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OFFICE OF THE CHIEF OF NAVAL OPERATIONS  
2000 NAVY PENTAGON  
WASHINGTON, D.C. 20350-2000

IN REPLY REFER TO

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N00ND  
8 Nov 2013

From: ADM John M. Richardson, USN  
To: Secretary of the Navy

Subj: INVESTIGATION INTO THE FATAL SHOOTING INCIDENT AT THE WASHINGTON NAVY YARD (WNY) ON 16 SEPTEMBER 2013 AND ASSOCIATED SECURITY, PERSONNEL, AND CONTRACTING POLICIES AND PRACTICES

Ref: (a) SECNAV ltr dtd 25 Sep 13  
(b) Mtg SECNAV/ADM Richardson of 2 Oct 2013  
(c) SECNAV memo dtd 11 Oct 13

Encl: (1) Final Report

1. Reference (a) directed that I lead an in-depth investigation into the full range of security, contractor, personnel and other factors related to the 16 September 2013 incident at the Washington Navy Yard (WNY). References (b) and (c) supplemented reference (a) and presented additional matters to be addressed. Enclosure (1) is the required report.

2. The investigation reviewed execution and compliance for the programs, plans and procedures in effect at the WNY on 16 September 2013. The Investigation Team observed work and conducted site visits, program reviews, and interviews. During the course of the investigation, the Team received outstanding support from all organizations, including the Federal Bureau of Investigation and the Washington, DC Metropolitan Police Department.



J. M. RICHARDSON

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REPORT OF THE INVESTIGATION  
INTO THE FATAL SHOOTING  
INCIDENT AT THE WASHINGTON  
NAVY YARD ON SEPTEMBER 16, 2013  
AND ASSOCIATED SECURITY,  
PERSONNEL, AND CONTRACTING  
POLICIES AND PRACTICES

November 8, 2013

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## Executive Summary

At 0744 on the morning of September 16, 2013, Aaron Alexis, an employee of The Experts, Inc., drove through the 6<sup>th</sup> Street Gate onto the Washington Navy Yard (WNY). He used his valid Common Access Card to gain access to the base. He parked in Building 28, a garage across the street from Building 197, the Naval Sea Systems Command (NAVSEA) Headquarters. At 0802, Alexis entered Building 197, where he had been tasked to perform updates to classified computers, carrying a concealed, sawed-off shotgun. Alexis used a valid temporary access badge to go through the electronic badge reader and past the guard station. He proceeded to the fourth floor and entered a restroom. At 0815, he emerged from the restroom carrying the sawed-off shotgun and began shooting. The initial report of an active shooter was made at 0816. Law enforcement forces from the WNY and external agencies responded quickly and effectively to contain and eliminate the threat. Alexis was shot and killed at 0925. Before he was stopped, he had killed twelve personnel and wounded four more. Post-incident response efforts began immediately to support the wounded, families of the deceased, and affected employees. The overall post-incident response was timely, plentiful, and responsive to the needs of those affected by the incident.

On September 25, 2013, the Secretary of the Navy appointed Admiral John Richardson, USN, to conduct an in-depth investigation into the full range of security, contractor, personnel, and other factors related to the September 16, 2013 incident at the WNY. The investigative effort was organized into five areas:

1. The history of Alexis to include time on active duty as a Sailor in the U.S. Navy from May 8, 2007, to January 31, 2011, his time in the Individual Ready Reserve, and his employment with an information technology company, The Experts, from September 5, 2012, to

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December 27, 2012, and again from July 8, 2013, to September 16, 2013.

2. The personnel security program (PSP), designed to vet applicants for initial authorization to access secure assets; and once approved, to continuously evaluate personnel for suitability for continued access.
3. The force protection program, designed to prevent unauthorized personnel and material from accessing secure facilities.
4. The incident response and emergency management programs, designed to respond, to contain and eliminate a threat should the PSP and force protection barriers fail.
5. The response after the incident, designed to mitigate the damage to people, property, information systems and operations after an incident occurs.

On October 11, 2013, the Secretary of the Navy approved the recommendations of the rapid reviews conducted by the Assistant Secretary of the Navy Manpower & Reserve Affairs and the General Counsel of the Navy. The findings and recommendations of this report support and build upon the findings and recommendations of those rapid reviews.

## **Findings**

The cause of this incident was that Alexis, using valid credentials, entered the WNY with a concealed personally-owned shotgun, and used that weapon to shoot and kill 12 personnel in Building 197. This investigation concluded Alexis was an insider threat. The insider threat obtains and uses valid credentials to do damage from inside the force protection defenses.



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Before September 16<sup>th</sup>, Alexis was observed by several people, including his supervisors at The Experts, Inc, and HP Enterprise Services LLC, to behave in a way that raised concerns about his mental stability and presented indicators that he may cause harm to others. This information was not reported to the government as required. Had this information been reported, properly adjudicated, and acted upon, Alexis' authorization to access secure facilities and information would have been revoked.

The findings of this investigation fall into three groups, depending on their potential to prevent the incident on September 16, 2013:

Category A: Findings relating to the contractors' compliance with the PSP. For these findings, had proper procedures been followed, the chain of events that led to the WNY shooting incident on September 16, 2013, would have been interrupted.

1. Senior managers at the information technology company "The Experts," a subcontractor to HP Enterprise Services, LLC, for the Navy Marine Corps Intranet Continuity of Services Contract, failed to meet their contractually-required responsibility to continuously evaluate their employee Alexis and report adverse information to Department of Defense Central Adjudication Facility and U.S. Navy installation commanders. Specifically, the company leadership decided not to inform the government of adverse information concerning Alexis' emotional, mental, or personality condition, even when they had concerns that Alexis may cause harm to others, as required by the National Industrial Security Program Operating Manual.
2. HP Enterprise Services, LLC, the prime contractor for the Navy Marine Corps Intranet Continuity of Services Contract, failed to meet their contractually-required responsibility to continuously evaluate Alexis and report adverse information to Department of Defense Central Adjudication Facility and U.S. Navy installation commanders. Specifically, HP Enterprise Services, LLC, did not inform the

government of adverse information concerning Alexis' emotional, mental, or personality condition, as was required by the National Industrial Security Program Operating Manual.

Category B: Findings relating to other commands' or organizations' oversight of and compliance with the PSP with respect to Alexis. For these findings, had proper procedures been followed, the chain of events that led to the WNY shooting incident on September 16, 2013, may have been interrupted, earlier in Alexis' career.

3. Department of the Navy Central Adjudication Facility did not resolve important questions that arose from gaps and inconsistencies in the investigation report and failed to retain the required record of its adjudicative process. This hampered the investigation's ability to understand the factors that led to Department of the Navy Central Adjudication Facility's decision to grant Alexis a SECRET security clearance.

4. Fleet Logistics Support Squadron FOUR SIX did not properly continuously evaluate Alexis and report adverse information to Department of the Navy Central Adjudication Facility, as required by SECNAV M-5510.30.

5. The Navy's Space and Naval Warfare Systems Command, Program Executive Office for Enterprise Information Systems, and Naval Enterprise Networks Program Manager, Warfare, did not exercise effective oversight of personnel security-related aspects of contractor performance for the Navy Marine Corps Intranet Continuity of Services Contract.

Category C: Findings relating to the conduct of force protection and emergency management on the WNY on September 16, 2013. For these findings, even had proper procedures been followed, there would have been no direct impact on the chain of events that led to the WNY shooting incident on September 16, 2013. These findings still require correction to

address critical performance gaps and improve the WNY's capability against a wide range of threats.

6. The Naval Support Activity Washington's Antiterrorism Program is deficient in several areas.

7. The Physical Security and Law Enforcement Programs at Naval Support Activity Washington and the Physical Security Program at the Naval Sea Systems Command Headquarters are deficient in several areas.

8. The access control methods and practices employed by Naval Support Activity Washington and Naval Sea Systems Command to vet unescorted visitors do not comply with local, Department of the Navy, and Department of Defense instructions.

9. The Naval Support Activity Washington Naval Security Forces and Naval District Washington Fire and Emergency Services' response was swift and heroic. At the operational level, Naval Support Activity Washington and Naval District Washington Operations Centers did not effectively communicate and coordinate actions with the Metropolitan Police Department Unified Command until after the threat had been neutralized. As such, Navy Command and Control assets did not play a meaningful role in the initial incident response.

10. Naval Support Activity Washington and Naval District Washington did not have effective emergency management programs. Oversight of emergency management by Naval District Washington and Commander, Navy Installations Command did not identify the deficiencies.

11. Department of the Navy leadership proactively executed highly effective post-incident actions. Some areas for improvement were identified.

## Recommendations

This report presents recommendations to improve Navy capability against all threats, with a focus on the insider threat. Immediate actions to address Category A, B and C findings will improve PSP execution by DON organizations and contractors, and critical gaps in the force protection and emergency management programs on the Washington Navy Yard.

1. Immediately reinforce with DON leadership and DON contractors and subcontractors their responsibility to comply with existing PSP requirements as laid out in SECNAV M-5510.30, Department of the Navy PSP, and the National Industry Security Program Operating Manual including prompt and accurate reporting of adverse information and removing access to secure assets when warranted.
2. Direct ASN (M&RA) and Deputy Under Secretary of the Navy for Plans, Policy, Oversight and Integration to develop DON training material, supplemented by a case study based on the WNY shooting incident, to train personnel on the principles of the PSP, the importance of compliance, and consequences of non-compliance. This material should be incorporated into leadership schools and civilian continuing training programs.
3. Direct CNO and CMC to order self-assessments, at the unit level, of compliance with the requirements of SECNAV M-5510.30, including security manager training, reporting of adverse information, commentary in performance evaluations regarding handling of classified material, and follow up of Department of Defense Central Adjudication Facility (DoDCAF) letters of concern.

4. Direct ASN Research, Development & Acquisition (RD&A) to clarify expectations for Program Executive Offices, Program Offices, Contracting Offices and Commands regarding oversight and administration of the security aspects of DON contracts. This should include audits of contractor compliance with PSP requirements. As part of this effort, ASN (RD&A) should validate that DON contracts include appropriate security clauses.
5. Direct ASN (M&RA) to require that all adverse information developed during investigations, deliberations, and formal adjudications, beginning with the recruitment process, be thoroughly documented, properly retained, and readily accessible by authorized personnel. This will help to provide a complete and detailed record to support future suitability determinations.
6. Immediately and forcefully reinforce with DON leadership their responsibility to oversee compliance with existing physical security, law enforcement, and antiterrorism program requirements.
7. Direct that ASN (M&RA) develop DON training material, supplemented by a case study based on the WNY shooting incident, to train personnel on the principles of force protection, the importance of compliance, and consequences of non-compliance. This material should be incorporated into leadership schools and civilian continuing training programs.
8. Direct Chief of Naval Operations (CNO) and Commandant of the Marine Corps (CMC) to update Antiterrorism Level 1 Awareness Training to include lessons learned from the Fort Hood incident and the WNY incident.
9. Direct the CNO and CMC to conduct a self-assessment of installation compliance with higher headquarters directives in force protection and emergency management. This assessment must

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focus on actual compliance at the installation, not a review of administration, and should include:

- a. Implementation of deadly force policy.
- b. Adequacy of program oversight.
- c. Adequacy of training and drill programs.
- d. Adequacy of resources.

10. Direct the CNO and CMC to identify, prioritize and execute the most cost effective, high impact actions that could mitigate known force protection and emergency management capability gaps. This should include effective use of random antiterrorism measures to deter, detect and disrupt potential attacks, revitalized training, and the establishment and subsequent exercising of mutual aid agreements to enhance incident response.

11. Direct the CNO and CMC to conduct a review of DON requirements for force protection and emergency management as compared to the available resources and assess threat. This review should also address how the operational commander and the resource provider reach agreement on the final resource distribution as balanced against the resultant risk.

12. Direct that ASN (M&RA) address DON policy gaps for post-incident response in the areas of personnel casualty matters, family support programs, and the fleet and family support center program.

Further, on perhaps a less urgent basis, in the interests of improving capability against the insider threat, in particular the effectiveness of the PSP, this report further recommends:

13. That the Secretary of the Navy forward the finding and recommendations of this report to the Secretary of Defense for use in broader efforts to assess the effectiveness of the PSP.

14. That the Secretary of the Navy recommend the Secretary of Defense establish a single authority, who will report directly to him, to compile all recommendations and direction resulting from the investigations into the Fort Hood shooting, USS MIAMI fire, the release of information by Manning and Snowden, the WNY shooting, and other incidents that may be pertinent. An assessment should be done to determine which actions have been completed. Those recommendations that remain open should be prioritized and overseen to completion. A routine report to the Secretary of Defense should be made to formally record progress and completion of these actions.

## **Accountability**

It is recommended that the Secretary of the Navy refer this matter to the Chief of Naval Operations and the Assistant Secretary of the Navy (Research, Development & Acquisition) for review, consideration, further investigation, and action as appropriate.

## Chapter 1 - Introduction

At 0744 on the morning of September 16, 2013, Aaron Alexis, an employee of The Experts, Inc., drove through the 6<sup>th</sup> Street Gate onto the Washington Navy Yard (WNY). He used his valid Common Access Card to gain access to the base. He parked in Building 28, a garage across the street from Building 197, the Naval Sea Systems Command (NAVSEA) Headquarters. At 0802, Alexis entered Building 197, where he had been tasked to perform updates to classified computers, carrying a concealed, sawed-off shotgun. Alexis used a valid temporary access badge to go through the electronic badge reader and past the guard station. He proceeded to the fourth floor and entered a restroom. At 0815, he emerged from the restroom carrying the sawed-off shotgun and began shooting. The Naval District Washington (NDW) Region Dispatch Center (RDC) received reports of an active shooter within Building 197 at 0816. Naval Support Activity Washington (NSAW) Naval Security Force (NSF) members were dispatched and NDW RDC requested assistance from District of Columbia Metropolitan Police Department.

NSAW NSF members were the first law enforcement personnel to enter Building 197 at approximately 0820. By 0837, a unified command post led by the District of Columbia Metropolitan Police Department was established at the O Street Gate to coordinate the multi-agency response. At approximately 0925, Alexis was confirmed dead. Before being killed by law enforcement, Alexis fatally shot twelve people and wounded four others. The remainder of the day at the WNY was spent verifying no other threats existed, evacuating personnel, and carrying out post incident response actions.<sup>1</sup>

### Scope of Investigation

On September 25, 2013, the Secretary of the Navy (SECNAV) directed an in-depth investigation into the full range of security, contractor, personnel, and other factors related to the September 16, 2013, incident at the WNY.



