the convoy, the SOTF (b)(1)1.4a Operations center did not inform the SOTF (b)(1)1.4a leadership or the ODA CDR. (mIRC log at 0540, 0542, 0622, 0740, 0741)

c (U) The fact that the formation had moved 12 KM to the west away from the ODA no longer posing an immediate threat.

d (U) Only after the SOTF (b)(1)1.4a CDR was brought into the fight (by the CJSOTF-A CDR) did the application of judgment come into play resulting in a decision to execute an escalation of force rather than employing ordinance – unfortunately, this course of action was not realized due to the timing of the strike.

4 (U) The SOTF (b)(1)1.4a S3 did not fully understand the elements of target declaration, TIC, imminent threat, nor was he reflexively aware of the command post battle drills. He was aware of the inexperience of the Night Battle CPT referring to his skills as rudimentary, but took minimal actions and did not take appropriate training actions to "check ride" him into the position. (MAJ (b)(3), (b)(6) Book 3, Exhibit 25, page 21). Specifically, the final "check ride" should ensure that the Night Battle CPT is capable of doing the job and could execute the appropriate battle drills when an action occurs. Instead, this task was handed off to the outgoing NCO without supervision or certification. (MAJ (b)(3), (b)(6) Book 3, Exhibit 25, page 7).

5 (U) The SOTF (b)(1)1.4a CDR did not understand the elements of target declaration, TIC, imminent threat, nor was he reflexively aware of the command post battle drills. (LTC (b)(3), (b)(6) Book 4, Exhibit 2 pages 6-7; 14). He was unable to clearly tell the Investigating Officer what his wake up criteria were. (LTC (b)(3), (b)(6) Book 4, Exhibit 2, page4). He was well aware of the battle rhythm of the "big three" (SOTF (b)(1)1.4a CDR, XO, S3) which has all of them asleep at the same time (LTC (b)(3) and (b)(6) Book 4, Exhibit 2, page 3). Finally, the SOTF (b)(1) 1.4a CDR oversaw the following:

a (U) No Field Grade officer was on duty in the SOTF (b)(1)1.4a Operations Center. (LTC (b)(3), (b)(6) Book 4, Exhibit 2, page 3). This alone is a risk, but it is an unacceptable risk when there is an on-going air infiltration and follow-on ground cordon and search.

b (U) Except for the Fires Officer, all other positions in the command post at night were filled by personnel who were significantly less experienced then the day shift counterparts. The day Battle Captain is a former ODA CDR, while the night Battle Captain is right out of the Special Forces Qualifications Course, the OPSCEN SGM works during the day and the night NCOIC is a Sergeant First Class, the ISR manager during the day is a Lieutenant and at night an Airman First Class. (MAJ (b)(3), (b)(6) Book 3, Exhibit 25, and CPT (b)(3), (b)(6) Book 4, Exhibit 9, page 1).

6 (U) Battle drills were not understood by the night command post team. As a result, no battle drills were performed especially those generated by the declaration of TIC and the possibility for civilians at the target site. Wake up criteria were not understood by the SOTF -12 CDR, S3, nor Battle Captain and consequently not executed.

(c) (U) CJSOTF-A HQs was not fully engaged in the fight. Specifically, the Night JOC Director was not adequately involved in monitoring the situation. He was

unaware of the mIRC chat that expressed the potential for children and/or adolescents in the convoy, despite having these feeds on hand. (MAJ (b)(3), (b)(6) Book 4, Exhibit 21, page 5). As a result, he did not conduct any battle drills and failed to fully inform COL(b)(3), (b)(6) of the situation. (COL(b)(3), (b)(6) Book 3, Exhibit 4). Although, at least part of the blame for COL (b)(3), (b)(6) lack of information was COL(b)(3), (b)(6) interjecting and cutting off the JOC's briefing to him. (COL(b)(3), (b)(6) Book 3, Exhibit 4). The J2X operations NCO assumed the JOC Director was monitoring the same feeds he was so he did not call reports to the JOC director's attention. (PO(b)(3), (b)(6) Book 4, Exhibit 4, pages 5-7). The Night JOC Director, MAJ (b)(3), (b)(6) had limited situational awareness of ongoing operations, and was unaware of the Predator reports of children and adolescents in the vicinity of the vehicles. This was true despite the Night J2 Operations NCO stating he noted the reports in the mIRC, and that the mIRC was posted on a screen for all to see.

