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

t. (U) **Any other matters you deem relevant.** See Recommendations at Tab B.

(1) Recommend assembling a team to review composite risk management principles and assess their viability to be used to address mitigating civilian casualties in a COIN environment.

(2) (U) After any operation where there are confirmed civilian casualties, mitigation operations are essential. Operations must focus on the village of the deceased/wounded to rebuild good-will in that area. SOTF (b)(1)1.4a conducted effective mitigation led by ODA (b)(1)1.4a Examples of SOTF (b)(1)1.4a actions that should be emulated include:

(a) (U) Key Leader Engagement (KLE) with village elders including a cultural dinner. ANSF/CF engage village elders and conduct Humanitarian Assistance by distributing food, medical supplies, and assisting in quick projects

(b) (U) Coordinate Community AID - USAID/ACAP conduct a site survey for future projects and provide additional assistance as needed based on their survey. Engagement of USAID to conduct on site medical assistance and veterinarian services. Engage PSYOP elements to conduct assessment and distribute radios to the local population.

(c) (U) Arrange for the payment of condolence payments - to families of deceased and to the injured. Include the loss of property items, such as vehicles.

(d) (U) Re-integrate/return the wounded to their village and families; facilitate communication with their families while they are being treated. Follow-up on the care being provided to the wounded and insure a long-term plan for providing care.

(3) During the investigation I noted a potential conflict of interest, also noted by the Special Forces team. A husband and wife working on the same team as Distributed Common Ground System (DCGS) Screeners. Although my investigation team identified the potential for an issue with the husband and wife screeners, I found no action or inaction by the Screeners that negatively influenced the engagement. I note this potential conflict of interest as it may affect future operations.

3. (U) The point of contact for this memorandum is the USFOR-A Deputy SJA, LTC (b)(3), (b)(6) (b)(3), (b)(6) at VoSIP (b)(2) or e-mail at (b)(3), (b)(6), (b)(2)

TIMOTHY MCHALE
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Deputy Commander, Support
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TAB B – RECOMMENDATIONS FOR 21 FEB 2010 CIVCAS INCIDENT IN URUZGAN PROVINCE

The 21 February 2010 tragic Civilian Casualties Incident in Uruzgan Province where up to 23 local nationals were killed and 12 others injured when the convoy they were travelling in was mistaken for an insurgent force and was engaged with air to ground missiles was preventable.

Based on the findings submitted above, and in addition to the recommendations for changes to TTPs at paragraph p, above, I make the following recommendations:

There were 4 Major Causes for this incident. 1) Ineffective Command Posts, 2) Predator Crew Actions 3) Decision to Engage, and 4) Ill-defined Terminology

Cause 1 - Ineffective Command Posts: Both SOTF-(b)(1)1.4a and CJSOTF-A Command Posts were manned and well equipped with the latest technology to properly command and control this operation. Both command posts had the authority, responsibility and capacity to engage and assist the ODA CDR in this operation. A series of breakdowns in leadership and poorly functioning command posts led to the bad strike and bad reporting following the strike. The contributing factors that led to the CIVCAS were many, including:

- Command Posts monitoring only and not providing engaged C2
- ODB not properly manned and resourced to perform C2 functions beyond battle tracking
- Poor and not understood CP Procedures/CCIRs (Battle Drills execution)
- Lack of understanding of the terms associated with the Rules of Engagement, Tactical Directive & Target Development; such as; PID, Hostile Intent, and Imminent Threat
- In SOTF-(b)(1)1.4a All 3 Field Grade Officers were on same battle rhythm with no senior leaders on duty
- SOTF-(b)(1)1.4a Battle Captain was poorly trained and unaware of CCIR and Battle Drills
- CJSOTF-A JOC Chief was not engaged and unaware of children in the convoy
- Leaders not engaged in leading, educating and training their personnel
- Poor internal communication and synchronization within the command posts

Recommendations to Address Cause 1:

1. Recommendation: Predeployment Training at home station and combat training centers must ensure Command Posts are put through a rigorous series of COIN training evolutions driven by challenging scenarios. Tasks, Iterations, Conditions, Task Standards and Commander/Leader Assessment on Go/No-Go Performance Measures and certification is a must before deploying to theater.

2. Recommendation: Deployed 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.

TAB B – RECOMMENDATIONS FOR
21 FEB 2010 CIVCAS INCIDENT IN URUZGAN PROVINCE

3. Recommendation: Develop a Mobile Training Team to deploy to the CJOA to evaluate, educate, train and certify units' Command Posts in COIN Operations.