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SECNAV also directed other reviews, which were used to inform this investigation.<sup>2</sup> This investigation addresses the following:

- The military service record, performance history, disciplinary record, discharge documentation, employment status and history, security clearance eligibility adjudication record of former Sailor Aaron Alexis, as well as his criminal, medical and mental health background and records, to include whether any adverse information contained in such records was reported to Department of the Navy (DON) by governmental or private sector record custodians prior to September 16, 2013;
- The execution of and compliance with DON programs, policies and procedures pertaining to personnel security as applied to Aaron Alexis in his former status as an enlisted Sailor in the Navy Reserve and subsequently as a civilian employee of a DON sub-contractor;
- The execution of and compliance with DON programs, policies and procedures pertaining to installation and facility access and security at WNY on September 16, 2013, generally, and specifically as applied to Aaron Alexis;
- The execution of and compliance with DON programs, policies and procedures pertaining to force protection and emergency response management at WNY on September 16, 2013, including an assessment of whether DON response was delayed or impeded;
- The execution of DON post-incident response related to medical response; support to victims, survivors and their families; mission continuity; and communication; and
- Specific opinions as to the adequacy of applicable Departmental programs, policies and procedures as applied to this incident, as well as the execution thereof and compliance therewith, and recommendations to address any concerns, lessons learned, or other issues identified during the course of the investigation.

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In a discussion with ADM Richardson on October 2, 2013, SECNAV also directed the investigation to address whether lessons learned and recommendations from Fort Hood were evident in the procedures, policies and practices in place at the WNY on September 16, 2013.<sup>3</sup>

On October 11, 2013, SECNAV directed that the investigation also address the following:

- Identify, and determine whether HP Enterprise Services, LLC (HPES) and The Experts complied with the applicable background investigation requirements for Alexis under The Experts' subcontract, including those required for security clearance reviews, routine physical access to a federally controlled facility, and routine access to a federally controlled information system, as well as the criminal background check required under the subcontract;
- Evaluate the information available to subcontractor, contractor, and Government officials regarding Alexis' behavior since being assigned to the Continuity of Services Contract (CoSC), including the events that occurred in Newport, Rhode Island, in August, 2013;
- Determine whether all applicable reporting requirements were complied with in relation to these events;
- Determine why The Experts administratively debriefed Alexis from classified information on August 7, 2013, and re-indoctrinated him on August 9, 2013;
- Determine whether any adverse information notifications regarding Alexis were provided to the Cognizant Security Agency (CSA) or installation commander(s) based on events that occurred while he was performing work in support of Government contracts; and
- If any adverse information reports were received, determine whether the appropriate procedures were followed and assessments made.<sup>4</sup>

## Methodology

The Investigation Team, led by Admiral Richardson, consisted of 30 investigators and ten support personnel. The team consisted of a range of subject matter experts, to include personnel with extensive experience in the fields of force protection, government contracts, installation management, emergency management, medicine, and the law. A majority of the investigators have extensive experience in conducting administrative inquiries and audits. A complete roster of team members is included in Appendix I.

The Investigation Team focused on the non-criminal aspects of the incident, and at no time did its investigation interfere with the ongoing investigations by the Naval Criminal Investigative Service and the Federal Bureau of Investigation. This report does not evaluate the response by non-DON agencies, nor does it address matters that are included in the criminal investigation still underway. Any reference to tactical operations conducted by non-DoD law enforcement are included solely to place the DON response in perspective.

The investigation team reviewed documents, interviewed witnesses, and conducted field observations. Additionally, Admiral Richardson, or a senior representative, discussed the purpose and scope of the investigation, and solicited subject matter expertise and any information relevant to the investigation with: Commander, U.S. Fleet Forces Command; Commander, Navy Installations Command; Commander, Naval Facilities Engineering Facilities Command; Commandant, Naval District Washington; and Commanding Officer, Naval Support Activity Washington. This dialogue continued throughout the investigation. Similar discussions occurred with the Assistant Secretary of the Navy (Research, Development & Acquisition), Assistant Secretary of the Navy (Energy, Installations and Environment); Commander, Space and Naval Warfare Systems Command; and Program Executive Officer for Enterprise Information Systems. Admiral Richardson also discussed the results of the “Quick Look” reports and their relevance to this investigation with the Chief of

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Naval Operations, Commandant of the Marine Corps, and Commander, U.S. Fleet Forces Command.

The report is organized in chapters that analyze the major elements of the appointing order. Chapter 2 provides a summary of events concerning Alexis. It begins with his graduation from high school in 1999 and continues through the post-incident response period following the shooting incident on September 16, 2013. Chapter 3 examines the Personnel Security Program (PSP), through which Alexis was granted access to the WNY and NAVSEA Building 197. Chapter 4 examines elements of force protection (e.g., antiterrorism, physical security, law enforcement, and access control measures) employed at the WNY and at NAVSEA. Chapter 5 analyzes the incident response on September 16, 2013, including the immediate reaction of the NSAW NSF, emergency response, and emergency management. Chapter 6 examines the post-incident response on September 16, 2013, and the days following, including casualty assistance to the victims and their families, employee assistance programs, and continuity of operations.

The findings of this investigation fall into three groups, depending on their potential to have prevented the incident on September 16, 2013:

- Category A: Findings relating to the contractors' compliance with the PSP. For these findings, had proper procedures been followed, the chain of events that led to the WNY shooting incident on September 16, 2013, would have been interrupted.
- Category B: Findings relating to other commands' or organizations' oversight of and compliance with the PSP with respect to Alexis. For these findings, had proper procedures been followed, the chain of events that led to the WNY shooting incident on September 16, 2013, may have been interrupted, earlier in Alexis' career.
- Category C: Findings relating to the conduct of force protection and emergency management on the WNY on September 16, 2013. For these findings, even had proper procedures been followed, there

would have been no direct impact on the chain of events that led to the WNY shooting incident on September 16, 2013. These findings still require correction to address critical performance gaps and improve the WNY's capability against a wide range of threats.

Similarities between this investigation's findings and any related lessons learned from the 2009 shooting incident at Fort Hood, Texas, are highlighted in various sections of the report. The final chapter contains the recommendations developed as part of this investigation. The appendices contain supporting documentation, including a detailed chronology of events related to all of the areas discussed above.

## **BACKGROUND**

### The Washington Navy Yard

The WNY, located in the southeast section of Washington, District of Columbia, is the Navy's oldest shore establishment. As depicted in Figure 1.1, the WNY incorporates 68 acres along the bank of the Anacostia River. Most of the structures on the WNY are historic 19<sup>th</sup> and 20<sup>th</sup> century industrial and residential buildings. There are also a few new office buildings.<sup>5</sup> In addition, the National Museum of the U.S. Navy is located on the WNY and is accessible to the public.<sup>6</sup>

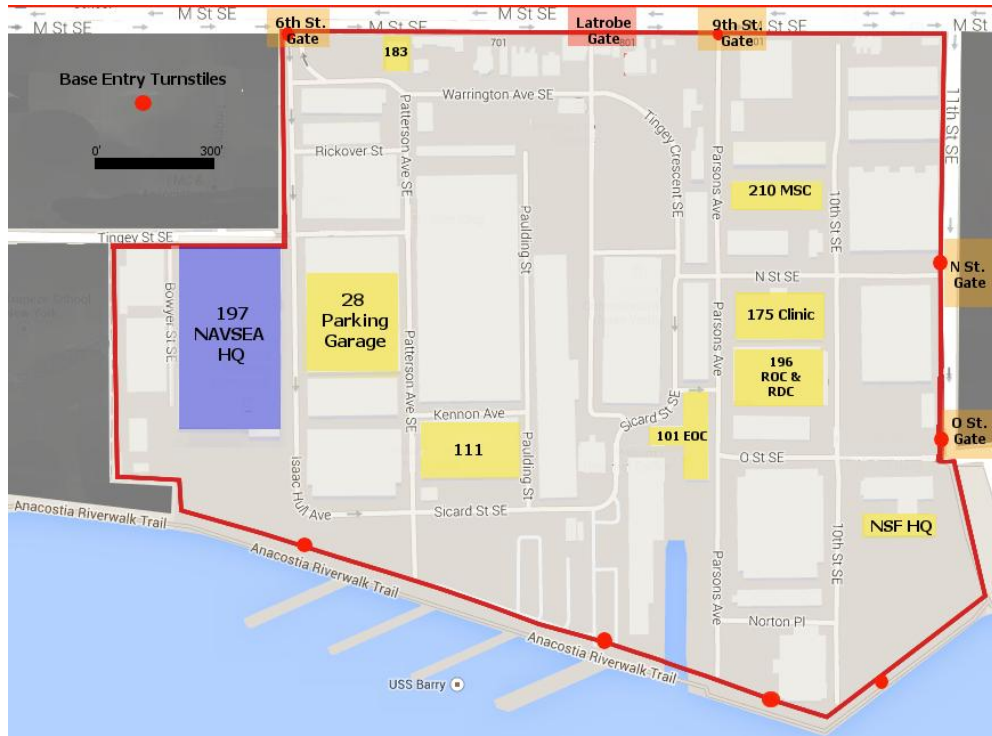


Figure 1.1 Washington Navy Yard

The WNY is one of six locations in the National Capital Region that falls under the authority of the Commanding Officer, NSAW.<sup>7</sup> Naval Support Activity Washington (NSAW) is one of seven installations included in NDW.<sup>8</sup> The WNY hosts 67 tenant organizations and commands, including the headquarters for Commander, Navy Installations Command (CNIC), Commander, NAVSEA, Commander, Naval Facilities Engineering Command (NAVFAC), and Commandant, NDW.<sup>9</sup> On a typical workday, a diverse workforce of more than 17,000 military, civilian and contractor personnel are likely to be aboard the WNY.<sup>10</sup>

The largest tenant on the WNY is NAVSEA.<sup>11</sup> The NAVSEA mission is to design, construct, and maintain ships, as well as shipboard weapons systems.<sup>12</sup> NAVSEA Headquarters, Building 197, is a 638,000 square foot, five-story building that consists of office spaces, training facilities, conference rooms, auditoriums, and secure communications areas for more than 3,000 military, government, and contractor personnel.<sup>13</sup> The main entrance to Building 197 is on the east side of the building bordering

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Isaac Hull Avenue. Just inside the entryway of Building 197 are the Visitor Control Center, the main entry guard station, and five electronic badge readers to monitor personnel access.

The WNY perimeter consists of fences, walls, and buildings. Access to the WNY is normally provided through four main vehicle entry control point gates that allow for pedestrian and vehicle access, four pedestrian turnstile entry control points along the Anacostia Riverwalk, and a ceremonial gate (Latrobe Gate).

The NSAW NSF consists of approximately 100 Department of Defense civilian and military police officers. NSF operates a Pass and ID Office with the capability for commercial vehicle inspections at the O Street Gate.

There is also an independent armed security force that guards access to secured buildings on the WNY, including Building 197. The guards are supplied via a contract between HBC Management Services, Inc., and NAVFAC.<sup>14</sup> These contract security guards act as a component of access control to Building 197 but are not members of NSAW's NSF and have no law enforcement authority.

As another component of the regional emergency response capability, NDW maintains a single engine fire company, providing a 24/7 response capability and fire inspector services at the WNY.

## Pertinent Chains of Command

Chains of command pertinent to this investigation are depicted in figure 1.2 below.

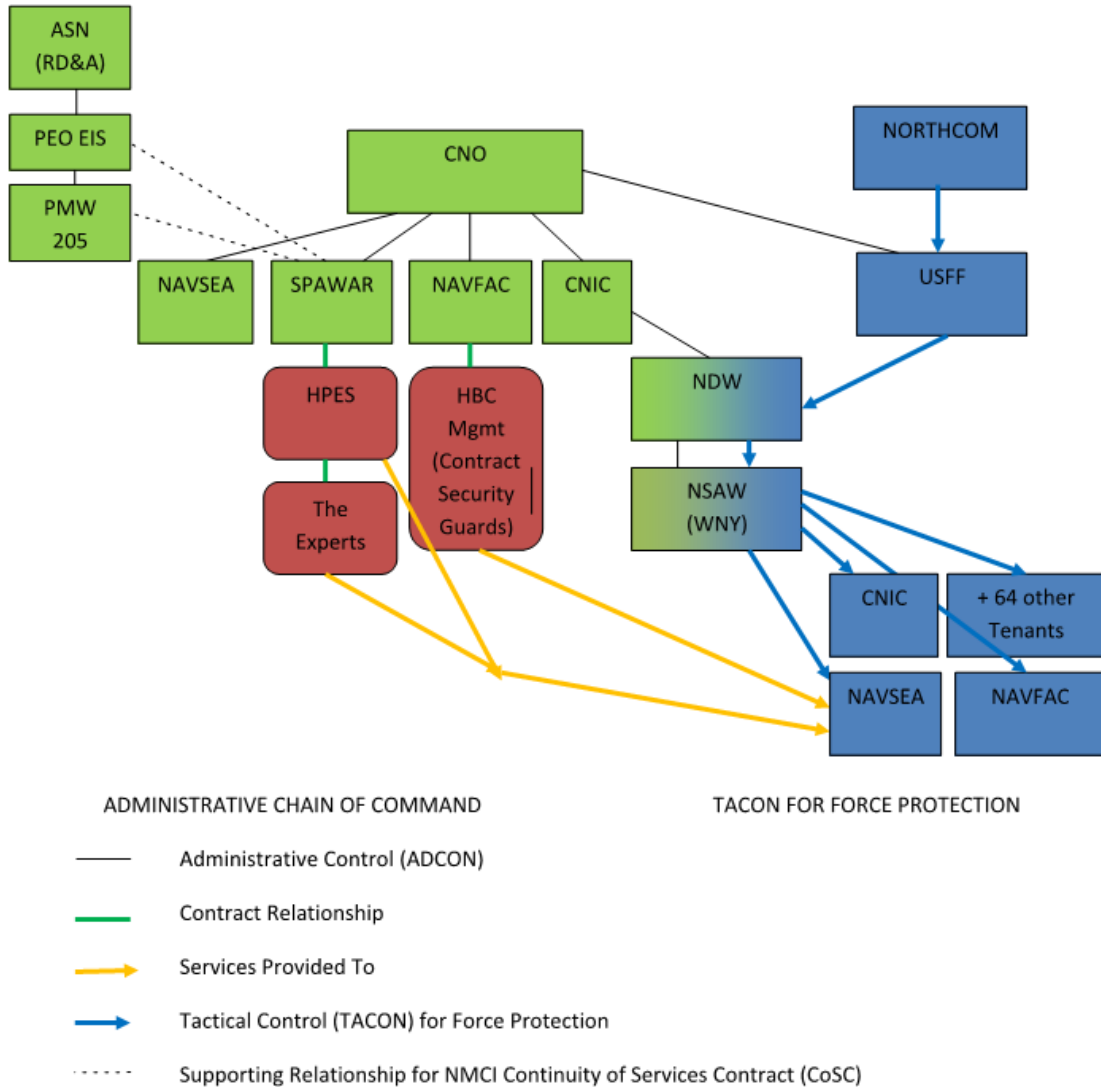


Figure 1.2 Chains of Command at the WNY



## **Description of Force Protection and Personnel Security Program**

Force protection of property, information, or people is accomplished by a system of defenses and response capabilities meant to address both external and internal threats. The system of defenses addresses threats by preventing unauthorized personnel from gaining access to protected assets and by screening and monitoring authorized personnel to ensure they can be trusted to have access to protected assets. Response capabilities act to contain and eliminate active threats and mitigate damage, should the defenses fail.