(4) (U) Request that Headquarters Air Force (HAF) appoint Air Combat Command (ACC) as lead MAJCOM to quickly codify command level guidance on DCGS/RPA (Distributed Common Ground System/Remote Piloted Vehicle) tactics, techniques and procedures (TTPs) and conflict resolution in an Air Force Tactics Techniques and Procedures (AFTTP) manual. It will require coordination across ACC and AFSOC commands and should include joint participation to include the supported customers. The TTPs should then be introduced to the joint community through an Air, Land, and Sea Applications Center (ALSA) Tactics Bulletin and eventually codified in a Joint Forces Command Joint Publication.

(a) (U) The Predator crew demonstrated a propensity for kinetic operations based on their internal communications transcript. They clearly hoped this operation would lead to Predator weapons employment, and seemed to bias their assessments to support this. Simply stated, their lack of professionalism in their communication, coordination, and behavior contributed to a faulty threat assessment by the ground commander. The Predator crew's actions biased the ODA CDR to a kinetic solution. Areas of specific concern are:

1 (U) While the Screener assessed the vehicles appeared to be attempting to egress the area, the Predator crew assessed the vehicles to be attempting to flank the ODA's position. (b)(1)1.4a Log, Book 5, Exhibit X).

2 (U) When the Screeners identified Children, the Sensor Operators and Pilot responded with "B…S…". (b)(1)1.4a Log, Book 5, Exhibit X).

3 (U) The Predator pilot and crew constantly challenged the Screeners assessment whenever there was an indication that it may not have been a hostile target. See e.g.(b)(1)1.4a audio log 0537 "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"

4 (U) The Predator pilot made the assessment that a scuffle within the target location was due to using some of the passengers as a "human shield." There was no basis or experience for this assessment. (b)(1)1.4a Log, Book 5, Exhibit X).

5 (U) After the initial strike, they identified the women on the objective as men in women's clothes with earrings and jewelry. (b)(1)1.4a Log, Book 5, Exhibit X). They refused to accept the fact that there were women on the object.

(b) (U) There are many more examples throughout the internal transcript. What is most concerning is when you cross walk the transcript between the Screeners in Hurlburt Field, Florida to the Predator pilot in Creech AFB, Nevada, then crosswalk the actual transmission, between the Predator pilot and ODA CDR, it becomes clear where the Predator Pilot and selected members of the crew independently skewed the ground picture.

(c) (U) Questioning revealed that the Predator crew members' understanding of the terms PID, imminent threat, and hostile intent are not to standard. They also were only vaguely familiar with COMISAF's Tactical Directive. This contributed to an incorrect estimate of the threat situation, as well as a bias to kinetic solutions.

(d) (U) Finally, target hand off between the Predator crew and the OH-58Ds was lacking key information – there was no mention of adolescents by the Predator crew as confirmed in the internal crew transcript. The OH 58D pilots testified if they would have known of adolescents in the convoy they would not have engaged until cleared from their higher. (CW2 (b)(3), (b)(6) Book 4, Exhibit 19, page 7).

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

q. (U) **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?**

(1) (U) A battle damage assessment was done by the ODA team, led by CPT (b)(3), (b)(6) and the sensitive site exploitation assessment was completed by Ensign (b)(3), (b)(6) (b)(3), (b)(6) with the ODA team.

(2) (U) It was not conducted within two hours of the strike, but was begun around 1214D, which was three and a half hours after the strike. There was a delay in conducting the BDA as the tasking of this assessment was in question. The SOTF- did not take ownership of the BDA task initially as they presumed that TF South would be responsible. In addition, there was a question as to if the ODB team would conduct the assessment instead of the ODA team that was conducting operations in the Village of Khod. The general strike site area was under surveillance by the Predator from time of the strike throughout the initial stages of the

SSE /BDA, however, many times it moved off site as it would follow individuals leaving the scene. In addition, when the SSE team was en route, the Predator crew moved to monitor the surrounding area to ensure that there were no insurgent forces preparing for an ambush.

r. ~~(S)~~ What were the community leaders' impressions and opinions of the strike?