4. Recommendation: 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.

5. Recommendation: Resource and task ODBs to provide company level C2 for ODAs conducting missions.

Cause 2 - Predator Crew Actions: The Predator crew demonstrated a propensity/bias for kinetic operations and failed to accurately and professionally pass Distributed Common Ground System (DCGS) Screener assessments to the JTAC that could have prevented the strike. This is based on their external and internal communications transcripts. The Predator crew's bias toward kinetic operations skewed their reports. The Predator crew emphasized information suggesting the vehicles were hostile, while downplaying or ignoring information to the contrary. The AC-130/JTAC communications and JTAC brief given to the Predator crew when they arrived on station conveyed the GFC's intent to attack the convoy but tasked (b)(1)1.4a with PID. From that point forward, (b)(1)1.4a worked to determine PID in order to support a kinetic strike. The Predator pilot made or changed key assessments that influenced the ground force commander's decision to strike the vehicles. The Predator pilot's descriptive communications referencing tactical maneuvers and human shields influenced the GFC's decision. Additionally, the Predator crew inaccurately and unprofessionally modified or excluded DCGS assessments that could have caused the GFC to question the PID or validity of the imminent threat; thereby preventing the strike. The Predator pilot failed to pass the DCGS assessment that the vehicles appeared to be evading the area and replaced it with his own assessment that the vehicles were flanking. Finally, the Predator pilot excluded the DCGS assessment of adolescents in the convoy, passing only MAMs or military aged males to the OH-58Ds. Listed are some of the contributing factors that led to the CIVCAS associated with the Predator crew actions:

- Assessments made without foundation and failing to accurately pass Screener assessments resulted in faulty assessments by the ODA CDR
- A desire to engage inconsistent with evolving target actions
- Lack of understanding of the ROE and Tactical Directive
- Poor target hand off between Predator and OH-58D (No mention of children or adolescents at target site passed by Predator)

Recommendation to Address Cause 2:

- Request that the 432nd Air Expeditionary Wing Commander convene a Commander's Directed Investigation (CDI). The CDI should focus on (b)(1)1.4a crew's inaccurate and unprofessional passing of DCGS Screener assessments and bias toward kinetic attack when the DCGS assessments questioned PID and imminent threat.

TAB B – RECOMMENDATIONS FOR
21 FEB 2010 CIVCAS INCIDENT IN URUZGAN PROVINCE

- Request that Headquarters Air Force (HAF) appoint Air Combat Command (ACC) as lead MAJCOM to quickly codify command level guidance on DCGS/RPA TTPs and conflict resolution in an Air Force Tactics Techniques and Procedures (AFTTP) manual. It should then be introduced to the joint community through an Air, Land, and Sea Applications Center (ALSA) Tactics Bulletin and codified in a Joint Forces Command Joint Publication.

Cause 3 - Decision to Engage: The ODA Commander's decision to engage the vehicles evolved over several hours. During that time he received many bits of data and information that he had to fuse together to form his decision. Biased and inaccurate reporting by the Predator crew and lack of support by his supporting command posts led to the strike. A few of the contributing factors that influenced his decision are listed below:

- The ODA CDR had good initial situational awareness and situational understanding. Over time he was unable to refine target estimate due to a myriad of tasks being executed and inaccurate information being relayed from ISR platforms
- Task Saturation due to SOTF (b)(1)1.4a and CJSOTF-A Command Posts not providing C2 support (AVN, AC130, Intel, Predator Analysis, Close Fight tracking)
- ODA CDR determined Imminent Threat based on the information confirmed/unconfirmed provided to him through multiple sources
- ODA CDR fired before it was necessary, failing to scrutinize and limit the use of force in accordance with the Tactical Directive.

Recommendation to address Cause 3:

Review programs of instruction in Pre Deployment Home Station, Combat Training Centers and at the COIN Training Center to further develop the targeting process, responsibilities and engagement criteria at all levels of command in accordance with the ROE and the Tactical Directive.

Cause 4 – Ill-defined Terminology: The use of imprecise non-standard terms and the misuse of doctrinal terms led to confusion throughout the operation. Listed are some of the contributing factors that led to the CIVCAS from the use of ill-defined terminology:

- MAMs- 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 or thirteen years-old.
- Adolescent – The screeners assessed two individuals as "adolescents" without a definition of what age range they were referring to as an adolescent. The Predator crew assumed that meant a teenager and passed that to the ODA. The ODA assumed that the teenagers may be combatants.
- AirTIC – the use of the term AirTIC for situations where troops are not actually in combat to bring resources to the team cuts short the air crews' preparations and creates a false sense of urgency. The use of the term creates risk and diverts resources that may be

TAB B – RECOMMENDATIONS FOR
21 FEB 2010 CIVCAS INCIDENT IN URUZGAN PROVINCE

urgently needed elsewhere. The appropriate term for bringing air assets to a potential engagement is "priority immediate."