Physical security systems are designed to deter, detect, and deny unauthorized personnel and material (e.g., weapons) from accessing protected assets. Physical security systems are made up of physical barriers (e.g., fences and guards), operational measures (e.g., antiterrorism measures) and administrative measures (e.g., escort policies, access badges). These measures are intended to work together to prevent unauthorized access.

Authorized personnel who routinely have a need to access secure assets (e.g., facilities and information) are initially vetted and continuously evaluated under the Personnel Security Program (PSP). Access is granted only if reliability criteria are met. An initial vetting determines a person's suitability and eligibility to have access by examining the person's past and making a judgment on future reliability. If deemed reliable, permission to access is granted and identification badges are provided to streamline daily access. Once cleared, a continuous evaluation process is designed to examine a person's behavior to ensure continued reliability.

The level of physical security and the PSP is adjusted relative to the value of the protected asset and the severity of the perceived threat.

In the event that physical security or PSP fail, an incident response capability is required to contain and eliminate the threat, and reestablish

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the defenses. Post-incident response mitigates the damage done by the threat by providing support to affected personnel and by restoring mission capability.

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<sup>1</sup> Appendix B, Timeline.

<sup>2</sup> Appendix A, Secretary of the Navy (SECNAV) memo of 25 Sep 2013, Investigation into the Fatal Shooting Incident at the Washington Navy Yard (WNY) on 16 Sep 2013 and Associated Security, Personnel, and Contracting Policies; RD 1.1 SECNAV memo of 19 Sep 2013, Review of Security Procedures at Navy and Marine Corps Installations in the United States and its Possessions; RD 1.2 SECNAV memo and 25 Sep 2013, Tasking Memorandum for Rapid Review and In-Depth Investigation.

<sup>3</sup> Secretary of the Navy and ADM Richardson meeting on 2 Oct 2013; SECDEF Memo of 18 Aug 2010, endorsing Fort Hood recommendations.

<sup>4</sup> SECNAV memo of 11 Oct 2013, Tasking Memorandum for Approved Recommendations from Rapid Reviews.

<sup>5</sup> History of the Washington Navy Yard (available at <http://www.history.navy.mil/faqs/faq52-1.htm>).

<sup>6</sup> *Id.*

<sup>7</sup> RD 1.3 NSAW Strategic Services Integrator e-mail of 10 Oct 2013 regarding number of commands on the WNY, number of acres comprising the WNY, and estimate of people on the WNY during a workday (with supporting enclosures).

<sup>8</sup> OPNAVNOTE 5400, Standard Naval Distribution List (available at <http://doni.documentservices.dla.mil/sndl.aspx>).

<sup>9</sup> RD 1.3 NSAW Strategic Services Integrator e-mail of 10 Oct 2013 regarding number of commands on the WNY, number of acres comprising WNY, and estimate of people on the WNY during a workday (with supporting enclosures).

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> See <http://www.navsea.navy.mil/aboutNAVSEA.aspx>.

<sup>13</sup> Final Architectural Design for Building 197 of 22 Jan 99; RD 1.3 NSAW Strategic Services Integrator e-mail of 10 Oct 2013 regarding number of commands on the WNY, number of acres comprising WNY, and estimate of people on the WNY during a workday (with supporting enclosures).

<sup>14</sup> Contract No. N40080-12-D-0467, effective 1 Apr 2012.

## Chapter 2 - Timeline

The following timeline is a general overview of events to provide context to understanding the Washington Navy Yard shooting incident on September 16, 2013. This summary includes the events leading up to the attack, the incident response to the active shooter, and the post-incident response actions that followed. A comprehensive chronology is provided in Appendix B.

### History of Alexis Before Entering the Navy

When Alexis applied for a security clearance, he provided the following information:

- In 1999, Alexis graduated from Hillcrest High School in Jamaica, New York.<sup>1</sup>
- After graduating, he lived in the New York City area until 2001.<sup>2</sup>
- He reported moving to Seattle, Washington, in 2001, remaining there until 2007.<sup>3</sup>
- He was employed at the Borough of Manhattan Community College between 2001 and 2003.<sup>4</sup>
- He then described himself as unemployed from February 9, 2003 until he joined the Navy in 2007.<sup>5</sup>

This investigation uncovered the following additional information about Alexis' pre-service history:

On January 21, 2003, Alexis enrolled at DeVry University and subsequently withdrew in March of 2004.<sup>6</sup> During this period Alexis took out several student loans but failed to pay them back (he made partial payments).<sup>7</sup>

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While living in Seattle, he received six traffic tickets with fines ranging from \$105 to \$590. He failed to pay all but one of those fines prior to his enlistment.<sup>8</sup>

On June 3, 2004, Alexis was arrested by the Seattle Police Department and charged with felony “Malicious Mischief” after shooting out the rear tires of a construction worker’s vehicle. When interviewed by the police, Alexis said that he perceived the construction worker disrespected him. This perception led to what Alexis described as “a ‘blackout’ fueled by anger.”<sup>9</sup> On June 7, 2004, charges were dropped.<sup>10</sup>

Alexis traveled to Bangkok, Thailand, from April 28, 2006, to May 12, 2006.<sup>11</sup>

On November 5, 2006, the tires of five vehicles at Alexis’ apartment complex were slashed. Alexis was named by the Bellevue, Washington, Police as the “involved person.” The vehicles belonged to residents or guests of residents living directly above, below and adjacent to Alexis, all of whom were involved in previous complaints made by Alexis.<sup>12</sup> No arrest was made in this case.

From November 30, 2006, to January 8, 2007, Alexis again visited Bangkok, Thailand.<sup>13</sup>

In February of 2007, Alexis returned from Seattle to New York.<sup>14</sup>

## **Military Service in the U.S. Navy and Actions of the Personnel Security Program ICO Alexis**

In March of 2007, Alexis began suitability screening at Naval Recruiting District (NRD) New York. Screening interviews are used to assist the recruiting command in identifying disqualifying conditions, e.g., arrest records, substance abuse, citizenship. Despite his history of arrests, other involvement with law enforcement, and several cases of money owed, Alexis reported no criminal activity and no indebtedness.<sup>15</sup>

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On March 19, 2007, Alexis took the Armed Services Vocational Aptitude Battery and received a score of 78<sup>16</sup> - above the 63.08 average for Fiscal Year 2007.<sup>17</sup>

On March 22, 2007, Alexis went to the Military Entrance Processing Station at Fort Hamilton, New York, for his medical screening. This screening included providing a medical history. Alexis reported no past mental or physical conditions.<sup>18</sup> He was found medically suitable for enlistment.

On March 22, 2007, following the normal recruitment process, the Office of Personnel Management (OPM) initiated a records check, referred to as an Entrance National Agency Check (ENTNAC),<sup>19</sup> to support NRD New York's suitability determination.<sup>20</sup> In accordance with the Navy Recruiting Manual, NRD New York did not separately perform a Police Records Check because Alexis had reported no criminal activity during his screening interview.<sup>21</sup>

Alexis intended to enlist into the Advanced Electronics and Computer Field, which required access to classified information.<sup>22</sup> On March 22, 2007, Alexis completed an Electronic Personnel Security Questionnaire (EPSQ). The questionnaire was used by OPM to conduct a separate investigation to support a Department of the Navy Central Adjudication Facility (DONCAF) determination on whether or not to grant Alexis access to classified information. This OPM investigation is referred to as a National Agency Check with Law and Credit (NACLC). The NACLC checks the same databases as the ENTNAC, with the addition of local agency law enforcement checks, verification of birth date and place, and credit bureau checks. On his EPSQ, Alexis answered "No" to all questions on the questionnaire pertaining to prior treatment for mental health conditions, arrests, convictions, traffic fines greater than \$150, prior use of illegal drugs, abuse of alcohol, or having any financial delinquencies. Alexis also failed to report his attendance at DeVry University and one of his trips to Thailand.<sup>23</sup>

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On April 6, 2007, OPM provided NRD New York the results of the ENTNAC for enlistment suitability.<sup>24</sup> These results contained an “FBI Identification Record” citing that, in June 2004, Alexis was arrested by the Seattle Police Department for “Malicious Mischief.”<sup>25</sup> As part of the suitability process, NRD New York obtained Alexis’ written account of the matter, and a police records check with associated court documents from Seattle. Because Alexis was originally arrested for Malicious Mischief, which was a felony in Washington State, the issue had to be forwarded to Commander, Navy Recruiting Command (CNRC) for adjudication.<sup>26</sup>

On April 27, 2007, NRD New York received a legal determination from CNRC of “no adverse adjudication” related to the Malicious Mischief charge. NRD New York recorded this determination in Alexis’ Record of Military Processing, which determined that Alexis was suitable for enlistment.<sup>27</sup>

There is no evidence that the ENTNAC investigation revealed the specific events behind the Malicious Mischief offense. Specifically, there was no mention that the charge involved discharging a firearm in public to shoot out the tires of a vehicle.

On May 5, 2007, Alexis enlisted in the Navy for eight years total (five years on active duty and three years in reserve)<sup>28</sup> as an Aviation Electrician’s Mate, a military rating that requires handling classified information. He reported to boot camp on May 8, 2007.<sup>29</sup>

On July 10, 2007, Alexis completed boot camp and immediately started his initial technical training. Although the Aviation Electrician’s Mate rating required a security clearance, his technical training did not.

On July 16, 2007, Alexis was interviewed by an OPM investigator as part of the security clearance process to address unreported adverse information pertaining to the cited arrest in Seattle and financial delinquencies.<sup>30</sup> An interview is not a normal part of a NACLIC; however, OPM was required to expand the investigation in order to address the

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adverse information that had been uncovered by the records checks performed.<sup>31</sup> In the interview, Alexis said he was charged with Malicious Mischief after he “retaliated by deflating the male person’s tires.”<sup>32</sup> He said the charge was dropped and that he was advised by his lawyer that because the charge was dropped, he did not have to report it. Alexis also advised that he was working on or establishing repayment plans for his financial delinquencies.<sup>33</sup>

On August 24, 2007, OPM closed the NACLIC and issued a report to DONCAF for use in adjudicating Alexis’ eligibility to access classified information up to the SECRET level.<sup>34</sup>

On December 15, 2007, Alexis reported to Fleet Logistics Squadron FOUR SIX (VR 46) in Marietta, Georgia.<sup>35</sup>

- After several minor disciplinary issues early in this assignment, the Commanding Officer and other command members conducted mentoring sessions with Alexis with the aim of helping him adjust to Navy life.<sup>36</sup>

On March 6, 2008, DONCAF ordered a current credit report on Alexis to support an eligibility determination for access to classified information.<sup>37</sup>

On March 11, 2008, DONCAF determined Alexis was eligible for access to classified information up to the SECRET level.<sup>38</sup> DONCAF made an entry reporting the favorable adjudication in the Joint Personnel Adjudication System (JPAS), which is used across the Department of Defense (DoD) to record eligibility determinations and other personnel security program actions.

- Within JPAS, the adjudicator recorded the following narrative entry: “Personal Conduct; Financial Considerations; Criminal Conduct: Does not pose a security concern at this time.”<sup>39</sup>

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- The adjudicator's narrative entry is visible only to other DONCAF adjudicators. Most other JPAS users are only able to see the clearance level and date of eligibility.
- The complete OPM investigation was only visible to DONCAF. OPM retains a copy of their investigation. The records for the adjudication decision could not be found when requested by this investigation.

On March 11, 2008, in a letter to Alexis, forwarded through VR 46, DONCAF informed Alexis of his eligibility for access to classified information, noting several undisclosed financial issues. As such, DONCAF directed VR 46 to conduct financial counseling for Alexis.<sup>40</sup>

- There is no requirement to keep a record of this counseling and no record was retained.
- The former Security Officer from VR 46 stated that it was normal practice to conduct required counseling in cases such as these.<sup>41</sup>
- On August 28, 2008, Alexis was granted access to classified information. By this action, Alexis was cleared for and had access to classified information while at VR 46. His assigned duties did not normally require that he view or handle classified information.<sup>42</sup>

On July 15, 2008, Alexis' first periodic evaluation report was issued. He was rated below average and received a promotion recommendation of "Must Promote" (there are five possible recommendations for a Commanding Officer to make on an enlisted evaluation report: early promote, must promote, promote, progressing, and significant problems). The retention recommendation was for "retention" (evaluations are required to contain a recommendation regarding whether a sailor should be retained or not). No adverse material was included on the evaluation form.<sup>43</sup>

On August 10, 2008, Alexis was arrested for Disorderly Conduct in DeKalb County, Georgia.