(1) (U) CPT (b)(3), (b)(6) met with the individuals who came on the scene and informed them that it was his decision to make the strike. In addition, as of 1430D, the AOB CDR had contacted the Uruzgan Provincial Governor, Gov. Hamdan and the Provincial Police Chief, Juma Ghul. CPT (b)(3), (b)(6) also contacted District ANP in order to secure the remains of the KIA as well as to assist in conducting the evacuation of the twelve wounded Afghans.

(2) (U) The initial assessment from the GIRoA Ministry of Interior representative, BG Sayed Anwar, was that he acknowledged that this was an area controlled by the Taliban and that he acknowledged that this was a mistake. There was initially a question as to if there were Taliban elements mixed into the convoy in order to use the women as shields, however, this has never been substantiated. BG Sayed Anwar, indicated that the Taliban knew of our Rules of Engagement not to strike when there are women and children present so they would intentionally move with women and children in order to avoid being targeted.

(3) (U) Meetings were held with the Provincial Police Chief, Juma Ghul, two local police men, the Afghan Security Force CDR in this area, as well as the ANA CDR for that area. All acknowledge that this was a tragic mistake. The Afghan Security Force CDR knew at least three individuals in the strike and knew the villages where the individuals came from very well. He indicated that the strike was a tragic mistake.

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

(5) (U) In essence, the Afghan leader acknowledged the area is Taliban controlled and that the engagement of the vehicles of civilians was a mistake.

s. (U) 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?

(1) (U) Were initial reports of the incident accurate? Yes. The OH58D, call sign (b)(1)1.4a identified and reported bright colored clothing on the objective and

reported that they suspected there were females at the strike site. (Kiowa Radio Traffic, Book 2, Exhibit CC, page 6). Once they identified potential females, they stopped the engagement and then attempted to define the composition of the personnel at the strike site. The OH-58D crew informed the Predator Crew what they had identified. The Predator Crew relayed to the ODA CDR the assessment made by the OH-58Ds. Upon notification of "bright colored clothing", the ODA CDR immediately informed the leadership within his ODA Team, then called SOTF (higher HQs) at approximately 0910 with a report of potential non-combatants on the objective. (CPT Book 3, Exhibit 24; LTC Book 4, Exhibit 2, page 22). When the ODA CDR conducted on the strike site three and a half hours later, he rendered a confirmed CIVCAS assessment to the SOTF-HQs at approximately 1400D. The report indicated only MAMs being MEDEVAC'd but also included reference to 1 woman and 1 child injured but not being MEDEVAC'd. (CPT Book 3, Exhibit 24; LTC Book 4, Exhibit 2, page 20).

(2) (U) **If not, was there an attempt to intentionally mislead the chain of command?** At both the SOTF and CJSOTF-A level there was a reluctance to mention CIVCAS unless and until it was confirmed. Captain the ODA CDR reported his suspicion of CIVCAS in a timely and accurate manner to SOTF The SOTF CDR instructed the ODA CDR not to second guess himself and assessed that it was still a good strike. The SOTF CDR verbally passed the information to CJSOTF-A, but neither command initiated the mandatory reporting. (LTC Book 4, Exhibit 2, p. 25). The ODA CDR followed up his suspected CIVCAS report with a confirmed CIVCAS assessment when he conducted the four hours later. The initial BDA report indicated that only adult males were sufficiently injured to require MEDEVAC. SOTF chose not to report what they believed to be minor injuries to one woman and one child. (CPT Book 3, Exhibit 24,page 46; LTC Book 4, Exhibit 2 p. 40). The CJSOTF-A CDR exercised poor judgment when he was provided a report generated by TF that there were reported civilian casualties on the objective. Instead of reading the report being handed to him by LTC and MAJ , the CJSOTF-A CDR rejected the report out right, without reading it, stating since it was not from his unit, and he had boots on the ground he would not consider it. (COL Book 3, Exhibit 4, page 7). This action by the CDR is in direct contradiction to his own directive to his subordinates to report confirmed or alleged civilian casualties to the chain of command. (CJSOTF-A FRAGO 02 Operational Guidance, Book 2, Exhibit I). His actions are also in direct contradiction to the tactical directive which requires reporting of "suspected" civilian casualties. (Tactical Directive, Book 2, Exhibit D).

