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Statement
of

Mr. Thomas F. Gimble
Acting Inspector General
Department of Defense

before the

House Oversight and Government Reform Committee
on

Investigations by the Office of the Inspector General,
Department of Defense, concerning
the Death of Corporal Patrick Tillman and
the Rescue of Private First Class Jessica Lynch

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to appear before this committee to discuss the investigations conducted by the Office of the Inspector General, Department of Defense, concerning the death of Corporal Patrick Tillman and the rescue of Private First Class Jessica Lynch.

Investigation concerning the Death of Corporal Patrick Tillman

On behalf of the Office of the Inspector General, I want to again offer our sympathies to the Tillman family on the loss of a husband, son and brother. On March 26, 2007, my office and the Army Criminal Investigative Division briefed the Tillman family, interested Members of Congress and their staff, and the public on the results of two separate but coordinated reviews of the events before and after the death of Corporal Patrick Tillman.

The Army Inspector General, as well as members of Congress, asked my Office to review the circumstances of Corporal Tillman's death. We determined the most efficient way to accomplish the review was to separate it into two parts. We asked Army CID to determine the facts up to and through the incident itself, while we reviewed the events after the incident. We focused on three areas: adequacy of the investigations, notification of next of kin, and the accuracy of documentation to justify the award of the Silver Star. My office also reviewed the Army CID investigation and concurred with their finding.

The scope of our review included interviews of over 100 witnesses and encompassed over 20,000 staff hours.

There were three sequential Army Regulation 15-6 investigations into the death of CPL Tillman. The investigations occurred at the battalion, regimental, and later at command level. As a preliminary matter, we concluded that despite shortcomings, each investigation established the basic facts of CPL Tillman's death – that it was caused by friendly fire, that occupants of one vehicle in CPL Tillman's platoon were responsible, and that circumstances on the ground at the time caused those occupants to misidentify friendly forces as hostile. None of the investigations suggested CPL Tillman's death was other than accidental. Our review, as well as the investigation by Army CID, revealed no evidence contrary to those findings.

Adequacy of the Investigations

Overall, our review concluded CPL Tillman's chain of command made critical errors in reporting and assigning investigative jurisdiction in the days following his death, and bears ultimate responsibility for the inaccuracies, misunderstandings, and perceptions of concealment that led to our review.

After clear evidence of fratricide emerged the day following the incident, CPL Tillman's battalion commander, with the concurrence of his regimental commander,

improperly appointed a subordinate Army captain to investigate. This appointment was contrary to Department of Defense guidance which requires the Combatant Commander, in this case U.S. Central Command, to convene a legal investigation into a friendly fire death. Additionally, the regimental commander failed to notify the Army Safety Center of a suspected friendly fire death as required by Army regulation and a safety investigation was not initiated at that time.

The captain conducted his investigation in about 2 weeks, concluding CPL Tillman was killed by friendly fire. However, the regimental commander determined that the first investigation was not thorough, did not approve the draft report, and ordered his executive officer, a lieutenant colonel, to continue to investigate the death. That second investigation, building on the first, was completed in about 8 days, confirmed death by friendly fire, and provided expanded findings on the contributing tactical errors.

We determined both investigations were deficient, primarily because each investigating officer failed to visit the scene to gather evidence and failed to interview all relevant witnesses. As a result, the first two investigations lacked credibility and contributed to perceptions that Army officials purposefully withheld key information concerning the deaths and injuries.

In November 2004, because of lingering concerns regarding CPL Tillman's death, the Acting Secretary of the Army directed that the Commander, Army Special Operations

Command, conduct an investigation. In turn, the Commander, Army Special Operations Command, appointed a subordinate brigadier general to conduct the third investigation.

That investigation was more thorough than the first two and included an on-site visit. However, we determined the third investigation was also deficient, primarily because the investigating officer failed to interview all relevant witnesses, and did not assess accountability for the chain of command's failure to comply with requirements including failure to report and investigate friendly fire incidents; failure to provide timely information concerning suspected friendly fire to CPL Tillman's next of kin; and failure to ensure accuracy in documentation submitted in support of the Silver Star.