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- He was removed from a night club for causing damage to furnishings and, once outside, was disorderly and continued to yell profanities.
- Alexis was arrested, jailed, and issued a summons to appear in court.<sup>44</sup>
- He did not return to VR 46 until 1855, August 11, 2008, making him absent without leave.<sup>45</sup>
- On September 23, 2008, Alexis received Non-Judicial Punishment (NJP) by his Commanding Officer for being absent without leave.<sup>46</sup>
- On January 30, 2009, Alexis' charge of Disorderly Conduct in DeKalb County was dismissed.<sup>47</sup>
- No report of the arrest was made to DONCAF by VR 46.<sup>48</sup>

On April 15, 2009, Alexis transfers to Fort Worth, Texas as part of VR 46 relocation.<sup>49</sup>

On May 17, 2009, Alexis was at a nightclub in Fort Worth, Texas. After consuming several alcoholic drinks, he leapt from stairs in a parking garage and fractured his right ankle.<sup>50</sup>

- On July 12, 2009, Alexis received NJP for Disorderly Conduct - Drunkenness.<sup>51</sup>
- In conjunction with the NJP proceedings, the command initiated administrative separation procedures.<sup>52</sup>
- No report of the incident was made to DONCAF.<sup>53</sup>
- On July 15, 2009, Alexis filed an appeal of his July 12, 2009, NJP.<sup>54</sup>
- On July 20, 2009, after conferring with legal representation, Alexis re-filed his appeal.<sup>55</sup>

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On July 22, 2009, Alexis received a performance evaluation for the reporting period ending July 15, 2009. He was the only Sailor rated at this time. He received a promotion recommendation of "Significant Problems" and a retention recommendation of "Not Recommended."<sup>56</sup>

On August 16, 2009, a change of command occurred at VR 46.<sup>57</sup>

On December 3, 2009, Commanding Officer VR 46, after conferring with his chain of command, set aside the NJP from July 12, 2009, citing lack of evidence that Alexis was intoxicated as his rationale.<sup>58</sup>

- VR 46 stopped administrative separation actions because, without a second NJP, the requirements to administratively separate Alexis were not met.<sup>59</sup>

On February 28, 2010, Alexis received an evaluation upon advancement to E4 with a promotion recommendation of "Promotable," and a retention recommendation of "Recommended." No adverse information was included. The set-aside of the NJP held on July 12, 2009, was included in the evaluation.<sup>60</sup>

On June 15, 2010, Alexis received a periodic evaluation. He was rated below average with a promotion recommendation of "Promotable" and a retention recommendation of "Recommended."<sup>61</sup> No adverse information was included.

On September 4, 2010, Alexis was arrested in Fort Worth for discharging a firearm within a municipality of a population of 100,000 or more.<sup>62</sup>

- As a result of this arrest, VR 46 started a new administrative separation action.<sup>63</sup>
- On September 14, 2010, the District Attorney's Office, Fort Worth, Texas dropped the charge.

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- Once the civilian charges were dropped, the Commanding Officer of VR 46 chose not to pursue NJP because he thought there was insufficient evidence to support a guilty finding.<sup>64</sup> He also discontinued administrative separation actions.<sup>65</sup>
- No report of the arrest was made to DONCAF.<sup>66</sup>

On December 2, 2010, Alexis applied for the Enlisted Early Transition Program,<sup>67</sup> a program that allowed certain enlisted members in specified ratings to separate within one year of the end of their obligated service.

On December 9, 2010, Navy Personnel Command (NPC) authorized an early separation date of no later than January 31, 2011, for Alexis and characterized his discharge as honorable.<sup>68</sup>

On December 15, 2010, Alexis signed a Security Termination Statement certifying all classified material was returned and he would hereafter not communicate classified information to any person or agency. An entry was made in JPAS recording his detachment from the command.<sup>69</sup>

On January 31, 2011, Alexis was discharged from active duty with an honorable characterization of service and assigned a favorable reentry code of "RE-1," allowing reenlistment.<sup>70</sup> Reentry codes are assigned whenever an individual separates from the service and are used to assist recruiters in assessing suitability for re-enlistment.

- Alexis received a "Detachment of Individual" evaluation. He was the only Sailor rated at this time. He received a promotion recommendation of "Promotable" and retention recommendation of "Recommended."<sup>71</sup> He did not receive a more favorable promotion recommendation of "Must Promote" or "Early Promote."
- He did not meet the requirements for the most favorable reentry code of "RE-R1," preferred reenlistment, because he had not passed the Second Class Petty Officer Advancement Examination.<sup>72</sup>

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- Alexis' medical records from his active duty time contained no adverse information or indications of mental illness.<sup>73</sup>

### **Service in the U.S. Navy Individual Ready Reserve**

Upon discharge Alexis was transferred to the Individual Ready Reserve. As a member of the Individual Ready Reserves, Alexis was required to complete an annual screening questionnaire and report to Commander, Navy Personnel Command any changes of address, contact information, employment information, or physical or medical condition that could affect readiness for recall to active duty. Navy personnel records indicate that Alexis completed his required annual screening in June of 2012 and 2013.<sup>74</sup>

On February 16, 2011, Alexis filed for Texas unemployment benefits as a "permanent layoff."<sup>75</sup>

On March 1, 2011, Alexis began receiving payments from the Department of Veteran's Affairs.<sup>76</sup>

- His rated disabilities initially included right rotator cuff sprain, lumbar degenerative disc disease, and later tinnitus.
- Alexis' total monthly payment from the Department of Veteran's Affairs for an overall combined rating of 30% disability was approximately \$400 per month.<sup>77</sup>

### **Employment with The Experts, Inc., and Actions of the Personnel Security Program in the Case of Aaron Alexis**

On September 5, 2012, Alexis applied for employment as a technician with The Experts, Inc. (The Experts).<sup>78</sup> The Experts is a subcontractor to HP Enterprise Services, LLC (HPES), a prime contractor performing work under the Navy's Navy-Marine Corps Intranet (NMCI) Continuity of Service

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Contract (CoSC).<sup>79</sup> The contract is overseen by the Space and Naval Warfare Systems Command (SPAWAR), Program Executive Officer for Enterprise Information Systems (PEO EIS), and Naval Enterprise Networks Program Office, Warfare (PMW 205). The CoSC invokes the National Industrial Security Program Operating Manual (NISPOM), which defines the security requirements for cleared defense contractors.

- The Experts is a contractor approved by the Defense Security Service to engage in contracts with access to classified information.
- The Experts appointed a Facility Security Officer (FSO), reporting to the Chief Operating Officer (COO), with the responsibility to manage its security program.<sup>80</sup>
- Under the NISPOM, Alexis' security eligibility was still valid because less than 24 months had lapsed since his separation from the Navy.<sup>81</sup>
- The Experts' FSO recorded in JPAS that Alexis was an active employee of The Experts requiring access to classified information.
- Separate from the government security requirements, HPES required The Experts to conduct pre-employment suitability checks on individuals assigned to CoSC, which involved a drug test, a motor vehicle driving record check, and criminal convictions checks.<sup>82</sup>

On September 6, 2012, HPES resource management personnel authorized 28 of The Experts' technicians, including Alexis, to begin work prior to receiving the results of their criminal convictions check.<sup>83</sup> The contract did not prohibit this action.

From September 10, 2012, until December of 2012, Alexis worked under the CoSC, providing services at six project sites in Texas, California, and Japan.<sup>84</sup>

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- On September 19, 2012, The Experts background check of Alexis was completed with no convictions reported.<sup>85</sup>
- He resigned on December 27, 2012.<sup>86</sup>

On June 27, 2013, Alexis re-applied with The Experts as a technician. Since The Experts' FSO had not removed Alexis' access to classified information within JPAS following his resignation, The Experts took no further actions relative to Alexis' eligibility for access to classified information.<sup>87</sup>

- The Experts repeated the drug test and pre-employment background checks required by HPES.<sup>88</sup>
- From July to September 2013, The Experts assigned Alexis work in several locations, including Virginia, Rhode Island and Maryland.<sup>89</sup>

### **Events while Alexis was assigned to Naval Undersea Warfare Center (NUWC) at Naval Station Newport, Rhode Island**

On August 4, 2013, Alexis traveled from Norfolk, Virginia, to Providence, Rhode Island, on assignment to the Naval Undersea Warfare Center (NUWC) at Naval Station Newport, Rhode Island.<sup>90</sup>

On August 4, 2013, while Alexis was at the Norfolk airport awaiting a flight to Providence, he called The Experts' project coordinator for the CoSC to say that a male, seated across the aisle from him, was making fun of him. Alexis said he was getting angry at the individual. In a 20-minute phone call, the project coordinator calmed Alexis down, instructed him to get away from the person, and to seek help from airport security. The next morning, the project coordinator reported Alexis' call to The Experts CoSC program team.<sup>91</sup>

On August 5, 2013, Alexis contacted The Experts' travel coordinator seeking assistance in moving from the Residence Inn, Middletown, Rhode

Island to the Navy Gateway Inns & Suites on Naval Station Newport because of noisiness at the Residence Inn.<sup>92</sup>

On August 6, 2013, at around 0200, Naval Station Newport Police Department received the first of four calls (0218, 2118, and 2216; and August 7 at 0254) from and about Alexis at the Navy Gateway Inns & Suites. The calls and subsequent interactions involved noise complaints from Alexis and neighboring guests at the Navy Gateway Inns & Suites.

- In one instance (2118), the front desk clerk at the Navy Gateway Inns & Suites requested that Naval Station Newport Police keep an officer close to the Navy Gateway Inns & Suites in case Alexis hurt someone.
- This request was based on a phone call from The Experts' travel coordinator to the Navy Gateway Inns & Suites expressing concern that Alexis may harm others.<sup>93\*</sup>

When the officers responded to the Navy Gateway Inns & Suites, they learned that Alexis had taken apart his bed, believing someone was hiding under it, and observed that Alexis had taped a microphone to the ceiling to record the voices of people that were following him.<sup>94</sup>

- The Naval Station Newport Police Officers did not place Alexis in protective custody because they believed he was not a threat, nor in need of immediate care or treatment.<sup>95</sup>
- During a later interaction at 2118 with other Naval Station Newport Police Officers, Alexis mentioned a chip in his head and microwave signals.<sup>96</sup>

On August 6, 2013, around 1800, Alexis reported to The Experts' travel coordinator that two men and one female had followed him from the Residence Inn to the Navy Gateway Inns & Suites. Alexis reported that three people were talking about him through the walls of the adjacent room and were using a machine to keep him awake. The machine was allegedly

an ultrasonic device that Alexis said was physically pinning him to the bed.<sup>97</sup> Later that same evening, Alexis made a similar report to The Experts' program manager for CoSC.<sup>98</sup>

On August 6, 2013, around 2045, during a call from The Experts' travel coordinator, the desk clerk at the Navy Gateway Inns & Suites read the desk log that documented:

- Alexis disrupting other guests in the early morning hours of August 6, 2013, by knocking on walls and asking people to stop making noise.
- That Security had talked to Alexis and noted that Alexis had "disheveled the bed."<sup>99</sup>

The travel coordinator gave her contact information and that of The Experts' program manager to the desk clerk.<sup>100\*</sup>

The Navy Gateway Inns & Suites desk log included the following entry at 2045 on August 6, 2013:

"[Travel coordinator's full name] called regarding PO3 Alexis, [Alexis] called her explaining that three people followed him from The Residence Inn when he was moved over here, he told her they keep yelling at him & following him. Call her if you have any questions or concerns. She is very worried & is afraid he can harm others. Her # is XXX-XXX-XXXX or [Program Manager's first name] who is the other manager her # is XXX-XXX-XXXX."<sup>101</sup>

- Note that in subsequent interviews, the Experts' travel coordinator denied stating she expressed Alexis might harm others.<sup>102</sup>

On August 6, 2013, after completing the 2045 call with the desk clerk at Navy Gateway Inns & Suites, the travel coordinator called The Experts' program manager of CoSC to report the information gathered.<sup>103</sup>



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On August 6, 2013, late evening, the program manager of CoSC, her immediate manager, and the FSO held a conference call to discuss the reports concerning Alexis. The management team concluded that Alexis should leave Newport and return to Fort Worth because they were concerned about his behavior.<sup>104</sup>

On August 6, 2013, late in the evening, The Experts program manager had a telephone conversation with Alexis regarding removal from the Newport assignment to return to Fort Worth, for rest. Alexis said he wanted to stay and work.<sup>105</sup>

On August 6, 2013 at 2335, the FSO, using the Joint Clearance Access Verification System tool within JPAS (which is used to pass clearance information on visitors to various sites and make visit requests), cancelled the visit notification for Aaron Alexis that the FSO previously established for access to NUWC.<sup>106</sup>

- The FSO believed that NUWC verified Joint Clearance Access Verification System data daily for each visitor and that canceling the visit would prevent Alexis from accessing NUWC.<sup>107</sup>

On August 7, 2013, at 0112, The Experts program manager sent an email to HPES representatives and The Experts CoSC team stating Alexis was not feeling well and would not complete the work assignment at Newport.<sup>108</sup> She also booked airline tickets for Alexis' return to Fort Worth.<sup>109</sup>

On August 7, 2013, at about 0300, Alexis called the HPES second shift deployment supervisor asking to stay in her room at the Marriott, Newport because he had to move out of his room believing some people had followed him to the Navy Gateway Inn & Suites. Alexis had previously worked with this supervisor in Japan. She agreed to let him stay in her room.<sup>110</sup>

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Upon arrival, Alexis told the HPES second shift deployment supervisor that three people, who traveled on the plane with him from Norfolk, and had checked into the same hotel as Alexis did, began making noise and threats against him.

- Alexis also said those same people had followed him from one hotel to another and were now checked into the room below the HPES second shift deployment supervisor's room.
- Alexis asked her, "Can't you hear that?" The second shift deployment supervisor said she did not hear anything and told Alexis so.
- The HPES second shift deployment supervisor thought his story was "preposterous" and went back to bed.
- Alexis called the City of Newport police to report the people he thought were following him.<sup>111</sup>

On August 7, 2013, around 0620, the City of Newport Police responded to a call from Alexis at the Marriott, regarding a report of harassment. Alexis described to the responding officers an earlier verbal altercation with an unknown party at the Norfolk Airport.

- Alexis told the officers that this party had sent three people to follow him and to keep him awake by talking to him and sending vibrations into his body.
- Alexis reported first hearing them through the wall while at the Residence Inn in Middletown, Rhode Island.
- Alexis informed the officer that the three individuals were now speaking to him through the walls, floor, and ceiling.

