. Injured/treated have available resources at local hospital to conduct on-going communications with family members.

(b) (U) Long term care is a combination of medical follow-ups and employment of USAID facilitated Afghan Civil Assistance Program help. Our relationships with the patients are quite strong and they remain remarkably forgiving and accepting of this event, and thankful for the sustained medical attention / care.

(c) (U) Prosthetics will be coordinated for the three amputees when they are medically able to be fitted for the devices. LCDR (b)(3), (b)(6) works closely with a United States Agency for International Development (USAID) representative that has connections with the International Committee of the Red Cross (ICRC) prosthetics in Kabul. Patients requiring prosthetics will be placed on Non-Governmental Organization (NGO) ring flights from TK to Kabul to have that work done after that six week post-op visit. So, in five to six weeks, nine of twelve patients will be home and three should be ready for prosthetic limbs

n. (U) How many Afghan Nationals were killed in the incident? What are the names of the individuals that were killed and what are the names of the individuals wounded? Is there any evidence that any of the individuals killed or wounded were associated with Anti-Afghan Forces?

(1) (U) How many Afghan Nationals were killed in the incident?

(U) According to the (b)(6) team, there were 15-16 Afghan Nationals killed in the incident. There were no women or children killed in the incident. The catastrophic nature of the strike makes an exact determination of the number killed impossible. Although the BDA at the strike site indicated 15-16 killed, the village elders identified 23 men who were killed and claims were paid to the families of all 23 identified by the elders as killed.

(2) ~~(FOUO)~~ What are the names of the individuals that were killed?

~~(FOUO)~~ The following individuals were identified by village leaders as killed in the strike:
Dawood s/o (b)(6) Ghulam Nabi s/o (b)(6) Sima s/o (b)(6) Entezar s/o
(b)(6) Sebqutullah s/o (b)(6) Merza s/o (b)(6) Sarwar s/o (b)(6)
(b)(6) Wali jan s/o (b)(6) Neyamahillah s/o (b)(6) Abas s/o (b)(6) Gulestan
s/o (b)(6) Muhammad s/o (b)(6) Yoonus s/o (b)(6) Efadar s/o (b)(6) Dawood s/o
(b)(6) NAHMAT s/o, (b)(6) s/o, (b)(6) s/o (b)(6) Nasim/o (b)(6)
Qahraman, Narenj s/o (b)(6) Muhammad s/o (b)(6) Ali Yawar s/o (b)(6) Gul ya s/o
(b)(6)

(3) ~~(FOUO)~~ What are the names of the individuals wounded?

~~(FOUO)~~ The names of the wounded were (b)(6) (patient #2199),
(b)(6) (#2204), (b)(6) (#4225) (b)(6)
(b)(6) (# 2202), (b)(6) (#2201), (b)(6) (#4224), (b)(6)
(#4226), (b)(6) (#4227), (b)(6) (#4228),
(b)(6) (#4223), (b)(6) (female) (#2200), and (b)(6) (5 year old boy)(#2203). The

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following individuals were identified as being in the vehicles, however, we do not know if they were killed or left the scene uninjured. The individuals in the first vehicle were (b)(6)

(b)(6)
The individuals in second vehicle were (b)(6) with his four children (including (b)(6) who was injured), (b)(6) (female), (b)(6) (female) and (b)(6) (female). The individuals in the third vehicle were (b)(6)

(b)(6) There are also six individuals for whom we do not have a name. We do not know how many of the six named above were killed and how many left the scene.

(4) (U) Is there any evidence that any of the individuals killed or wounded were associated with Anti-Afghan Forces?

There is no evidence that any of the individuals killed or wounded were associated with AAF; however, one of the wounded individuals interviewed indicated at one time that he was not sure if there were Taliban elements in the convoy.

o. (U) Were solatia or CERP condolence payments made? If not, would such payments be appropriate? What actions have the chain of command taken with regard to contacting or caring for the wounded? What actions have the chain of command taken to mitigate the negative impact of this incident with local community leaders?

(1) (U) Have solatia or condolence payments been made? If not, are they appropriate?