(3) (U) **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?**

a. (U) The ODA CDR almost immediately after the strike became aware that there was a potential for CIVCAS and subsequently reported it up the chain. The ODA CDR learned that people in brightly colored clothes were spotted on the objective. Log, Book 5, Exhibit W). CPT contacted LTC via Iridium phone at approximately 0910D and reported that he has a possible incident involving non-combatants. (CPT Book 3, Exhibit 24, pages 36-37; LTC Book 4, Exhibit 2). Three and a half hours later when the ground unit arrived at the strike site to conduct the ODA CDR confirmed it and rendered a follow up report to his higher HQs providing how many were injured

including the one woman and one child whom he was aware of. (CPT (b)(3), (b)(6) Book 3, Exhibit 24 page 46; LTC (b)(3), (b)(6) Book 4, Exhibit 2).

b. However, there was confusion on the report the ODA CDR did render. He informed his higher HQs that seven military age males were being evacuated, three women and three children were unharmed, and one woman and one child were injured. (CPT (b)(3), (b)(6) Book 3, Exhibit 24, pages 45-46). Initially, CPT (b)(3), (b)(6) believed only seven (7) adult males required MEDEVAC. As the helicopters landed, he moved away from the MEDEVAC site in order to better communicate with SOTF-12 (CPT (b)(3), (b)(6) Book 3, Exhibit 24 pages 45). In fact, twelve personnel were medically evacuated from the strike site of which three were children and one was a woman – all injured to some degree. CPT (b)(3), (b)(6) did not learn of the increase in the number MEDEVAC until much later. Shortly after the MEDEVAC lifted off CPT (b)(3), (b)(6) had to shift his attention to ensuring security on the site. The ODA was expecting Afghan authorities from the village of Kajaran to come to take control of the bodies. Several vehicles arrived containing local nationals purporting to be the Karjaran police but the ODA was suspicious that they were not who they claimed because the vehicles arrived too quickly to have been from Kajaran and the locals did not appear to be dressed like ANP. (special Forces Meeting, Book 4, Exhibit 12 page 31) Fearing the vehicles might be hostile; CPT (b)(3),(b)(6) focused on security at the site and was unable to check on the MEDEVAC. (CPT (b)(3), (b)(6) Book 3, Exhibit 24, pages 48). The SOTF (b)(1)1.4a HQs only reported seven being evacuated and three women and three children were unharmed failing to report the status of the one woman and one child that were injured.

c. Although the ODA CDR incorrectly reported that seven (7) personnel were being MEDEVACed rather than the twelve (12) that were actually MEDEVACed, he did identify that one woman and one child were injured. The report of injured women and children was not acted on by SOTF (b)(1)1.4a (CPT (b)(3), (b)(6) Book 3, Exhibit 24 page 46; LTC (b)(3), (b)(6) Book 4, Exhibit 2 page 40).

d. Additionally, the ODA CDR's MEDEVAC requests lists all the wounded as local national civilians and not as enemy prisoners. (MEDEVAC Request, Book 2 Exhibit RR).

(4) (U) **Did any headquarters fail to timely notify its next higher headquarters?**

(a) (U) The ODA did not ever inform its higher HQs of the exact composition of the evacuated due to confusion and carnage at the Strike site – but they did report CIVCAS. (b)(3), (b)(6) Book 3, Exhibit 24, p. 46).