- Alexis said that the individuals were using “some sort of microwave machine” to send vibrations through the ceiling, and that these vibrations were penetrating his body such that he could not sleep.
- The police took Alexis’ report and left the hotel.<sup>112</sup>

On August 7, 2013 around 0930, the Newport Police Officer-in-Charge contacted the on-duty Naval Station Police Sergeant and advised her of Alexis' claims.<sup>113\*</sup> The City of Newport Police Department faxed a copy of its Police Report to the Naval Station Newport Security Office with the following note: "FYI on this. Just thought to pass it on to you in the event this person escalates."<sup>114</sup>

On August 7, 2013, around 1000 to 1030, the HPES second shift deployment supervisor awoke and left her room to call the HPES lead supervisor working at NUWC to inform him of the events from earlier in the morning with Alexis. The HPES lead deployment supervisor told her that The Experts had already issued an email early that morning saying Alexis was not feeling well and would be removed from the Newport project team.<sup>115</sup>

The HPES second shift deployment supervisor, after making the report, returned to her room and woke Alexis.

- Alexis told the HPES second shift deployment supervisor the people following him had now checked into the room above them.
- Alexis said the people were trying to disrupt his sleep and he wanted to acquire a radar gun in order to hear what they were saying.<sup>116</sup>

On August 7, 2013, at 1139, The Experts’ FSO entered a “Debrief” action in JPAS.<sup>117</sup>

- A debrief entry records an administrative decision that the individual no longer requires access to classified information and was entered by the FSO as another means of preventing Alexis’ access to

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NUWC. A 'debrief' does not convey any concern about Alexis' reliability.

On August 7, 2013, after having lunch with Alexis, the HPES second shift deployment supervisor reported to the NUWC jobsite and informed the HPES lead supervisor for the second time about the visit from Alexis and her discussions with him.<sup>118</sup> The HPES second shift deployment supervisor subsequently told a HPES co-worker about her encounter with Alexis.<sup>119</sup> There were no reports made to HPES security officials or off-site management.

On August 7, 2013, early in the afternoon, The Experts' human resources (HR) director engaged legal counsel and initiated an investigation into the information about Alexis, including contacting police departments.<sup>120</sup>

On August 7, 2013, The Experts program manager called the HPES second shift deployment supervisor. The HPES supervisor said that Alexis had left the Navy Gateway Inns & Suites in the early morning hours of August 7, 2013, to stay in her room at Marriott Hotel in Newport because of the noise people were making.<sup>121</sup>

On August 7, 2013, mid-afternoon, The Experts' HR Director contacted the Middletown, Rhode Island, Police Department to collect any police reports regarding Alexis. The Experts' HR Director believed that the Middletown Police Department provided police coverage for all of the hotels in which Alexis resided while in Newport, Rhode Island. There were no police reports found with Middletown Police Department.<sup>122</sup>

On August 7, 2013, Alexis departed Newport, staying the night at the Best Western Hotel, Providence airport. On August 8, 2013, he transited from Providence airport to the Dallas-Fort Worth, Texas airport.<sup>123</sup>

On August 9, 2013, The Experts HR director called Alexis' mother who said that Alexis had been paranoid and this was not the first episode he had experienced.<sup>124</sup>

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On August 9, 2013, early afternoon, The Experts' CoSC management team, including the HR director and FSO, discussed actions that should be taken regarding Alexis. The Experts concluded Alexis should rest before being reassigned to another CoSC deployment.

- The Experts' considered whether to file an adverse information report concerning Alexis to the Department of Defense Central Adjudication Facility (DoDCAF).<sup>125</sup>
- FSOs are required to submit adverse information reports directly to DoDCAF through the JPAS continuous evaluation incident report feature.<sup>126</sup>

The Experts' CoSC management team concluded that the information collected about Alexis was based on rumor and innuendo, and therefore a report to the government should not be made, since doing so may infringe on Alexis' privacy rights.<sup>127</sup> Following The Experts' decision to return Alexis to a work status, the FSO, on August 9, 2013 at 1455, recorded in JPAS an "indoctrination" action.<sup>128</sup> This action reestablished Alexis as an individual authorized access to classified information under the cognizance of The Experts.

Between August 12, 2013, and September 6, 2013, The Experts assigned Alexis as follows:

- Williamsburg, Virginia from August 12-16, 2013
- Newport, Rhode Island from August 19-23, 2013
- Carderock, Maryland, from August 26-30, 2013
- Crystal City, Virginia from September 3-6, 2013<sup>129</sup>

On August 23 and 28, 2013, Alexis made emergency room visits to Veteran's Affairs treatment facilities in Providence, Rhode Island, and Washington, DC, respectively, with complaints of insomnia.<sup>130</sup> He was

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prescribed a low dose antidepressant, Trazodone, due to the medication's property of being lightly sedating and the lack of potential for addiction or abuse. Records from the August 23, 2013, visit indicate that when asked if he had thoughts of harming someone else, Alexis answered, "no."<sup>131</sup>

On September 1, 2013, Alexis exchanged several emails with the president of Freedom from Covert Harassment and Surveillance discussing, "constant bombardment from some type of ELF weapon," that had "almost cost him his job."<sup>132</sup>

On September 9, 2013, The Experts assigned Alexis to work at the Washington Navy Yard (WNY). During the week of September 9, 2013, other than leaving a disk in a classified computer, no performance issues were noted.<sup>133</sup>

On September 14, 2013, Alexis purchased a Remington-870, 12-gauge shotgun in Lorton, Virginia.<sup>134</sup>

### Events of September 16, 2013

At 0730, eight day-shift Naval Support Activity Washington (NSAW) Naval Security Force (NSF) personnel were on duty at the WNY and assigned to posts. There were four gate Entry Control Points (ECPs) at the WNY manned by a total of seven personnel, and the NSF Chief of Police was assigned to the roving post.<sup>135</sup>

Fifteen additional NSF members were at the WNY -- ten NSF members attending an annual training class, two instructors, an off-duty NSF supervisor, an additional supervisor from the Naval Research Laboratory (NRL), and the NSAW Security Officer, a Master-at-Arms Chief Petty Officer.

At 0744, Alexis entered the WNY at the 6<sup>th</sup> Street gate in his vehicle, a rented blue Toyota Prius with New York plates.<sup>136</sup> He used a valid CAC for entry.

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At 0746, Alexis entered the parking garage Building 28 at Washington Navy Yard, located directly across from Building 197.<sup>137</sup>

At 0802, Alexis entered the Building 197 lobby using the electronic badge reader farthest away<sup>138</sup> from the contract security guard station with a bag and carrying a concealed shotgun and ammunition.<sup>139</sup> He used a valid temporary building pass for entry.

At approximately 0815, Alexis exited the 4<sup>th</sup> floor bathroom and began shooting people.<sup>140</sup>

At 0816, Naval District Washington (NDW) Region Dispatch Center received a phone call reporting an active shooter on the fourth floor of Building 197.<sup>141</sup>

At 0817, NDW Region Dispatch Center notified NDW Fire and Emergency Services<sup>142</sup> and the NSAW NSF of the shooting. The Washington, District of Columbia (D.C.) Metropolitan Police Department (MPD) was notified of the shooting by NDW Region Dispatch Center<sup>143</sup> and 911 calls.<sup>144</sup> NSAW activated the Emergency Operations Center (EOC)<sup>145</sup> and the NDW Regional Operations Center (ROC) was notified of an active shooter.<sup>146</sup>

Concurrently at 0817, the NDW Region Dispatch Center ordered all NSAW NSF units to report to Building 197.<sup>147</sup> NSF personnel closed three of four vehicle perimeter gates and responded to Building 197.<sup>148</sup> At the O Street Gate, one NSF member responded to Building 197 while the other remained at the O Street Gate to allow access for responding forces.<sup>149</sup>

At approximately 0820, the NSF Chief of Police and two NSF members arrived at Building 197 and immediately entered the building.<sup>150</sup> They were the first law enforcement officers to arrive. The officers proceeded directly to the 4<sup>th</sup> floor where the shots had been reported. Within minutes, eight additional NSF members entered Building 197.<sup>151</sup>

At 0823, the MPD Chief of Police was notified and responded to the WNY.<sup>152</sup>

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At 0827, while en route to the WNY, the NDW Battalion Fire Chief called the District of Columbia Fire Department and requested assistance in the form of a Mass Casualty Task Force.<sup>153</sup>

At approximately 0830, the NSF instructor conducting the training class being held on the WNY received notification of an active shooter. He directed the nine qualified NSF members in the class to retrieve their duty gear and report to the armory.<sup>154</sup> Ultimately, 15 NSF members were actively engaged in the emergency response operations in Building 197, tactically coordinating with members of outside law enforcement agencies who responded in support.<sup>155</sup>

At 0830, the ROC Battle Watch Captain called the ROC emergency management planner, who immediately reported to and activated the ROC.<sup>156</sup>

At approximately 0831, the MPD Chief of Police arrived at the WNY 11<sup>th</sup> and O Street Gate and began establishing the Unified Command.

- Her priorities were establishing a Unified Command to respond to the shooter, establishing a Joint Information Center, and developing a process to evacuate personnel sheltered-in-place.<sup>157</sup>

At 0834, the NSAW EOC issued a mass electronic communication via computers, text, email, and cellular telephones directing "ALL HANDS on WNY shelter in place."<sup>158</sup>

At 0836, NDW Fire and Emergency Services personnel began arriving at the staging area at 6<sup>th</sup> and M Street.<sup>159</sup>

At 0836, NSAW EOC issued a loud speaker mass notification notifying WNY personnel to shelter-in-place.<sup>160</sup>

At approximately 0837, the Unified Command headed by MPD was established at 11<sup>th</sup> and O Street.<sup>161</sup>



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- At this time, NSAW NSF transitioned to a support role and teamed with external law enforcement agencies in pursuing Alexis.<sup>162</sup>

At approximately 0838, Alexis fires his last fatal gunshot.<sup>163</sup>

At approximately 0840, a wounded NAVSEA employee who had been shot in the hand walked from Building 197 to the NDW Branch Health Clinic, Building 175, where she received medical treatment and was prepared for transport to a hospital.<sup>164</sup>

At approximately 0840, a Reserve Navy Hospital Corpsman Chief Petty Officer (HMC), serving on active duty at the Navy History and Heritage Command, independently established a medical triage area in Building 28, the parking garage across from Building 197.<sup>165</sup> The HMC sent a messenger to the WNY Branch Health Clinic to obtain Fleet Marine Force corpsmen and supplies. Within 35 minutes, three medical doctors and six corpsmen arrived at Building 28.<sup>166</sup>

At approximately 0845, a second NSF supervisor and a Master-at-Arms First Class (MA1) responding from the NRL arrived at the 6<sup>th</sup> Street gate. The supervisor manned the gate to control access to responding forces while the MA1 proceeded to Building 197.<sup>167</sup>

At approximately 0845, the Federal Bureau of Investigation (FBI) arrived at the Unified Command at 11<sup>th</sup> and O Street.<sup>168</sup>

At 0850, the NDW Battalion Fire Chief established and led a medical command post at the Building 183 parking lot. This command post consisted of NDW Fire and Emergency Services, MPD, D.C. Fire and Emergency Services, and the FBI.<sup>169</sup>

At 0854 on September 16, 2013, NSAW ordered a muster for all tenant commands.<sup>170</sup> NAVSEA completed its muster on the afternoon of September 16, 2013.<sup>171</sup>

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At approximately 0857, a Joint Information Center was established at the Unified Command.<sup>172</sup>

At approximately 0900, Commander, Navy Installations Command (CNIC) directed establishment of the Emergency Family Assistance Center, which consisted of counseling services provided by Navy Family Advocacy Counselors, Navy Medicine Counselors, and various individuals from other agencies. The center operated around the clock for ten days.<sup>173</sup>

At 0915, the NDW medical command post directed establishment of a medical triage area at 11<sup>th</sup> and O Streets. From the perspective of MPD Unified Command, this was the primary and only official triage area established.<sup>174</sup>

At 0925, Aaron Alexis was shot and killed.<sup>175</sup>

At 0928, shooter was reported down to the EOC.<sup>176</sup>

At approximately 0930, MPD personnel leave the Unified Command to view available video feeds at the ROC.<sup>177</sup>

At 0956, NDW notified regional Casualty Assistance Calls Officers (CACOs) of the possible need to provide support and benefits information to the families of the DON civilian decedents.<sup>178</sup>

At approximately 1039, two NDW medics and two FBI tactical medics used NDW Fire and Emergency Services Utility Truck 2 to transport the wounded NAVSEA employee from the WNY Branch Health Clinic to the 11<sup>th</sup> and O Streets triage area.<sup>179</sup>

At approximately 1100, the Navy Chief of Information (CHINFO) directed CNIC's Public Affairs Officer to lead the Navy's post-incident communication plan.<sup>180</sup>

Beginning at 1114, NDW posted a message on Twitter providing a phone number for families to call for information. The Secretary of the Navy (SECNAV), CHINFO, CNIC, NDW, and NAVSEA used distribution tools

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such as Twitter, Facebook postings, all-hands emails, blogs, navy.mil stories, interviews, press conferences, and internet videos to communicate information about the available medical and counseling services, the meeting point for families, base closure and reporting instructions, and locations for support services throughout the week.

NSF members provided security to personnel evacuating from Building 197, perimeter and gate security, responded to various calls of possible additional shooters, and cleared buildings throughout the WNY.<sup>181</sup>

Throughout the day, additional personnel in need of medical care were transported from multiple locations to the 11<sup>th</sup> and O Streets triage area.

At 1220, NDW announced that Nationals Park would be used to evacuate people from the WNY and serve as a meeting point for families.<sup>182</sup>

At 1400, NAVSEA leadership established an alternate command center for NAVSEA operations in the Military Sealift Command (Building 210) consistent with their Continuity of Operations Plan.<sup>183</sup>

At 1500, four Navy chaplains arrived at Nationals Park. Two teamed up with the FBI to notify six families, who were present at Nationals Park, that a family member was deceased.<sup>184</sup> Law Enforcement notified two additional families of victims.