(U) Condolence payments were made by SFC (b)(3), (b)(6) (CA Staff NCOIC) for individuals who were injured, killed, and/or damaged equipment. Identification of family members of the deceased was made with assistance of the village elders. Additional claims made during OPERATION Rebuild Hope were paid for injury or death in lieu of disputing the claim by SOTF (b)(1), (b)(6) forces. Payments were made as follows:

(a) (U) 23 death payments made to surviving family members as identified by village elders. \$5,000.00 per death was paid to surviving family member. Total: \$115,000.00.

(b) (U) 15 injured claims were paid at \$3,000.00 per claim. Total: \$45,000.00

(c) (U) Reimbursement for three (3) destroyed vehicles was paid to the surviving family members at \$5,000.00 per vehicle.

(d) (U) Condolence payments were made under USFOR-A CERP SOP.

(e) (U) Form listing payees and their signatures/mark and a re-typed by name list is attached. (Exhibit Condolence Payment List)

(f) (U) Total condolence funds paid: \$175,000.00.

(g) (U) Each family member of the deceased was also given one goat as a sign of respect/condolence under local village tradition.

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(h) (U) Payments were made in Afghani currency. Final conversion amount may vary slightly from final dollar amount.

(i) (U) All dead were buried near the village of Kandu-Ye-Bala (41S QS 4150 7400) and the village of Bagh Ban (41S QS 5590 7910), Kajran District, DayKundi Province.

(2) (U) What has the chain of command done in terms of contacting or caring for the wounded?

(a) (U) Background: All wounded personnel received lifesaving and stabilizing care by SOTF-12 personnel at the point of injury. Six (6) patients were then transported to the US FST at Tarin Kowt (TK) and six (6) patients were evacuated to the Dutch Role 2 at TK. Four (4) of the 12 patients had significant wounds and were further evacuated to the Role 3 at Kandahar Airfield (KAF). The remaining eight (8) Patients at TK facilities received definitive treatment for their injuries and were transferred to the Local National (LN) Hospital in TK to begin convalescent care and recovery. The four (4) patients sent to KAF received definitive treatment for their wounds and were transferred back to the TK US FST before being transferred to the TK LN Hospital.

(b) (U) Current Situation: All remaining patients are collocated at the TK LN Hospital. The TK US FST is conducting regular follow up appointments with the wounded to ensure that their wounds are healing well. Two of the patients have fully recovered and are back in their home village. The other ten (10) patients will continue follow up with TK US FST until their wounds fully heal (Approx. 6 Weeks). The FST will also help coordinate prosthetics for the three (3) amputees through USAID and the ICRC prosthetic lab in Kabul (Also done at 6 weeks). All patients have received top notch care since the incident and will continue to receive the same level of care until they are cleared by US medical providers.

(c) (U) SOTF (b)(1), (4) Actions:

(U) - Phase 1: Immediately following the time of hospitalization, the SOTF (b)(1), (4) CDR assigned the SOTF (b)(1), (4) Surgeon to serve as patient advocate and liaison and directed the surgeon to provide daily patient reports to the CDR and the assigned project officer. For patients that remained at TK, the SOTF (b)(1), (4) CDR directed AOB CDR and Medic to conduct daily rounds with patients and report to SOTF (b)(1), (4) twice daily. While on Fire Base facilities, AOB medic met with patients daily and assisted US FSE and Dutch Role 2 with patient care. The SOTF (b)(1), (4) Surgeon discussed care directly with FSE and Dutch Role 2 twice weekly. Following definitive surgical treatment, patients were transferred to the LN Hospital for convalescent care with scheduled follow up appointments with the FSE and Role 2. The AOB medic coordinated transfer of patients to and from their follow up appointments and assisted with treatment. The AOB medic contacts the TK LN hospital daily to obtain patient status and progress and report findings to the SOTF (b)(1), (4) CDR. He continues to coordinate follow up appointments. For the patients that were transferred to KAF Role 3, the SOTF (b)(1), (4) Surgeon served as liaison between medical providers and facilitated patient transfer to Role 3. The SOTF (b)(1), (4) Surgeon conducted daily patient rounds with KAF Role 3 physicians and visited patients twice a day. The SOTF (b)(1), (4) CDR visited patients on hospital ward twice weekly. He discusses their well being and satisfaction with care. The SOTF (b)(1), (4) Surgeon has developed long term treatment with the KAF Role 3 and TK FSE providers. The patients desired transfer closer to home so the SOTF (b)(1), (4) Surgeon coordinated treatment plan at TK