(b) (U) The SOTF (b)(1)1.4a withheld suspected CIVCAS from its higher HQs to seemingly wait to get confirmation that there were actually civilian casualties. The SOTF (b)(1)1.4a HQs knew within minutes after the strike that there were potential CIVCAS (~0900D) and then confirmed CIVCAS (~1400D). (LTC (b)(3), (b)(6) Book 4. Exhibit 2, pages 22, 23, 40). However, SOTF (b)(1)1.4a never took any direct action to determine if civilians were injured. It is still unclear as to why the SOTF (b)(1)1.4a HQs did not report the potential and/or suspected CIVCAS.

1 (U) LTC (b)(3), (b)(6) received reports of suspected CIVCAS and although he spoke with the CJSOTF-A CDR, he did not send the required reports. Before the strike he

had been told of potential children in the vehicles (LTC (b)(3), (b)(6) Book 4, Exhibit 2 page 24). At approximately 0920D, CPT (b)(3), (b)(6) reported, "I think we may have an incident…" involving non-combatants (CPT (b)(3), (b)(6) Book 3, Exhibit 24, page 36), LTC (b)(3), (b)(6) Fires Officer, ISR manager, and the Battle Captain all identified the potential of women on the strike sight within minutes after the strike, yet LTC (b)(3), (b)(6) only action was to order the ODA CDR to conduct (b)(1)1.4a to try to confirm CIVCAS. (LTC (b)(3), (b)(6) Book 4, Exhibit 2, page 24). His communication with the ODA CDR was limited after the strike and non-existent before the strike. (LTC (b)(3), (b)(6) Book 4, Exhibit 2, page 22). After identifying the ODA CDR was emotionally distraught with the potential for CIVCAS he took no action to address it – in fact – he assigned additional tasks to the ODA CDR and his unit. (LTC (b)(3), (b)(6) Book 4, Exhibit 2, page 18) He was not organized to execute the contingency plan of committing the QRF. Finally, because the ODB was removed from the fight as a C2 HQs, the SOTF (b)(1)1.4a HQs was the only available HQs to assist with consequence management following the strike. SOTF-(b)(1)1.4a failed to do so in a timely manner, not getting boots on the ground until more than three hours after the strike. (CPT (b)(3), (b)(6) Book 3, Exhibit 24; TSgt (b)(3), (b)(6) Book 4, Exhibit 22).

2 Throughout the day the SOTF (b)(1)1.4a CDR continued to believe the vehicles had been a valid target. When asked for his assessment after the SSE, LTC (b)(3), (b)(6) stated "I felt that we had engaged a good military target and that we got lucky by not wounding women and children." (LTC (b)(3), (b)(6) Book 4, Exhibit 2 page 14). LTC (b)(3), (b)(6) indicated that he believed the vehicles were collecting MAMs, that they were armed and they were massing on the ODA. (LTC (b)(3), (b)(6) Book 4, Exhibit 2 page 17). LTC (b)(3), (b)(6) clung to this conclusion despite no weapons being found at the strike site, stating "The key piece to me was when he said we have 15 KIA, 7 males WIA, 3 women and children unharmed. That's when I felt the target was good, with little collateral damage." (LTC (b)(3), (b)(6) Book 4, Exhibit 2 page 53). Eventually LTC (b)(3), (b)(6) became suspicious that the adult males were civilians and not insurgents. When asked about males, he stated "I didn't make the leap that it was CIVCAS, my line of thinking was this was a good target and we need compelling data that they were CIVCAS. One data point that we may have missed was the potential that they were Hazaaras." By that evening, LTC (b)(3), (b)(6) had concluded that all the injured were civilians and not insurgents. LTC (b)(3), (b)(6) explained, "Later that night I had three indicators that came to me, the first being the possibility of women and children, the second being no weapons, and the third being information that some of them were Hazaara on the site." However, as CIVCAS had already been declared, LTC (b)(3), (b)(6) did not send a revised report. (LTC (b)(3), (b)(6) Book 4, Exhibit 2 page 20).