At approximately 1500, the triage area at Building 28 was disestablished.<sup>185</sup>

At approximately 1500, the Emergency Family Assistance Center received notification that WNY personnel were being evacuated to Nationals Park and dispatched three licensed clinical social workers to the Park to provide counseling services.<sup>186</sup>

At approximately 1545, SECNAV, the Chief of Naval Operations, and Assistant Secretary of the Navy (Research, Development & Acquisition) participated in a press briefing by Chief Medical Officer Dr. Janis

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Orlowski at MedStar Washington Hospital after visiting with victims and families to provide contact information to the public. SECNAV also provided phone numbers for available counseling services.<sup>187</sup>

At 1600, the Navy Surgeon General directed Navy Medicine East to deploy the Navy Medicine Special Psychiatric Rapid Intervention Team (SPRINT) to provide psychiatric support for the victims and families. The SPRINT, consisting of 13 members from Portsmouth Naval Hospital, arrived at the WNY on the evening of September 16, 2013, set up a counseling center in Building 111 at approximately 1500 on September 17, 2013, and remained at the WNY for 17 days.<sup>188</sup>

At 1614, the Vice Chief of Naval Operations directed CNIC to stand-up and lead an Emergency Family Support Task Force to provide support to victims and families affected by the WNY shooting incident.<sup>189</sup>

At 1622, the Navy issued an "Order to Account," which required all Navy personnel within Washington, D.C. and neighboring counties to report their status.<sup>190</sup> NAVSEA completed reporting the status of personnel on September 18, 2013.<sup>191</sup>

At 1658, MPD secured the Unified Command post.<sup>192</sup>

At 1658, the medical command post in Building 183 was secured.<sup>193</sup>

At 1730, twelve additional Navy chaplains teamed up with the FBI and MPD to provide notifications to four families who were not present at Nationals Park.<sup>194</sup>

At 2046, SECNAV released a video played on multiple news stations that provided phone numbers for available counseling services and identified that designee status would be available for victims so they could have military medical care if necessary.<sup>195</sup>

Forces from NSAW NSF swing and mid-shifts, Joint Base Anacostia-Bolling NSF, and Naval Support Activity Dahlgren NSF reported during the

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course of the day and assisted in clearing buildings throughout the afternoon and evening.<sup>196</sup>

At 2203, Commander, NAVSEA solicited volunteers from headquarters' military officers to provide CACO services.<sup>197</sup>

### **Post-Incident Response after September 16, 2013**

By 0020 on September 17, 2013, all next-of-kin notifications had been completed.<sup>198</sup>

On the morning of September 17, 2013, Commander, NAVSEA assigned a team of a naval officer and chaplain to provide services to each of the seven families of the government employees who were killed.<sup>199</sup>

Additionally, on September 17, 2013, CNIC had cards printed with information regarding counseling services. They began distributing the cards to employees on September 18 and provided them to everyone who passed through the WNY gates on September 19 and 20.

From September 17 through September 20, 2013, SECNAV, CHINFO, CNIC, NDW, and NAVSEA Public Affairs continued to communicate information to Navy Yard employees and the public with more than 145 public communications.<sup>200</sup>

On the morning of September 18, 2013, Commander, NAVSEA expanded casualty assistance services to include families of the five deceased contractors.<sup>201</sup>

By the evening of September 18, 2013, a casualty assistance team had contacted each of the twelve families of the deceased and provided assistance and information.<sup>202</sup>

On the morning of September 19, 2013, the NAVSEA CACO, with the concurrence of Commander, NAVSEA, extended casualty assistance-type services to the four wounded individuals.<sup>203</sup> Also on the morning of

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September 19, 2013, SECNAV visited the WNY and held an all hands call with the Navy personnel on-site.

By September 19, 2013, NAVSEA established alternate work locations throughout the National Capital Region for essential functions.<sup>204</sup>

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<sup>1</sup> Reference Documents (RD) 2.1 DeVry University Documents of 17 Oct 2013.

<sup>2</sup> RD 2.2 Aaron Alexis Report of Investigation, Office of Personnel Management (OPM) Case # 07Q87334.

<sup>3</sup> RD 2.2 Alexis' OPM Case # 07Q87334.

<sup>4</sup> *Id.*

<sup>5</sup> *Id.*

<sup>6</sup> RD 2.1 DeVry University Documents of 17 Oct 2013.

<sup>7</sup> RD 2.1 DeVry University Documents of 17 Oct 2013; RD 2.2 Alexis' OPM Case # 07Q87334.

<sup>8</sup> RD 2.2 Alexis' OPM Case # 07Q87334.

<sup>9</sup> RD 2.3 Seattle Police Report, Incident Number 04-181918, 3 Jun 2004; King County District Court – West Division (Seattle District Court) Case 204022684, 4 Jun 2013 and 7 Jun 2013.

<sup>10</sup> RD 2.3 King County District Court – West Division (Seattle District Court) Case 204022684, 4 Jun 2013 and 7 Jun 2013.

<sup>11</sup> RD 2.2 Alexis' OPM Case # 07Q87334 cited the second of these trips. The NCIS Timeline based on FBI data referred to both trips.

<sup>12</sup> RD 2.4 City of Bellevue Police Case Report 06-12752, 5 Nov 2006.

<sup>13</sup> RD 2.2 Alexis' OPM Case # 07Q87334 cited the second of these trips. The NCIS Timeline based on FBI data referred to both trips.

<sup>14</sup> RD 2.2 Alexis' OPM Case # 07Q87334.

<sup>15</sup> *Id.*

<sup>16</sup> RD 2.5 Alexis' Official Military Personnel File (OMPF): Alexis' Record of Military Processing, DD Form 1966.

<sup>17</sup> RD 2.6 Email from (b) (6), CNRC Enlisted Recruiting Policy (N35E), 17 Oct 2013.

<sup>18</sup> RD 2.5 Alexis' OMPF: Alexis' Report of Medical Examination, 22 Mar 2007.

<sup>19</sup> An ENTNAC checks appropriate databases maintained by the FBI investigative and criminal history files, including fingerprint search, DoD's Defense Clearance and Investigation Index, and OPM's Security and Suitability Investigation files.

<sup>20</sup> SECNAV M-5510.30, Jun 2006 and RD 2.7 OPM ENTNAC Case No. 70318434, 6 Apr 2007.

<sup>21</sup> COMNAVCRUITCOMINST 1130.8G, Apr 2005.

<sup>22</sup> MILPERSMAN 1306-618.

<sup>23</sup> RD 2.2 Alexis' OPM Case # 07Q87334.

<sup>24</sup> OPM ENTNAC Case No. 70318434, 6 Apr 2007.

<sup>25</sup> *Id.*

<sup>26</sup> COMNAVCRUITCOMINST 1130.8G (Apr 2005); Summary of Interview (SI) 2.1 with Master Chief (b) (6), NRD New York (b) (6), 7 Oct 2013; SI 2.2 with (b) (6), CNRC Legal, 15 Oct 2013; SI 2.3 with Chief (b) (6), Alexis' Recruiter, 8 Oct 2013.

<sup>27</sup> RD 2.5 Alexis' OMPF.

<sup>28</sup> *Id.*

<sup>29</sup> RD 2.5 Alexis' OMPF: Alexis' Record of Military Processing, DD Form 1966.

<sup>30</sup> RD 2.2 Alexis' OPM Case # 07Q87334.

<sup>31</sup> RD 2.8 White House (Berger) Memorandum, Implementation of Executive Order 12968, March 24, 1997, p. 5.

<sup>32</sup> RD 2.2 Alexis' OPM Case # 07Q87334.

<sup>33</sup> *Id.*

- <sup>34</sup> *Id.*
- <sup>35</sup> RD 2.5 Alexis' OMPF.
- <sup>36</sup> SI 2.4 with CAPT (b) (6), Former Commanding Officer VR 46, 4 Oct 2013; SI 2.5 with Senior Chief (b) (6), Former Division Chief at VR 46, 10 Oct 2013; SI 2.6 with Master Chief (b) (6), Former Command Master Chief at VR 46, 9 Oct 2103; SI 2.7 with Senior Chief (b) (6), Former Division Chief at VR 46, 10 Oct 2013.
- <sup>37</sup> RD 2.9 Trans Union Employment Credit Report of Aaron Alexis, 6 Mar 2008.
- <sup>38</sup> RD 2.10 Director, Department of the Navy Central Adjudication Facility Ltr Ser 10FUH565 of 11 Mar 2008.
- <sup>39</sup> RD 2.11 Alexis' Joint Personnel Adjudication System (JPAS): Adjudication Summary Page.
- <sup>40</sup> RD 2.10 Director, Department of the Navy Central Adjudication Facility Ltr Ser 10FUH565 of 11 Mar 2008.
- <sup>41</sup> SI 2.8 with CDR (retired) (b) (6), Former Security Officer at VR 46, 8 and 18 Oct 2013; SI 2.9 with LCDR (retired) (b) (6), Former Security Officer at VR 46, 25 Oct 2013.
- <sup>42</sup> SI 2.12 with CAPT (b) (6), Former Commanding Officer at VR 46, 4 Oct 2014.
- <sup>43</sup> RD 2.5 Alexis' OMPF: Aaron Alexis Evaluation Report & Counseling Record (E1-E6), 15 Dec 2007 to 15 Jul 2008.
- <sup>44</sup> RD 2.12 Georgia Uniform Traffic Citation, Summons and Accusation, Citation 23852927, 10 Aug 2008.
- <sup>45</sup> RD 2.13 Aaron Alexis, Record of Unauthorized Absence, NAVPERS 1070/606 of 5 Nov 2008.
- <sup>46</sup> RD 2.5 Alexis' OMPF: NAVPERS 1070/613, Article 86: Absence Without Leave.
- <sup>47</sup> RD 2.14 Record of Disposition in the Records Court of DeKalb County, State of Georgia, 14 Oct 2013.
- <sup>48</sup> RD 2.11 Alexis' JPAS: Incident History Page.
- <sup>49</sup> RD 2.5 Alexis' OMPF: Alexis' History of Assignments.
- <sup>50</sup> RD 2.13 Alexis' OMPF: Aaron Alexis Report and Disposition of Offense(s), NAVPERS 1626/7, 24 Jun 2009.
- <sup>51</sup> RD 2.13 Alexis' OMPF: Aaron Alexis Report and Disposition of Offense(s), NAVPERS 1626/7, 24 Jun 2009.
- <sup>52</sup> SI 2.4 with CAPT (b) (6), Former Commanding Officer at VR 46, 4 Oct 2013; SI 2.5 with Senior Chief (b) (6), Former Division Chief at VR 46, 10 Oct 2013; SI 2.10 with LCDR (b) (6), Former Legal Officer at VR 46, 7 Oct 2014; SI 2.11 with Master Chief (b) (6), Former Command Master Chief at VR 46, 8 Oct 201; SI 2.12 with CAPT (b) (6), Former Commanding Officer at VR 46, 4 Oct 2014; SI 2.13 with AE1 (b) (6), Former Leading Petty Officer to Alexis at VR 46, 8 Oct 2014; SI 2.14 with Chief(retired) (b) (6), Former Leading Chief Petty Officer to Alexis at VR 46, 9 Oct 2014.
- <sup>53</sup> RD 2.11 Alexis' JPAS: Incident History Page.
- <sup>54</sup> RD 2.15 Aaron Alexis ltr, Subj: Appeal of Nonjudicial Punishment, 15 Jul 2009.
- <sup>55</sup> RD 2.16 Aaron Alexis ltr, Subj: Appeal of Nonjudicial Punishment, 20 Jul 2009.
- <sup>56</sup> Aaron Alexis Evaluation Report & Counseling Record (E1-E6), 16 Jul 2008 to 15 Jul 2009.
- <sup>57</sup> RD 2.17 ASN (M&RA) Rapid Review timeline of events concerning Aaron Alexis, 20 Sep 2013.
- <sup>58</sup> SI 2.12 with CAPT (b) (6), former Commanding Officer of VR 46, 4 Oct 2013; SI 2.15 with CAPT(retired) (b) (6), Former Commodore of Fleet Logistics Support Wing ISIC to VR 46, 9 Oct 2013; SI 2.10 with LCDR (b) (6), Former Legal Officer at VR 46, 7 Oct 2013; SI 2.16 with Chief (b) (6) Former Leading Chief Petty Officer to Alexis at VR 46, 7 Oct 2013; SI 2.14 with Chief(retired) (b) (6), Former Leading Chief Petty Officer to Alexis at VR 46, 9 Oct 2013; RD 2.18 Commanding Officer Fleet Logistics Support Squadron FOUR SIX, Ser N00/628 of 3 Dec 2009.
- <sup>59</sup> RD 2.18 Commanding Officer Fleet Logistics Support Squadron FOUR SIX, Ser N00/628 of 3 Dec 2009 and MILPERSMAN 1910-140, 21 Jul 2012.
- <sup>60</sup> RD 2.5 Alexis' OMPF: Aaron Alexis Evaluation Report & Counseling Record (E1-E6), 16 Jul 2009 to 28 Feb 2010.
- <sup>61</sup> *Id.*