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and facilitated that movement. The SOTF (b)(1), (b)(4) Surgeon will assist the TK FSE and Dutch Role 2 with continued treatment and will help coordinate movement to Kabul for those requiring prosthetics 6 weeks following last surgery. After completion of medical care, SOTF (b)(1), (b)(4) will assist with transporting patients to their home village.

(U) - Phase 2: The SOTF (b)(1), (b)(4) CDR designated, MAJ (b)(3), (b)(6) as a CIVCAS Mitigation Synchronization Officer. That individual is responsible for coordinating and tracking the efforts by CA, PYSOPS, MEDICAL, ODA, and all other elements. The initial focus has been the care and welfare of the wounded while developing a plan for future medical support to the injured personnel as required. A report is submitted every 48hrs of CIVCAS mitigation efforts through the SOTF (b)(1), (b)(4) CDR to MG Carter (RC-S CDR). Medical care and support by the SOTF (b)(1), (b)(4) Surgeon/Staff have been constant throughout the incident. The wounded care is overseen by SOTF (b)(1), (b)(4) AOB medical personnel on a daily basis. All twelve (12) wounded received care at the local TK hospital. Ten (10) are still receiving care at the TK hospital. On 8 March 2010, two of the wounded personnel, who were cleared (by US and local medical personnel) for release, were transported back to their village and families during the execution of Operation REBUILD HOPE.

(2) (U) What actions has the Chain of Command taken to mitigate the impact of this incident with local leaders?

(a) (U) On 8 Mar 2010, ANA, ANP and ODA 3124 conducted a 48 hour "Operation REBUILD HOPE" that focused on Kandue-Ye-Bala, Kajran District, Day Kundi Province the village of the deceased/wounded. This operation was planned and executed for the purpose of reestablishing rapport with the village of Kandue-Ye Bala after the incident on 21 Feb 10. The initial link-up with the elders from the village was an overwhelming success and very emotional on all parts. The elders prayed for the dead, for the ANSF, the SOTF (b)(1), (b)(4) and for keeping the future safe for them and other Afghans. The elders from all villages affected by this incident want to meet with some GICoA personnel but were extremely thankful for the ODA visit to their village and the medical services provided. The ANSF and SOTF (b)(1), (b)(4) have coordinated to conduct mutual supporting and humanitarian assistance operation with the ANP from this area based on the proximity of the village to the provincial border. The following actions occurred:

1 (U) KLE with village elders (conducted a cultural dinner the first night).

2 (U) ANSF/SOTF (b)(1), (b)(4) engaged village elders and conducted Humanitarian Assistance by distributing Food, medical supplies, and assisting in quick projects (this was overseen by the GFC and CA representative).

3 (U) The local villages were given humanitarian support, a Medical Civic Action Program (MEDCAP), a Veterinarian Civic Action Program (VETCAP), and a work for money program which paid for 71 local small projects such as digging a sewage drain, digging a trash hole, and carrying HA supplies to the distribution point.

4 (U) USAID Afghan Civilian Assistants Program (ACAP) also conducted a site survey to establish further projects in the village and local area. USAID

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ACAP will conduct a site survey for future projects and provide additional assistance as needed based on their survey.

5 (U) Many items were distributed to the local population including: 100 bags of rice, 100 bags of beans, 40 toys, 420 halal meals, 60 medicine packs, 160 radios, 300 articles of clothing and 1,000 hygiene products. TPT visited the school where over 1,000 notebooks, pens, pencils and erasers, as well as 100 compasses and protractor kits were distributed.

6 (U) MEDCAP and VETCAP was conducted on site by SOTF (b)(1), (b)(4) medical personnel and veterinarians, who treated 650 people and 1050 animals including camels, cows, donkeys, sheep, and goats.