The third investigator also reached findings related to the Silver Star that were not supported by testimony, and further exacerbated the situation by briefing those unsupported findings to Army Leaders, Congress, and the family.

Next of Kin Notification

With regard to the notification of CPL Tillman's next of kin, DoD and Army regulations require that next of kin be advised of additional information concerning a Service member's death as the information becomes available. In this case, although friendly fire was suspected by the battalion and regimental leadership the day following CPL Tillman's death, CPL Tillman's wife and family members were not told of that

suspicion, the investigations, and the subsequent fratricide determination until 35 days after his death. This was a result of the decision of CPL Tillman's regimental commander to keep information about the friendly fire investigation "close hold." Additionally, the Commander, Army Special Operations Command, knew friendly fire was suspected and was under investigation before he represented the Army at CPL Tillman's memorial service. At that time, he was in a position to ensure the family was notified of the friendly fire inquiry; however, he decided not to tell the family until all facts concerning the incident could be verified.

We found no reasonable explanation for this failure to comply with regulations.

Accuracy of Documentation to Justify the Award of the Silver Star

The citation and narrative justification submitted to support the award of the Silver Star to CPL Tillman contained inaccurate information that implied CPL Tillman was killed by enemy fire. The two supporting valorous witness statements attributed to two of CPL Tillman's platoon members were drafted by others and also contained inaccurate information.

We determined that several officers in CPL Tillman's chain of command were accountable for the inaccuracies and the failure to correct the record once they became aware the information was inaccurate. Further, the commanders of the Joint Task Force

and Army Special Operations Command, failed to inform the Silver Star approval authority that some circumstances in the recommendation package were under investigation and that fratricide was highly possible.

Summary of Conclusions and Accountability

To summarize the conclusions of our review:

First, related to the three investigations of CPL Tillman's death, we determined that:

- The regimental commander failed to initiate, through the chain of command, timely notification to the Army Safety Center and U.S. Central Command of suspected friendly fire in CPL Tillman's death. As a result, neither organization could comply with its respective responsibility to assess the need for a safety investigation or to convene a legal investigation.
- The Commander, Army Special Operations Command, failed to timely appoint a safety board to investigate the fratricide incident as required by Army regulation.

Each of the three investigations of CPL Tillman's death was deficient, and thereby contributed to inaccuracies, misunderstandings, and perceptions of concealment. Those deficiencies included:

- The first two investigating officers were not appointed properly; failed to visit the scene to visually reenact the incident, secure physical evidence, take photographs, and obtain accurate measurements; and failed to interview relevant witnesses and address factual inconsistencies in witness testimony.
- The first investigating officer failed to preserve or document physical evidence and in consultation with his legal advisor, withheld from the Armed Forces Medical Examiner and Army CID information that friendly fire was suspected.
- The second investigating officer drew conclusions not supported by evidence included in his investigative files.
- The third investigating officer failed to interview all of the Rangers in Serials 1 and 2 to resolve the uncertainty in the sequence of events that occurred on April 22, 2004; failed to apply relevant standards and assign accountability for the mishandling of physical evidence in the days following CPL Tillman's death; failed to fully address the next of kin notification issue as a violation of regulations; failed to pursue inaccuracies related to the Silver Star, reached findings not supported by testimony, and, exacerbated the situation by sharing those findings with family members, senior Army officials, and Members of Congress during official briefings.

- The Commander, Army Special Operations Command, misled the third investigating officer and this office when he denied he knew friendly fire was suspected before the memorial service for CPL Tillman.
- Related to that issue, we also determined that the third investigating officer failed to pursue those misrepresentations by the Commander, Army Special Operations Command.

With regard to our second area of focus, notification of next of kin, we concluded that responsible Army officials failed to notify the primary next of kin as soon as they reasonably suspected friendly fire. We determined that the regimental commander was accountable for his decision to delay notification to the primary next of kin, and the Commander, Army Special Operations Command, was also accountable because he was in a position to ensure the primary next of kin was notified prior to, or immediately after, CPL Tillman's memorial service but decided not to do so.