- <sup>62</sup> RD 2.19 Fort Worth Police Department report, case number 10-94577, 4 Sep 2010.
- <sup>63</sup> RD 2.20 Undated and Unsigned Recommendation for Administrative Separation letter ICO Aaron Alexis, (Bates # 006089-009091).
- <sup>64</sup> SI 2.12 with CAPT (b) (6), Former Commanding Officer at VR 46, 4 Oct 2013; SI 2.17 with AE1 (b) (6), Former Leading Petty Officer to Alexis at VR 46, 8 Oct 2013; SI 2.14 with Chief (retired) (b) (6), Former Leading Chief Petty Officer to Alexis at VR 46, 9 Oct 2013; SI 2.18 with Senior Chief (b) (6), Former Division Chief at VR 46, 10 Oct 2013; SI 2.8 with CDR (retired) (b) (6), Former Security Officer at VR 46, 8/18 Oct 2013; SI 2.19 with Master Chief (b) (6), Former Command Master Chief at VR 46, 8 Oct 2013; SI 2.16 with Chief (b) (6), Former Chief Petty Officer at VR 46, 7 Oct 2013.
- <sup>65</sup> MILPERSMAN 1910-140.
- <sup>66</sup> RD 2.11 Alexis' JPAS: Incident History Page.
- <sup>67</sup> RD 2.5 Alexis' OMPF: Aaron Alexis' application for EETP, 2 Dec 2010.
- <sup>68</sup> RD 2.5 Alexis' OMPF: CNPC Millington TN, Msg DTG 091218Z Dec 10.
- <sup>69</sup> RD 2.5 Alexis' OMPF: JPAS Database and Security Termination Statement, 15 Dec 2010.
- <sup>70</sup> RD 2.5 Alexis' OMPF: DD Form 214, Certificate of Release or Discharge from Active Duty.
- <sup>71</sup> RD 2.5 Alexis' OMPF: Aaron Alexis Evaluation Report & Counseling Record (E1-E6), 16 Jun 2010 to 31 Jan 2010.
- <sup>72</sup> MILPERSMAN 1160-030.
- <sup>73</sup> Alexis' Medical Record.
- <sup>74</sup> RD 2.22 Email of NAVPERS RE COMNAVPERSCOM Response to SECNAV tasking RE Individual Ready Reserve dated 18 Oct 2013; RD 2.49 Email from CAPT (b) (6) (PERS-9B) to CAPT (b) (6) dated 7 Nov 2013.
- <sup>75</sup> RD 2.21 Texas Fusion Center Research Report Created on 16 Sep 2013 by analyst AMB.
- <sup>76</sup> VETSNET Compensation and Pension Award of 11 Apr 2012.
- <sup>77</sup> Department of Veterans Affairs Letter 349/214D CSS 056 68 2185 to Aaron Alexis, 21 Dec 2012.
- <sup>78</sup> RD 2.23 Alexis' Application for Employment to The Experts 4 Sep 2012.
- <sup>79</sup> Continuity of Services Contract for Navy Marine Corps Intranet Services.
- <sup>80</sup> SI 2.20 (b) (6), FSO The Experts, 14 Oct 2013.
- <sup>81</sup> NISPOM, Para. 2-200.e, Feb 2006.
- <sup>82</sup> SI 2.21 (b) (6), HR Director for The Experts, 16 Oct 2013 and HPES Statement of Work for Subcontracting of Solutions and Projects in Support of CoSC N00039-10-D-0010 Agreement #1 Version #2 dated 11 Jan 2012.
- <sup>83</sup> RD 2.24 Email chain dated 6 Sep 2012 between (b) (6) of The Experts and (b) (6) of HPES, attached to email dated 16 Oct 2013 from (b) (6) of Hunton & Williams to (b) (6), Investigation Team.
- <sup>84</sup> RD 2.25 HPES letter dated 27 Sep 2013 to Defense Security Service, re: "Navy Yard Incident".
- <sup>85</sup> RD 2.26 LexisNexis Background Report ordered 14 Sep 2012 included in CD hand-delivered to WNY by Hunton & Williams (11 OCT 2013).
- <sup>86</sup> RD 2.33 Hunton and Williams Letter Re: The Experts, Inc./Navy Yard Matter, 11 Oct 2013; RD 2.45 Consultant Change Form for Aaron Alexis, effective 21 Dec 2012.
- <sup>87</sup> SI 2.20 (b) (6), FSO The Experts, 14 Oct 2013.
- <sup>88</sup> RD 2.27 HPES Statement of Work for Subcontracting of Solutions and Projects in Support of CoSC N00039-10-D-0010 Agreement #1 Version #2 dated 11 Jan 2012.
- <sup>89</sup> RD 2.25 HPES letter dated 27 Sep 2013 to Defense Security Service, re: "Navy Yard Incident".
- <sup>90</sup> *Id.*
- <sup>91</sup> SI 2.22 (b) (6), Project Coordinator for The Experts, 14 Oct 2013.
- <sup>92</sup> SI 2.23 (b) (6), Travel Coordinator for The Experts, 14 Oct 2013.
- <sup>93</sup> RD 2.28 NCIS Interview of (b) (6), (b) (7)(C), Navy Gateway Inns & Suites (NGIS) Desk Clerk at NGIS, 24 Sep 2013; RD 2.46 Naval Station Newport NGIS Handwritten Desk Log for 6 Aug 2013 and 7 Aug 2013.



- <sup>94</sup> RD 2.30 NCIS Interview of MA3 (b) (6); RD 2.31 NCIS Interview of MA2 (b) (6) on 24 Sep 2013.
- <sup>95</sup> Rhode Island Statute 40.1-5-7.
- <sup>96</sup> RD 2.30; RD 2.31 NCIS Interview of MA2 (b) and MA3 (b) (6) on 24 Sep 2013.
- <sup>97</sup> SI 2.23 (b) (6), Travel Coordinator for The Experts, 14 Oct 2013.
- <sup>98</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013.
- <sup>99</sup> SI 2.23 (b) (6), Travel Coordinator for The Experts, 14 Oct 2013.
- <sup>100</sup> SI 2.23 (b) (6), (b) (7)(C), Travel Coordinator for The Experts, 14 Oct 2013; RD 2.28 NCIS Interview of (b) (6), (b) (7)(C), Front Desk Clerk at NGIS, 24 Sep 2013.
- <sup>101</sup> RD 2.46 NGIS Desk Log for 6 Aug 2013.
- <sup>102</sup> SI 2.23 (b) (6), Travel Coordinator for The Experts, 14 Oct 2013.
- <sup>103</sup> SI 2.23 (b) (6), Travel Coordinator for The Experts, 14 Oct 2013; SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013.
- <sup>104</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013.
- <sup>105</sup> *Id.*
- <sup>106</sup> RD 2.29 Email from (b) (6), Personnel Security/Assurance, Defense Manpower Data Center to (b) (6), 3 Oct 2013; SI 2.20 (b) (6), FSO, The Experts, (10 Oct 2013).
- <sup>107</sup> SI 2.20 (b) (6), FSO The Experts, 14 Oct 2013.
- <sup>108</sup> RD 2.25 HPES letter dated 27 Sep 2013 to Defense Security Service, re: "Navy Yard Incident".
- <sup>109</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013.
- <sup>110</sup> SI 2.25 (b) (6), 2<sup>nd</sup> Shift Deployment Supervisor for HPES, 14 Oct 2013.
- <sup>111</sup> *Id.*
- <sup>112</sup> RD 2.32 City of Newport Police Dept Report # 13-17827-OF, 7 Aug 2013.
- <sup>113</sup> R.D. 2.44 E-mail from (b) (6), (b), NCIS, dated 18 Sep 2013, citing an NCIS report to Wendy Kay, Deputy Under Secretary of the Navy.
- <sup>114</sup> RD 2.32 Newport Rhode Island Police Department Fax Cover Sheet dated 7 Sep 2013.
- <sup>115</sup> SI 2.25 (b) (6), 2<sup>nd</sup> Shift Deployment Supervisor for HPES, 14 Oct 2013; SI 2.26 (b) (6), Lead Shift Deployment Supervisor for HPES, 14 Oct 2013.
- <sup>116</sup> SI 2.25 (b) (6), 2<sup>nd</sup> Shift Deployment Supervisor for HPES, 14 Oct 2013.
- <sup>117</sup> RD 2.29 Email from (b) (6), Personnel Security/Assurance, Defense Manpower Data Center to (b) (6), 3 Oct 2013; SI 2.20 (b) (6), FSO, The Experts, (14 Oct 2013).
- <sup>118</sup> SI 2.25 (b) (6), 2<sup>nd</sup> Shift Deployment Supervisor for HPES, 14 Oct 2013.
- <sup>119</sup> SI 2.25 (b) (6), 2<sup>nd</sup> Shift Deployment Supervisor for HPES, 14 Oct 2013; SI 2.27 (b) (6), HPES-Customer Services Representative, Naval Station Newport, 14 Oct 2013.
- <sup>120</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013; SI 2.21 (b) (6), HR Director for The Experts, 16 Oct 2013.
- <sup>121</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013; SI 2.25 (b) (6), 2<sup>nd</sup> Shift Deployment Supervisor for HPES, 14 Oct 2013.
- <sup>122</sup> SI 2.21 (b) (6), HR Director for The Experts, 16 Oct 2013.
- <sup>123</sup> SI 2.23 (b) (6), Travel Coordinator for The Experts, 14 Oct 2013.
- <sup>124</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013; SI 2.20 (b) (6), FSO The Experts, 14 Oct 2013.
- <sup>125</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013; SI 2.20 (b) (6), FSO The Experts, 14 Oct 2013; SI 2.21 (b) (6), Director HR for The Experts, 16 Oct 2013.
- <sup>126</sup> NISPOM, Para 1-302.a, Feb 2006.
- <sup>127</sup> SI 2.24 (b) (6), Program Manager for The Experts, 14 Oct 2013; SI 2.20 (b) (6), FSO The Experts, 14 Oct 2013; SI 2.21 (b) (6), Director HR for The Experts, 16 Oct 2013.
- <sup>128</sup> RD 2.29 Email from (b) (6), Personnel Security/Assurance, Defense Manpower Data Center to (b) (6), 3 Oct 2013; SI 2.20 (b) (6), FSO, The Experts, (10 Oct 2013).

- <sup>129</sup> RD 2.33 Hunton and Williams Letter Re: The Experts, Inc./Navy Yard Matter, 11 Oct 2013.
- <sup>130</sup> VA Department Triage Note on 23 and 28 Aug 2013.
- <sup>131</sup> VA Emergency Department Triage Note, 23 Aug 2013.
- <sup>132</sup> RD 2.34 Email from (b) (6) to Alexis dtd 1 Sep 2013 (The Silent Massacre).
- <sup>133</sup> SI 2.53 (b) (6), HPES Deployment Supervisor, 15 Oct 2013.
- <sup>134</sup> Naval Criminal Investigative Service (NCIS) Timeline based on FBI data.
- <sup>135</sup> SI 2.28 with Colonel (b) (6) on 7 and 9 Oct 2013.
- <sup>136</sup> NCIS provided Timeline based on FBI data.
- <sup>137</sup> RD 2.47 FBI Washington Field Office Press Release, Law Enforcement Shares Findings of the Investigation into the Washington Navy Yard Shootings, dated 25 Sep 2013.
- <sup>138</sup> Building 197 surveillance video dated 16 Sep 2013.
- <sup>139</sup> NCIS Timeline based on FBI data; Contracted security in Building 197 is supplied by HBC Management.
- <sup>140</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>141</sup> RD 2.35 Regional Dispatch Center automated telephone call log.
- <sup>142</sup> RD 2.35 Regional Dispatch Center automated telephone call log.
- <sup>143</sup> *Id.*
- <sup>144</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>145</sup> RD 2.36 Naval District Washington Battle Watch Logs dated 16 Sep 2013.
- <sup>146</sup> RD 2.36 Naval District Washington Battle Watch Logs dated 16 Sep 2013. [The Battle Watch logs annotate the time of the shooting at 0815, which is before the initial 911 telephone report time recorded by the automated telephone log.]
- <sup>147</sup> RD 2.36 Naval District Washington Battle Watch Logs dated 16 Sep 2013.
- <sup>148</sup> SI 2.29 with Captain (b) (6) on 14 Oct 2013 and Sergeant (b) (6) on 15 Oct 2013.
- <sup>149</sup> SI 2.31 with Corporal (b) (6) on 16 Oct 2013 .
- <sup>150</sup> SI 2.28 with Colonel (b) (6) on 7 and 9 Oct 2013.
- <sup>151</sup> SI 2.28 with Colonel (b) (6) on 7 and 9 Oct 2013; SI 2.29, 2.30, 2.32, 2.33, 2.34, 2.38, 2.50, and 2.55 Naval Security Force (NSF) members involved in the response to 16 Sep 2013 conducted between 14 and 17 Oct 2013.
- <sup>152</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>153</sup> RD 2.37 NDW Fire and Emergency Services Emergency Incident Critique Package, dated 25 Sep 2013.
- <sup>154</sup> SI 2.47 with Sergeant (b) (6) on 15 Oct 2013.
- <sup>155</sup> SI 2.29, 2.30, 2.32, 2.33, 2.34, 2.38, 2.50, and 2.55 Naval Security Force (NSF) members involved in the response to 16 Sep 2013 conducted between 14 and 17 Oct 2013.
- <sup>156</sup> Summary of Field Observation (SFO) 2.1 of Regional Operations Center dated 28 Oct 2013.
- <sup>157</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>158</sup> RD 2.38 NDW WAAN Use in support of WNY Active Shooter Incident (16-17 Sep 2013).
- <sup>159</sup> RD 2.37 Naval District Washington (NDW) Fire and Emergency Services Emergency Incident Critique Package dated 25 Sep 2013.
- <sup>160</sup> Giant Voice System Automated Log alarm number 0020604 from SFO 5.5 with ETC (b) (6) conducted on 3 Oct 2013.
- <sup>161</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>162</sup> SI 2.44 with CPL (b) (6) dated 14 Oct 2013.
- <sup>163</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>164</sup> RD 2.35 RDC Log – Police Events; RD 2.35 RDC Log – Fire Events; SI 5.6 LCDR (b) (6), Department Head, WNY Naval Health Clinic, on 9 and 15 Oct 2013. (6)
- <sup>165</sup> Summary of Interview (SI) 6.1 HMC (b) (6), Safety Manager, Naval History and Heritage Command, conducted on 9 Oct 2013.
- <sup>166</sup> SI 6.1 HMC (b) (6), Safety Manager, Naval History and Heritage Command, conducted on 9 Oct 2013; SI 6.2 (b) (6), President, Physical Evaluation Board, and CAPT (b) (6), Medical Officer, Physical Evaluation Board, conducted on 21 Oct 2013.
- <sup>167</sup> SI 2.36 with CAPT (b) (6) on 15 Oct 2013.