7 (U) The ODA team assisted in the return of two of the wounded to their village and families.

p. (U) **What recommendations concerning improvements, if any, to coalition force tactics, techniques, and procedures will help avoid this type of incident in the future?**

(1) (U) Train all U.S. units and Leaders to be able to apply the Tactical Directive (TD) in the manner it was intended. The intent of the TD is to judiciously apply the use of force while reducing the potential for civilian casualties and collateral damage. Specifically, conduct vignette training to certify TOCs as well as weekly sustainment training in their ability to apply the tactical directive in an operational setting.

(a) (U) The ODA CDR, SOTF (b)(1), (b)(4) Command Post, and the CJSOTF-A JOC failed to apply the TD in the manner it was intended. At all echelons there was concern to engage targets away from population centers. (COL (b)(3), (b)(6) Book 3, Exhibit 4, page 4). However, there was insufficient attention to the guidance to avoid a lethal engagement where possible. COMISAF/COMUSFOR-A's guidance in the Tactical Directive states that "we must avoid the trap of winning tactical victories- but suffering strategic defeats – by causing civilian casualties or excessive damage and thus alienating the people." (Tactical Directive, Book 2, Exhibit D, para 3. c.). The directive goes on to state that at times it is better to withdraw than to engage. (Tactical Directive, Book 2, Exhibit D, para 3 f.).

(b) (U) Although the ODA CDR was unaware of the potential for children in the convoy, the location of the enemy went from 5 KM from the ODA's position to 12 KM before striking. The SOTF HQ and the CJSOTF-A HQs were not adequately monitoring the mIRC and FMV nor battle tracking the maneuver of the suspected threat formation resulting in their inability to provide control, insights, analysis, or options to the ODA CDR. There were four (4) specific references to children and adolescents in the mIRC chat as well as the observation that the threat moved 12 KM west and then southwest away from the objective site. As a result, the ODA CDR made his decision to strike without understanding the threat was not an immediate threat to his formation and the fact that there may have been children / adolescents in the formation.

(c) (U) Except for the ODA, all other units indicate a desire to strike the target rather than assess the situation. This originated with the Predator internal transcripts where the Predator crew, numerous times challenged the assessment of the Screener by either

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rejecting it, challenging the accuracy, changing assessments, or determining assessments that had no foundation painting a picture for the ODA CDR enhancing the chances that this “target” would be struck. Although there are numerous examples of all of these, the most glaring was the assessment provided by the Predator crew to the ODA CDR referencing the potential use of human shields. At 0541D, the Predator spots a scuffle near one of the vehicles and reports to the JTAC “be advised there was a brief scuffle in the bed of the Highlux, prior to its departure, looks to be potential use of human shields, but definite suspicious movement, and definite tactical movement.” (b)(1)1.4a Log, Book 5, Exhibit X). The Predator crew had no sound foundation for that assessment.

(2) (U) Review warfighting terminology for use in a COIN environment. The COIN environment makes identifying combatants and non-combatants difficult and crucial. Recommend we quickly publish standard definitions for doctrinal terms and frequently used non-doctrinal terms throughout the CJOA. Incorporate the proper use of these terms in predeployment training, CTC and MTT training plans.

Reporting at all levels of command used these terms throughout the event from target identification through the strike in an incorrect and inconsistent manner. Lack of common term understanding added to the confusion at every level creating a perception of threat that may not have existed.

