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In the immediate wake of 9/11 OTS again returned to the subject of interrogation and that September contracted with recently retired Air Force SERE psychologist Jim Mitchell to produce a paper on al-Qa'ida resistance-to-interrogation techniques. Mitchell collaborated with another Air Force SERE psychologist, Bruce Jessen, and eventually produced "Recognizing and Developing Countermeasures to Al-Qa'ida Resistance to Interrogation Techniques: A Resistance Training Perspective."[21] Following AZ's capture, Mitchell was sent to [redacted] to serve as a behind-the-scenes consultant to interrogators and the on-site OTS staff psychologist (who was there to evaluate AZ psychologically, and explore possible approaches to interrogation and debriefing.)

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Under most circumstances, interrogators seek to exploit the initial shock of capture, which in AZ's case was long since past. In lieu of this they chose to take advantage of the "shock" of his return to detainee prisoner status, in the austerity of a [redacted] cell. One day after his return from the comfortable hospital setting, a three day period of interrogation was begun, employing all the previously approved measures. The on-site OMS physician monitored this closely, and found that neither the initial three-day period of sleep deprivation nor shorter periods repeated several days later that week impacted his continuing recovery. These measures also failed to garner any

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[21] Mitchell had 13 years of experience in the Air Force SERE program, and Jessen 19 years. Additionally, Jessen had worked with released U.S. military detainees in the Nineties.

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drainatic new intelligence. A one day repetition the following week was similarly ineffectual. As the on-site personnel assessed the situation, "there is unlikely to be a 'Perry Mason' moment where the subject ultimately gives up but rather will likely yield information slowly over the course of the interrogations. The subject currently is taking a highly sophisticated counter-interrogation resistance posture where his primary position is to avoid giving details."[22]

The next contemplated step—which was approved for use at the end of AZ's first week of interrogation—would have been more punitive: placing him in a "confinement" box akin to that previously used in the Agency's own training program. As OMS was advised, confinement boxes had been introduced [redacted] (b)(1) (b)(3) NatSecAct [redacted] The proposed Agency box was to be 30" x 20" x 85", which was more spacious than both the "prototype" [redacted] and the one once used in Agency training. The plan was to confine AZ in a reclining box for a trial period of 1-2 hours, repeated no more than 3 times a day, [redacted] (b)(1) (b)(3) NatSecAct believed that it would "achieve the desired effect."

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Given the lack of success with AZ, SERE psychologists Mitchell and Jessen (the latter having retired from he Air Force in May and became an OTS IC) were tasked wi h devising a more aggressive approach to interrogation. Their solution was to employ the full ra ge of SERE techniques. hey, together with other OTS psychologists, researched these techniques, soliciting information on effectiveness and harmful after effects from var ous psychologists, psychiatrists, academics, and the Joint Personnel Recovery Agency (JPRA), which oversaw military SERE programs.

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By early July a specific plan for the aggressive phase of AZ's interrogation had been worked out. The goal was to jarringly "dislocate" his expectations of treatment, and thereby motivate him to cooperate. (At the time AZ was believed to be author of the al-Qa'ida manual on interrogation resistance; he still seemed to think if he could hold out longer, he would be transferred into the benign U.S. judicial system.) The interrogations would be handled exclusively by the two contract SERE psychologists,[24] who would escalate quickly through a "menu" of pre-approved techniques. [redacted]

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[redacted] i.e., a senior OMS PA, who had worked in the previous Agency program—was to be present throughout and, when warranted, an OMS physician. The OMS medical officers' exclusive role was to assure AZ's safety during interrogation.

As a practical matter, and with OMS concurrence, there were to be two sizes of confinement boxes. Confinement in the previously described larger box would be limited to 8 hours (and no more than 18 hours total in a 24 hour period). A much smaller box also would be built, measuring 30" high x 21"x 30". Confinement in this box would be

[24] CTC described Jessen as a "SERE interrogation specialist" experienced "in the techniques of confrontational interrogations."