- Human Shield – the Predator Crew assessed a scuffle as the possible use of human shields. There was no basis for that determination and fed the impression that the vehicles were hostile.

Recommendation to Address Cause 4:

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. Contact JFCOM for support of this requirement.

Following the tragic strike causing Civilian Casualties the problem was compounded due to late CIVCAS reporting up the Chain of Command. Both Command Posts and all three Commanders knew shortly after the strike that there were civilians on the strike objective and that this was a possible CIVCAS incident. Poor communications coupled with the desire to believe it was a good strike, drove leaders' actions to confirm the CIVCAS vice following the Tactical Directive and their own SOPs to report suspected CIVCAS immediately up the chain of command.

There were 3 Major Causes for Late CIVCAS Reporting: 1) Delayed (b)(1)1.4c 2) SOTF (b)(1)1.4a CDR/Operations Center, 3) CJSOTF-A CDR/Operations Center

Late CIVCAS Reporting Cause 1 - Delayed (b)(1)1.4c Contributing Factors are as follows:

- The decision to engage target 12KM away from ODA location
- Failure to implement the contingency plan in the CONOP
- SOTF (b)(1)1.4a OPSCEN conducted no planning for (b)(1)1.4c until after the strike occurred
- Delay in (b)(1)1.4c Execution for 3.5 hours after strike.
- SOTF (b)(1)1.4a decision to employ ODA that was still engaged on the original target site and not employ the QRF
- No direction, guidance or procedures provided to control over the Predator, no clear direction to stay on site versus following "squirters"

Recommendations to Address Delayed (b)(1)1.4c

1. When a potential target is identified, a battle drill should be executed and the battle drill should include planning for (b)(1)1.4c

2. ISAF/USFOR-A publish a SSE FRAGO which outlines planning and resourcing requirements for (b)(1)1.4c The FRAGO should outline standards of resourcing as well as standards for maintaining the view of the strike site until (b)(1)1.4c element can arrive.

TAB B – RECOMMENDATIONS FOR
21 FEB 2010 CIVCAS INCIDENT IN URUZGAN PROVINCE

Late CIVCAS Reporting Cause 2 - SOTF (b)(1)1.4a CDR/Operations Center: After the strike the SOTF (b)(1)1.4a CDR and Operations Center continued to poorly conduct reporting operations. Contributing factors include:

- Poor assessment/logic not identifying potential children/adolescents injured despite multiple reports indicating they were in the convoy
- Despite seeing women and children on the OBJ directly following the strike, no report rendered, assumed uninjured despite being in the convoy
- SOTF (b)(1)1.4a CDR and Command Post chose not to report CIVCAS until it could be confirmed
- SOTF (b)(1)1.4a CDR ignored reports of injured who he believed did not require MEDEVAC
- Despite finding no weapons or explosives, assumed all adult males were insurgents and reported as EKIA/EWIA rather than as CIVCAS

Recommendation to Address Late CIVCAS Reporting Cause 2: Retrain SOTF (b)(1)1.4a on the Tactical Directive and develop standard operating procedures to address CIVCAS reporting. Incorporate CIVCAS reporting requirements training into predeployment and sustainment training.

Late CIVCAS Reporting Cause 3 CJSOTF-A CDR/ Operations Center: Following the strike CJSOTF CDR and Operations Center created a barrier for unimpeded flow of reporting up the Chain of Command. Contributing Factors include:

- Night JOC Director limited SA- Unaware of potential civilians in the convoy despite mIRC references
- Incomplete handoff between Night and Day JOC Directors
- Day JOC director knew of reports of children but took no action
- Entire leadership discarded observed civilians on the strike site as "locals villagers"
- Poor communication climate within CJSOTF-A "We do not have two way discussions"
- CJSOTF-A CDR rejected a TF (b)(1)1.4a FIR without reading, because "not my unit, and I have boots on the ground"
- Would not entertain the possibility of CIVCAS until SOF Chain of Command reported it-inconsistent with Tactical Directive and their own SOP.

Recommendation to Address Late CIVCAS Reporting Cause 3: Retrain CJSOTF-A on the Tactical Directive and develop standing operating procedures to address CIVCAS reporting. Incorporate CIVCAS reporting requirements training into predeployment and sustainment training.

TAB C – RECOMMENDATIONS FOR ADMINISTRATIVE AND DISCIPLINARY ACTIONS

(U) In consideration of the findings listed in Tab A, and based on my 32 years of commissioned military experience; I recommend the following administrative actions to address shortcomings in the command and control provided by SOTF (b)(1)1.4a and CJSOTF-A which led to the death of up to 23 local nationals and injury to 12 more local nationals and the failures at all levels to comply with reporting requirements for suspected CIVCAS.