(a) (U) The ODA CDR declared an “Air Troops in Contact” (Air TIC). (CPT (b)(3), (b)(6) Book 3, Exhibit 24). However, there is no such doctrinal term as “Air TIC” rather; it is a CJSOTF-A procedure used by CJSOTF-A forces to secure external air assets on station for a potential troops in contact situation. CPT (b)(3), (b)(6) stated “we use Air Tic to get assets in case the situation develops.” This approach was further endorsed by the SOTF (b)(1)1.4 and CJSOTF-A HQs. Furthermore, all levels of command described an “Air TIC” as a heightened sense of awareness and doesn’t always have to be an actual engagement, so that assets and resources can be routed to locations they need to be.” (CPT (b)(3), (b)(6) Book 3, Exhibit 24, page 15). This particular procedure is fraught with error and ensures confusion throughout the different levels of command and supporting forces because it puts at risk the rest of the theater by allocating air assets to a situation which does not require air support at the time of declaration. Additionally, this improper declaration informs the rest of the theater of an on-going exchange of munitions between forces or an immediate situation where ordinance will be exchanged. In this case – neither condition existed. Additionally, this declaration of TIC should have generated a series of battle drills at the SOTF (b)(1)1.4 and CJSOTF-A levels which resulted in bringing the leadership into the threat assessment process. In this instance the AirTIC did not trigger a wakeup call informing the SOTF (b)(1)1.4a and CJSOTF-A leadership. The appropriate term for bringing air assets to a potential engagement is “priority immediate.”

(b) (U) Initially the ODA CDR did properly develop all of the necessary elements to declare PID as well as demonstrate the desired tactical patience outlined in the Tactical Directive. However, each HQs above him, supporting commands (PREDATOR, AC130) and key leaders (all Battle Captains, SOTF (b)(1)1.4 S3, SOTF (b)(1)1.4 CDR, CJSOTF-A S3, CJSOTF-A JOC Directors) did not understand what PID meant – most believed it to mean the positive identification of a weapon. For example, MAJ (b)(3), (b)(6) defined PID as “that means you PID whatever it is you are identifying. If you PID a weapon then you saw a weapon.” (MAJ (b)(3), (b)(6) Book 3, Exhibit 19, page 4). LTC (b)(3), (b)(6) stated “PID means with a

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reasonable certainty that some form of surveillance has made identification of a person, vehicle, or compound. An example is that I can PID a compound and if I am handing it off to someone else, that is a form of PID. Obviously the term comes from individuals like I have positive ID of (b)(3), (b)(6) or whoever else through some means of recognition.” (LTC (b)(3), (b)(6) Book 4, Exhibit 2). Not one single maneuver leader or staff officer outside the (b)(1).4a community was able to define PID within the CJSTOF-A chain from the 06 command down to the ODA. As a result, different commands understood the situation to be a little different as “PID” was reported.

1 (U) Of great concern was the Predator Pilot understanding of PID – identification of a weapon and not identification of a legitimate military target. (b)(1).4a Log Book 5, Exhibit X, page 6). Each level of command thought PID meant something different – but all levels understood it was a necessary pre-requisite to engage.

2 (U) As additional facts, such as the presence of children and distinct movement away from the ODA, became available, no level of command reassessed the PID declaration. This is due, at least in part, to all levels of confusion at all levels of command with what PID means. Positive Identification of a weapon or object is a onetime determination. If you see a weapon, you have positively identified it. However, whether something is a legitimate military target must be based on a totality of the circumstances and is thus subject to review upon receipt of additional information. Once PID was declared early in the engagement, no level of command reviewed that determination despite the evidence of children in the convoy and movement away from the target.

(c) (U) Use of the term military age males or “MAMs” for adult males implies that all adult males are combatants and leads to a lack of discernment in target identification. Also, the term lacks a defined age. Based on the experience of encountering young teenage insurgents, several Officers identified MAMs as being as young as twelve to fourteen years-old. (COL (b)(3), (b)(6) Book 3, Exhibit 4, page 12; CPT (b)(3), (b)(6) Book 3, Exhibit 24, page 25). Other than the ODA CDR, no one involved considered the males as civilians at any time. The males were listed as “Enemy Killed in Action” (EKIA) and “Enemy wounded in Action” (EWIA) on the (b)(1).4a FIR (Book 2, Exhibit BB) and on the SOTF (b)(1).4a storyboards (book 3, Exhibit L). Both documents were created after the SSE failed to find any weapons or explosives.