(c) (U) CJSOTF-A became aware of suspected CIVCAS immediately after the strike as they saw women and children on the strike site but assumed that they had come from a local village. (MAJ (b)(3), (b)(6) Book 3, Exhibit 19, page 10; COL (b)(3), (b)(6) Book 3, Exhibit 4, page 5). CJSOTF-A had a report of confirmed CIVCAS at approximately 1430D and chose not to report it to CFSOCC-A (Higher HQs) because it would not accept the report of an adjacent unit as reliable. (COL (b)(3), (b)(6) Book 3, Exhibit 4, page 7). Even if CJSOTF-A did not treat the report from another unit as confirmed CIVCAS, at the very least, the report should have prompted a report of suspected CIVCAS and a concerted effort to validate the report.

1 (U) The Day JOC Director, MAJ (b)(3), (b)(6) noted the women and children in the engagement area just after the strike on the Predator FMV, but made the assumption they were from a nearby village. (MAJ (b)(3), (b)(6) Book 3, Exhibit 19, page 10).

He did not exhibit the intellectual curiosity to investigate this non-standard situation, and made an assumption that the target was valid "based on the multiple enablers involved." (MAJ (b)(3), (b)(6) Book 3, Exhibit 19, page 10). Even when TF (b)(1)1.4a submitted their FIR, he did not follow up on the report, other than bringing it to the CJSOTF-A CDR, since it came from outside the SOF reporting chain. (MAJ (b)(3), (b)(6) Book 3, Exhibit 19, page 12). His reluctance to act may have also been influenced by the CJSOTF-A CDR.

2 (U) The CJSOTF-A CDR rejected the TF (b)(1)1.4a FIR which referenced potential CIVCAS, refusing to read it since it was from an "adjacent unit." COL (b)(3), (b)(6) testified that "They attempted to hand me that report and I refused it. Again I asked is that coming from our guys. They said no. Where did it come from? From a TF down south? I refused to take that report because it was not from my element. So did I read that report, no, I refused that report." (COL (b)(3), (b)(6) Book 3, Exhibit 4, page 9). COL (b)(3), (b)(6) later explained he refused the report because he had "boots on the ground." (COL (b)(3), (b)(6) Book 3, Exhibit 4, page 9). While his justification was that he had boots-on-the-ground conducting (b)(1)1.4a when the FIR was received, he did not have the intellectual curiosity to want to know what another unit supporting his subordinate ODA was reporting. Additionally, the investigation team perceived a reluctance for subordinates to engage the CJSOTF-A CDR on negative issues, based on multiple reports he does not foster two-way communications. (MAJ (b)(3), (b)(6), Book 3, Exhibit 19; LTC (b)(3), (b)(6) Book 3, Exhibit 16; LTC (b)(3), (b)(6) Book 4, Exhibit 2). This climate may have prevented CJSOTF-A staffers from engaging the CJSOTF-A CDR on the need to rapidly investigate potential CIVCAS based on reports from multiple sources. His rationale was he wanted to wait until absolute confirmation, despite the Tactical Directive and his own guidance requiring the reporting of suspected or alleged CIVCAS. This approach cost several hours in the reporting process.

(d) (U) Retrain on reporting. The SOTF (b)(1)1.4a and CJSOTF-A HQs failed to report the CIVCAS in a timely manner.

(a) (U) Both HQs failed to report suspected or alleged CIVCAS up through the chain of command.

(b) (U) Both commands failure to report is in contradiction to the Tactical Directive which requires immediate reporting of suspected CIVCAS and the CJSOTF-A internal directive which requires immediate reporting of alleged CIVCAS. (CJSOTF-A FRAGO 02, Operational Guidance, Book 2, Exhibit I).

(e) (U) Improve Command Post Operations

(a) (U) Poorly functioning command posts contributed to the poor reporting. Battle Drills should include sending required reports.

(b) (U) A command post actively engaged in an operation is more likely to submit, timely and accurate reports. The initial confusion surrounding the strike contributed to the slow reporting. Had leaders at SOTF (b)(1)1.4a and CJSOTF-A been fully aware of reports of children or adolescents in the vehicles prior to the engagement, they may have immediately reported the potential for CIVCAS.