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event ally standing sleep deprivation, nakedness and cold showers. As these were not "enhanc d" techniques, no medical monitoring function was specified, nor was OMS advised of interrogations. When [redacted] detainees needed medical care, the PA assigned TDY [redacted] was called. This happened every week or two, largely for entirely routine complaints.[65] Interrogator at [redacted] left to their own devices, sometimes improvised. These improvisations vari d from unauthorized SERE techniques such as smoke blown into the face, a stabilizing stick behind the knees of a kneeling detainee, and cold showers, to undisciplined, physically aggressive "hard takedowns" and staged "executions" (though the latter proved too transparent a ruse).

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The only death tied directly to the detainee program took place in this context at [redacted] It came about as the result of [redacted] staff being left without clear guidance, or any monitoring requirement, at a time of dramatic temperature change.

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[redacted] October 2002, a suspected Afghan extremist named Gul Rahman was captured in Pakistan, and on November [redacted] rendered to [redacted] His principle interrogator was psychologist/interrogator Bruce Jessen, on site to conduct in-depth interrogations of several recently detained al-Qa'ida operatives. For a week, Rahman steadfastly refused to cooperate despite being kept naked and subjected to cold showers and sleep deprivation. Jessen was joined by psychologist/interrogator Mitchell on November [redacted] At this time the [redacted] PA visited [redacted] and found no pressing medical problems,[66] but in view of a recent temperature drop recommended that the detainees be provided with warmer clothing (between November [redacted] and [redacted] the [redacted] low had fallen eleven degrees to about 31°F). [redacted] the psychologist/interrogators performed a final mental status exam on Rahman and recommended "continual environmental deprivations." They, and the [redacted] PA, then departed [redacted] the evening of November [redacted]

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Over the next few days, temperatures [redacted] improved (highs up fifteen degrees [redacted] lows up nine degrees, [redacted] but Rahman's demeanor and level of cooperation did not. When his food was delivered on the [redacted] he threw it, his water bottle and his defecation bucket at the [redacted] guards, saying he knew their faces and would kill them when he was released. On learning this, the Site Manager directed that Rahman, who wore only a sweatshirt, be shackled hands and feet, with the shackles connected by a short chain. As such, he was nearly immobiliz d sitting on the concrete floor of his cell. The temperature had again dropped [redacted] the preceding evening, and

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the night Rahman was short-chained reached a low of 31°F. Although Rahman allegedly looked okay to the guards during the night, he was dead the following morning.

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An autopsy—performed by a [redacted] (b)(6) [redacted] pathologist [redacted] (b)(6) [redacted] and assisted by the [redacted] PA [redacted] to [redacted]—found no trauma, toxicology, or other pathology to explain the death. On a clinical basis, the pathologist attributed cause of death to hypothermia, consistent with the absence of specific findings. Rahman lost body heat from his bare skin directly to the concrete floor and was too immobilized to generate sufficient muscle activity to keep himself alive.[68]

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Gul Rahman's death triggered several internal actions, including the generation of formal DCI guidelines on the handling and interrogation of detainees (which basically codified existing RG practice), and the requirement that all those participating in the program document that they had read and understood these requirements.[69] The "Guidelines on Confinement Conditions for CIA Detainees" (28 January 2003) required, among other things: documented periodic medical (and when appropriate, psychological) evaluations; that detainee food and drink, nutrition and sanitary standards not fall below a minimally acceptable level; that clothing and/or the physical environment be sufficient to meet basic health needs; that there be sanitary facilities (which could be a bucket); and that there be time for exercise. The "Guidelines on Interrogations Conducted Pursuant to the Presidential Memorandum of Notification of 17 September 2001" specified that EITs could not be used without prior Headquarters approval, must be preceded by a physical and psychological exam, and must be monitored by medical personnel. Even standard techniques (those deemed not to incorporate significant physical or psychological pressure) required prior approval "whenever feasible." These standard techniques were described as including sleep deprivation (up to 72 hours, reduced to 48 hours in Dec 2003), diapering (generally not to exceed 72 hours), reduced caloric intake (still adequate to maintain general health), isolation, loud music or white noise, and denial of reading material.

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Renditions and Detainees Group (RDG, the renamed RG) in December was given responsibility for oversight of [redacted] Coincident with this, OMS took over psychologist coverage there, which began with the assessment of some [redacted] detainees then on site. The [redacted] (b)(1) PA also began monthly cable summaries of detainee physical health.

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