(d) The screeners, Predator crew and the ODA all used the term adolescent without a common understanding of what the term meant. The screener meant a child between seven (7) and thirteen years old. ((b)(3), (b)(6) Book 4, Exhibit 14, page 5). The Predator Pilot reported “Looks to be potential adolescents. We’re thinking early teens.” (b)(1).4a Log, Book 5, Exhibit X). The ODA CDR interpreted this as a fourteen or fifteen year-old, and determined they were essentially “MAMs.” (CPT (b)(3), (b)(6) Book 3, Exhibit 24, page 25). There needs to be standardized terms for local nationals which are as specific as possible, such as adult male, adult female, infant for child in adult’s arms, toddler for young child walking on their own, young female/male for an older child. Specific ages should be avoided as they cannot possibly be determined in a FMV.

(e) (U) There is a great deal of confusion as to what constitutes an imminent threat and how that term relates to a decision to strike a target. Except for a few leaders (b)(1).4a and OH 58 pilots) in the formation and supporting commands, no one understood what

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imminent threat means. Most believed it to be immediate threat to the formation and kinetic activities are going to happen momentarily. The SROE clearly states that imminent does not necessarily mean immediate or instantaneous.

(3) (U) We need to get every operations center fully engaged in the fight – we must change the culture within the CJSOTF-A units from a monitoring headquarters to a command and control node for subordinate commands.

(a) (U) The ODB which is the ODA Company level HQs was not in the fight. Once the ODA leaves the wire, the ODB's only role is to track the ODA's movement; all reports go directly to the SOTF (b)(1), (b)(4) (MAJ (b)(3), (b)(6) Book 4, Exhibit 5, page 3). This is an intentional condition despite current SOF doctrine which describes the ODB as an operational C2 HQ that can command and control from one to six ODAs. (MAJ (b)(3), (b)(6) Book 4, Exhibit 5, page 6). As a result, span of control for the SOTF (b)(1), (b)(4) goes from four (4) subordinate formations to 24 subordinate ODAs in addition to the existing 4 ODB level HQs. Some of this is due to the fact that equipment is broken – but testimony indicated that even if they had the necessary equipment on hand, the SOTF (b)(1), (b)(4) would still remain C2 of the ODAs upon leaving their (ODA) wire. (MAJ (b)(3), (b)(6) Book 4, Exhibit 5, page 6). This is counter to every instruction or principle as it relates to command and control and span of control.

(b) (U) The SOTF (b)(1), (b)(4) HQs was engaged in a passive role during this operation.

1 The Night Battle Captain, CPT (b)(3), (b)(6) was inexperienced and did not fully understand his role. He failed to execute any battle drill; did not battle track the operation; despite it being the primary on-going operation within the command that night, (CPT (b)(3), (b)(6) Book 4, Exhibit 26, page 4); did not monitor the mIRC Chat (method of tracking the fight via the Predator); did not understand the developing tactical situation, failed to provide any situational awareness, analysis or options to the ODA CDR; and generally was in a watch and learn mode.

2 (U) Once the assessed enemy formation stopped moving south towards the ODA position and started moving west away from it, the SOTF (b)(1), (b)(4) HQs did not provide any enemy courses of action analysis. (CPT (b)(3), (b)(6) Book 3, Exhibit 24). The threat which had appeared to be immediate was clearly becoming something other than immediate.

3 (U) The SOTF (b)(1), (b)(4) HQs did not provide any analysis once the Predator mIRC chat identified the potential for children in the convoy. Not only did the command post fail to provide intelligence analysis to the ODA CDR, but it failed to execute its own battle drill by informing their leadership of the potential for civilians in the assessed threat formation. Both MAJ (b)(3), (b)(6) and LTC (b)(3), (b)(6) stated that they should have been woken up much earlier. (MAJ (b)(3), (b)(6) Book 3, Exhibit 25, page 9; LTC (b)(3), (b)(6) Book 4, Exhibit 2, page 13) As the threat continued to move west then southwest, the command post did not provide any analysis reference regarding the following issues:

a (U) The number of weapons identified (3 weapons for 21 men) which may have adjusted the ODA CDR CDR assessment.

b (U) Continued discussion of children and or adolescents in the convoy. Despite discussion in the mIRC chat indicating that children or adolescents were in