On our final area of focus, the Silver Star, we concluded that responsible officials failed to comply with the Army military award regulation when they submitted a Silver Star recommendation that included inaccurate information and a misleading citation that implied CPL Tillman died by enemy fire. We determined that the battalion, regimental,

and Joint Task Force commanders are accountable for the inaccurate award recommendation, and the commanders of the Joint Task Force and Army Special Operations Command are accountable for the failure to inform the Army Silver Star approval authority that some circumstances in the recommendation package were under investigation.

Recommendations

I would like to note that while our review was underway the Department of the Army took a number of steps to remediate several issues identified during our review with regard to investigation of friendly fire deaths, notification of next of kin, and posthumous valor awards.

Based on our review, we made the following recommendations:

- The Acting Secretary of the Army take appropriate action with respect to officials whom we identified as accountable for the regulatory violations and errors in judgment described in our review; and initiate a review of the Silver Star award to ensure it meets regulatory requirements.
- The Commander, U.S. Central Command, issue implementing guidance on investigating friendly fire incidents.

I again offer our sympathy to the family for this tragic loss of life, and want to emphasize that while CPL Tillman's death was an accident, this in no way diminishes the fact that he was someone who displayed a high degree of patriotism and self sacrifice.

Investigation concerning the rescue of PFC Jessica Lynch

My office was also involved in reviewing allegations concerning the rescue of Private First Class (PFC) Jessica Lynch. We received a letter dated May 21, 2003, from Representatives Rahm Emanuel and Louise Slaughter, requesting an investigation following allegations reported by the British Broadcasting Corporation that the rescue of Private Lynch was a "premeditated fabrication." We also received a similar inquiry from Representative Pete Stark.

In coordination with the IG, Joint Staff, we tasked the IG, USCENTCOM, to conduct a preliminary inquiry. The USCENTCOM investigating officer interviewed over 30 witnesses, including those who conducted the rescue operation, and reviewed numerous classified operational documents. None of those sources were available to the media, which based the allegations largely on statements of physicians at the hospital where PFC Lynch was treated.

USCENTCOM determined, and we concurred, that the allegations were not substantiated. USCENTCOM found no evidence that the rescue mission of PFC Lynch

was a staged media event but determined that the rescue operation constituted a valid mission to recover a U.S. POW under combat conditions. Taking into account all of the planning factors used by U.S. Special Forces (USSOF) during the rescue mission, there did not appear to be any unnecessary delay in the execution of the mission nor did there appear to be any inappropriate influence on the planners or executors of the mission.

The rescue was filmed by a combat cameraman and a member of USSOF in accordance with standard procedures used by USSOF. USSOF routinely filmed high priority missions per verbal order of a USSOF leader; however, no public affairs personnel were involved in the planning or filming of the operation.

The forces selected to conduct the missions were based on the anticipated enemy threat and had to be able to counter all enemy capabilities within and near the hospital complex. The level of force used by USSOF to perform the mission was consistent with the anticipated resistance and established doctrine. USSOF received conflicting information regarding the number of enemy personnel in the hospital but fully expected to meet stiff resistance including guards on PFC Lynch's room.

THE USCENCOM IG also found no evidence that any U.S. military member exhibited inappropriate or dishonorable behavior in connection with the PFC Lynch rescue mission. USSOF conducted a personnel recovery mission, during wartime, in a non-permissive environment, to rescue a U.S. POW from a hostile enemy location. During the mission USSOF received enemy fire from the hospital building, the

surrounding complex, and nearby areas. They successfully engaged the enemy forces they encountered, and neutralized them without sustaining any casualties of their own.

During the conduct of the mission, members of USSOF followed the Tactics, Techniques and Procedures (TTP) and Rules of Engagement (ROE) relevant to the mission. None of the USSOF personnel saw or heard any mistreatment of Iraqis during the rescue. USCENTCOM further found no indication that any service member was “acting for the camera” during the rescue mission.

Thank you for the opportunity to appear before the committee today to address our investigations concerning the death of Corporal Patrick Tillman and the rescue of Private First Class Jessica Lynch.