A. (U) Commanders:

1. ~~(FOUO)~~ LTC (b)(3), (b)(6) Commander, SOTF (b)(1)1.4a I recommend a General Officer Memorandum of Reprimand (GOMOR) and Relief for Cause for his failure to ensure a properly functioning Operations Center. LTC (b)(3), (b)(6) failed to train his night battle staff to provide control, insights, analysis, or options to the ODAs under its control. LTC (b)(3), (b)(6) failed to ensure oversight of his untrained operations center by allowing all three Field Grade Officers in SOTF (b)(1)1.4a to maintain essentially the same battle rhythm, with all asleep at one of the most critical times for his forces. Additionally, LTC (b)(3), (b)(6) knew or should have known of the potential for CIVCAS immediately following the strike and was told of an injured woman and child during the afternoon but failed to report CIVCAS until after 2000D. I recommend the GOMOR be considered for filing in the officer's official file.

2. ~~(FOUO)~~ COL (b)(3), (b)(6) , Commander, CJSOTF-A, I recommend a General Officer Memorandum of Reprimand for his failure to timely report suspected or alleged CIVCAS. COL (b)(3), (b)(6) was aware of civilians at or near the strike site immediately after the strike but failed to take even minimal steps to ascertain where the civilians had come from. COL (b)(3), (b)(6) refused to read a report from the MEDEVAC unit that was presented to him at approximately 1430D. Despite several indications of a possible or even probable CIVCAS, COL (b)(3), (b)(6) failed to report CIVCAS until after 2000D. COL (b)(3), (b)(6) refusal to acknowledge the potential for CIVCAS and properly report that possibility significantly hindered ISAF/USFOR-A's ability to manage the consequences of this engagement. I recommend the GOMOR be considered for filing in the officer's official file.

3. ~~(FOUO)~~ CPT (b)(3), (b)(6) , ODA (b)(1)1.4a Commander, SOTF (b)(1)1.4a I recommend a General Officer Memorandum of Admonishment for failing to properly apply the Tactical Directive by engaging a target over 12 KM from his formation while aware that the formation contained adolescent males who had not been identified as carrying weapons. IAW AR 600-37, Unfavorable Information, paragraph 3-4, this incident is comprised of a series of "honest mistakes chargeable to sincere but misguided efforts." Therefore, I recommend that the General Officer Memorandum of Admonishment not be filed in the officer's official military personnel files.

B. (U) Staff Officers

1. ~~(FOUO)~~ MAJ (b)(3), (b)(6) , S3, OPCEN Director, SOTF (b)(1)1.4a I recommend a General Officer Memorandum of Reprimand (GOMOR) for his failure to ensure a properly functioning Operations Center. MAJ (b)(3), (b)(6) failed to train his night battle staff to provide control, insights,

analysis, or options to the ODAs under its control. I recommend the GOMOR be considered for filing in the officer's official file.

2. ~~(FOUO)~~ CPT (b)(3), (b)(6) Night Battle Captain, SOTF (b)(1)1.4a I recommend a General Officer Memorandum of Admonishment for his failure to meet even minimal performance expectations of a Company Grade Officer. While clearly the SOTF (b)(1)1.4a leadership failed to provide training and oversight, CPT (b)(3), (b)(6) must share some responsibility for failing to learn the most rudimentary aspects of his job. Captain (b)(3), (b)(6) failed to act on reports of; non-combatants in a potential kinetic target, a target moving away from US Forces and only three weapons being identified for a group of over twenty adult males. IAW AR 600-37, Unfavorable Information, paragraph 3-4, this incident is comprised of a series of "honest mistakes chargeable to sincere but misguided efforts." Therefore, I recommend that the General Officer Memorandum of Admonishment not be filed in the officer's official military personnel files.

3. ~~(FOUO)~~ MAJ (b)(3), (b)(6) , Night JOC, Chief CJSOTF-A, I recommend a General Officer Memorandum of Reprimand (GOMOR) for his failure to meet even minimal performance expectations of a Field Grade Officer. MAJ (b)(3), (b)(6) was on duty during the entire operation from before infill of the ODA until after the strike, but failed to realize that there were any reports of children or adolescents in the vehicles. MAJ (b)(3), (b)(6) failed to maintain minimally acceptable situational awareness for the JOC Director, despite the information being readily available in the mIRC chat, from the J2 Ops, and on the overhead screens. I recommend the GOMOR be considered for filing in the officer's official file.

C. (U) Additionally based on the inaccurate and unprofessional reporting of the USAF predator crew, I recommend the following:

~~(FOUO)~~ Request that the 432nd Air Expeditionary Wing Commander convene a Commander's Directed Investigation (CDI). The CDI should focus on (b)(1)1.4a crew's inaccurate and unprofessional passing of DCGS Screener assessments and bias toward kinetic attack when the DCGS assessments questioned PID and imminent threat.