- <sup>168</sup> SI 5.2 with FBI Special Agents (b) (6) and (b) (6) dated 11 Oct 2013.
- <sup>169</sup> RD 2.37 NDW Fire and Emergency Services Emergency Incident Critique Package, dated 25 Sep 2013; SI 5.4 (b) (6), NDW Battalion Fire Chief, conducted on 9 Oct 2013; SI 5.2 (b) (6) and (b) (6), Special Agents, National Capital Response Squad, FBI Washington Field Office, conducted on 11 Oct 2013.
- <sup>170</sup> RD 2.39 Emergency Operations Center (EOC) Logs of 16 Sep 2013.
- <sup>171</sup> SI 6.8 (b) (6), Division Head, NAVSEA Continuity Planning, conducted on 9 Oct 2013.
- <sup>172</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>173</sup> SI 2.56 (b) (6), CNIC Fleet and Family Readiness Programs, and (b) (6), CNIC Program Analyst for Family Readiness, conducted on 7 Oct 2013; SI 6.10 CAPT (b) (6), CNIC Staff Judge Advocate, conducted on 5 Oct 2013; SI 6.5 (b) (6) and (b) (6), NDW Fleet and Family Services Program Managers, conducted on 8 Oct 2013.
- <sup>174</sup> RD 2.37 NDW Fire and Emergency Services Emergency Incident Critique Package, dated 25 Sep 2013.
- <sup>175</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>176</sup> RD 2.39 EOC logs dated 16 Sep 2013. RD 2.35 Region Dispatch Logs dated 16 Sep 2013 confirmed the neutralized shooter to be Aaron Alexis at 1122.
- <sup>177</sup> SI 2.54 with MPD Chief of Police Cathy Lanier and (b) (6) on 29 Oct 2013.
- <sup>178</sup> SI 6.3 LT (b) (6), NAVSEA CACO Officer, conducted on 7 Oct 2013.
- <sup>179</sup> RD 2.35 RDC Log – Police Events; RD 2.35 RDC Log – Fire Events; RD 2.37 NDW Fire and Emergency Services Emergency Incident Critique Package, dated 25 Sep 2013; SI 5.6 LCDR (b) (6), Department Head, WNY Naval Health Clinic, on 9 and 15 Oct 2013; SI 5.4 (b) (6), NDW Battalion Fire Chief, conducted on 9 Oct 2013. (6)
- <sup>180</sup> SI 5.8 CDR (b) (6), CHINFO OI-3, conducted on 17 Oct 2013.
- <sup>181</sup> SI 2.29, 2.30, 2.32, 2.33, 2.34, 2.38, 2.50, and 2.55 Naval Security Force (NSF) members involved in the response to 16 Sep 2013 conducted between 14 and 17 Oct 2013.
- <sup>182</sup> RD 2.40 NDW Communication Timeline; SI 2.57 LCDR (b) (6), Deputy Executive Assistant to Chief of Chaplains, conducted on 8 Oct 2013.
- <sup>183</sup> SI 6.8 (b) (6), Division Head, NAVSEA Continuity Planning, conducted on 7 Oct 2013.
- <sup>184</sup> SI 2.59 CAPT (b) (6), CNIC Chaplain, conducted on 8 Oct 2013; SI 2.57 LCDR (b) (6), Deputy Executive Assistant to Chief of Chaplains, conducted on 8 Oct 2013; RD 2.48 Memo of CAPT (b) (6), Region Chaplain NDW Religious Ministry Metrics ICO Mass Casualty dated 16 Sep 2013.
- <sup>185</sup> SI 6.2 (b) (6), President, Physical Evaluation Board, and CAPT (b) (6), Medical Officer, Physical Evaluation Board, conducted on 21 Oct 2013; SI 5.6 LCDR (b) (6), Department Head, WNY Naval Health Clinic, on 9 and 15 Oct 2013. (6)
- <sup>186</sup> SI 6.5 (b) (6) and (b) (6), NDW Fleet and Family Services Program Managers, conducted on 8 Oct 2013.
- <sup>187</sup> See, e.g., Press Conference at the MedStar Washington Hospital (available at <http://www.wusa9.com/video/2676381662001/1937935919001/press-conference-at-the-medstar-washington-hospital-center>).
- <sup>188</sup> SI 6.6 CAPT (b) (6), Navy Medicine Psychiatry Specialty Leader, Navy Medicine East, conducted on 8 Oct 2013; SI 2.56 (b) (6), CNIC Fleet and Family Readiness Programs, and (b) (6), CNIC Program Analyst for Family Readiness, conducted on 7 Oct 2013; SI 6.7 CDR (b) (6), Public Health Service, conducted on 8 Oct 2013.
- <sup>189</sup> RD 2.41 Memorandum from the Vice Chief of Naval Operations to Commander, Navy Installations Command of 16 Sep 2013.
- <sup>190</sup> Status is reported via the Navy Family Accountability and Assessment System (NFAAS) or via their Chain of Command; see also NAVADMIN 233/13 (Washington Navy Yard Active Shooter Order to Account for Navy/Family).
- <sup>191</sup> SI 6.8 (b) (6), Division Head, NAVSEA Continuity Planning, conducted on 9 Oct 2013.
- <sup>192</sup> RD 2.35 RDC logs dated 16 Sep 2013.

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<sup>193</sup> RD 2.37 NDW Fire and Emergency Services Emergency Incident Critique Package, dated 25 Sep 2013; SI 5.4 (b) (6), NDW Battalion Fire Chief, conducted on 9 Oct 2013.

<sup>194</sup> SI 2.59 CAPT (b) (6), CNIC Chaplain, conducted on 8 Oct 2013; SI 2.57 LCDR (b) (6), Deputy Executive Assistant to Chief of Chaplains, conducted on 8 Oct 2013; RD (b) (6) 48 Memo of CAPT (b) (6) dated 16 Sep 2013.

<sup>195</sup> See <http://www.navy.mil/viewVideo.asp?id=188836>.

<sup>196</sup> SI 2.29, 2.30, 2.32, 2.33, 2.34, 2.38, 2.50, and 2.55 Naval Security Force (NSF) members involved in the response to 16 Sep 2013 conducted between 14 and 17 Oct 2013.

<sup>197</sup> RD 2.42 Email from VADM William Hilarides to (b) (6) at 2203 on 16 Sep 2013.

<sup>198</sup> SI 6.3 LT (b) (6), NAVSEA CACO Officer, conducted on 7 Oct 2013; RD 2.48 Memo of CAPT (b) (6) dated 16 Sep 2013.

<sup>199</sup> SI 6.3 LT (b) (6), NAVSEA CACO Officer, conducted on 7 Oct 2013; SI 6.4 CDR (b) (6), NAVSEA Staff Judge Advocate, conducted on 6 Oct 2013.

<sup>200</sup> SI 2.56 (b) (6) and (b) (6) CNIC N9 and Program Analyst for Family Readiness, conducted on 7 Oct 2013.

<sup>201</sup> SI 6.3 LT (b) (6), NAVSEA CACO Officer, conducted on 7 Oct 2013.

<sup>202</sup> SI 6.4 CDR (b) (6), NAVSEA Staff Judge Advocate, conducted on 6 Oct 2013; SI 6.3 LT (b) (6), NAVSEA CACO Officer, conducted on 7 Oct 2013.

<sup>203</sup> SI 2.60 Col (b) (6), Senior Marine Advisor, PEO-Ships/SEA-21, conducted on 15 Oct 2013; SI 6.4 CDR (b) (6), NAVSEA Staff Judge Advocate, conducted on 6 Oct 2013.

<sup>204</sup> SI 6.8 (b) (6), Division Head, NAVSEA Continuity Planning, conducted on 7 Oct 2013.

## **Chapter 3 - Alexis and the Personnel Security Program**

Deficiencies in the execution of the Personnel Security Program (PSP) allowed Alexis to acquire and maintain security credentials giving him access to the Washington Navy Yard (WNY) and Building 197 on September 16, 2013.

This chapter presents an assessment of whether available information was properly evaluated as part of his initial employment suitability and clearance eligibility determinations for military and civilian employment. The effectiveness of continuous evaluation for ongoing military and civilian employment and continued access to classified information is also assessed.

### **Compliance with the Personnel Security Program**

#### **Regulatory Background**

The objective of the PSP is to authorize initial and continued access to classified information and/or initial and continued assignment to sensitive duties to those persons whose loyalty, reliability, and trustworthiness are such that entrusting them with classified information or assigning them to sensitive duties is clearly consistent with the interests of national security.<sup>1</sup>

SECNAV M-5510.30 (Department of the Navy (DON) PSP) establishes the requirements and procedures to implement Executive Order (EO) 12968 (Access to Classified Information); EO 10450 (Security Requirements for Government Employees); and Department of Defense (DoD) 5200.2-R (DoD PSP Regulations<sup>2</sup> for all DON military members, civilian personnel, and contractors).<sup>3</sup> SECNAV M-5510.30 was the governing regulation for the PSP applicable to Alexis during his time as an enlisted Sailor.

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DoD 5220.22-M (National Industrial Security Program Operating Manual (NISPOM)) establishes the requirements and procedures for the National Industrial Security Program (NISP), which controls the authorized disclosure of classified information released by U.S. Government Executive Branch Departments and Agencies to their contractors.<sup>4</sup> The NISPOM was the governing regulation for the PSP applicable to Alexis during his time as an employee of a DON subcontractor.

**Fundamentals of The PSP**

A PSP involves three key elements:

- An initial suitability determination for employment,
- An initial eligibility determination for access to classified information, and
- Continuous evaluations of individuals informing both subsequent suitability and eligibility determinations.

Initial suitability and eligibility determination are informed by investigations of a level of detail appropriate to the type of access being granted. Figure 3-1 illustrates the interrelationships of these elements.

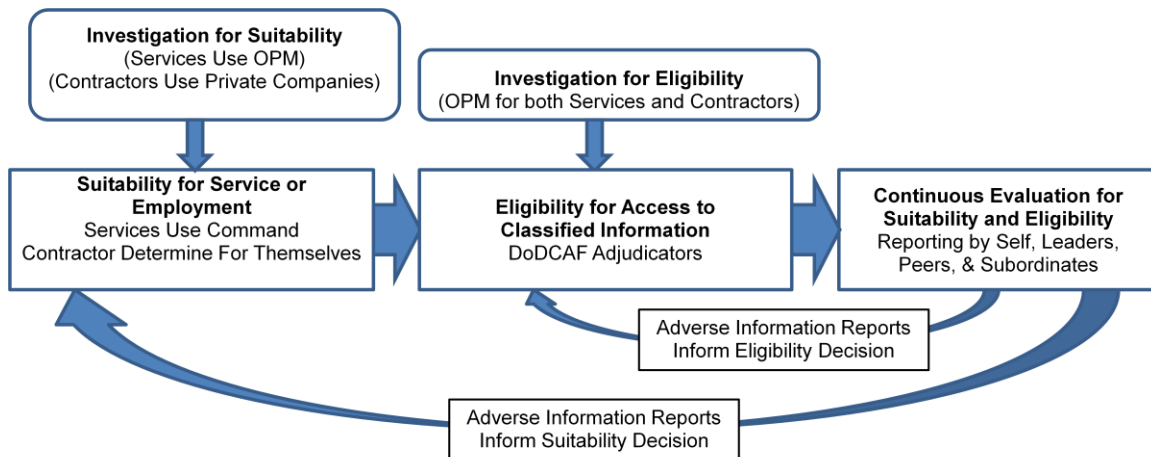


Figure 3-1: Key PSP Elements and Performing Activity

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Suitability Determinations are designed to determine whether the employment of an individual can reasonably be expected to promote the efficiency of the service or be a contributing part of the company (i.e., will the individual be a reliable member).<sup>5</sup>

Eligibility Determinations are designed to determine whether the authorization for access to classified information can reasonably be expected to be consistent with the interests of national security.<sup>6</sup> The adjudicators assess an individual's past behavior as a basis for predicting the individual's future trustworthiness.

Continuous Evaluation is the process by which all individuals who have received favorable security adjudication decisions are monitored to assure they continue to meet suitability and eligibility requirements for access to classified information.<sup>7</sup> Continuous evaluation requires the individual security clearance holder to self-report to the Security Manager or Facility Security Officer (FSO) adverse information that could affect the individual's continued eligibility for access to classified information, and requires co-workers, supervisors, and managers to similarly report adverse information, having potential security clearance significance, about other clearance holders.<sup>8</sup> Adverse information can also serve to inform decisions by the command or contractor for continued suitability of the individual for service or employment. In this context, adverse information reflects on the integrity or character of an individual across 13 criteria, including emotional, mental and personality disorders, criminal conduct, financial considerations, personal conduct, and alcohol consumption.

To assist in managing PSP transactions, DoD created the Joint Personnel Adjudication System (JPAS). JPAS provides an automated system of records for personnel and security management for DoD, providing security managers, FSOs, and adjudicators means to record and document personnel security actions. JPAS allows authorized users to view information they entered as well as personnel security investigation history and current status. The history of adjudicative eligibility

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determinations and reports of security-related incidents are viewable only to DONCAF adjudicators and not all JPAS users.<sup>9</sup>

For the industrial base, contractor FSOs have access to JPAS to record information and report issues pertaining to personnel under their purview. While Alexis had eligibility for access to classified information both as a former enlisted Sailor and as a DON subcontractor, his records were maintained in a common system, JPAS.

**Application of the Key PSP Elements to Alexis**

Figure 3-2 illustrates the application of the elements of the PSP to Alexis.

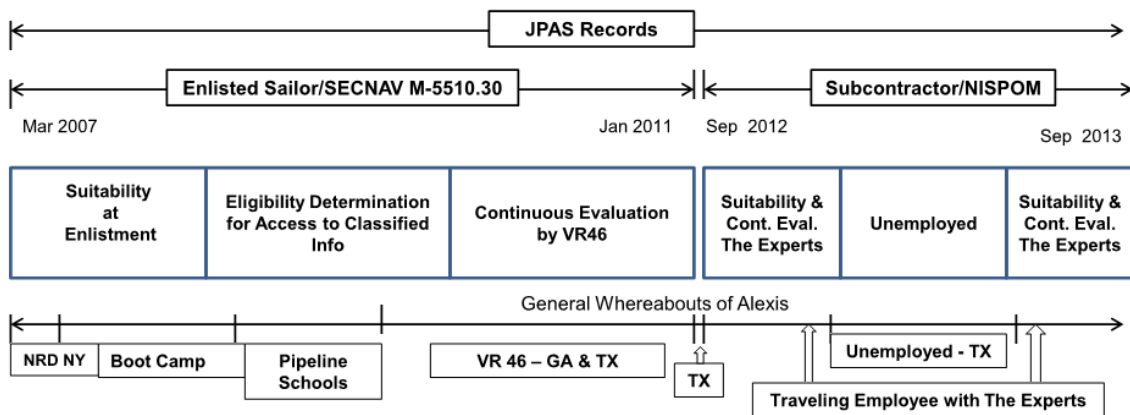


Figure 3-2: Application of PSP Activities to Aaron Alexis

**Assessment of the Personnel Security Program as Applied to Alexis**

**Suitability at Enlistment**

The existing record of Alexis’ military processing shows that PSP requirements were met. The detailed record and required documents of the suitability determination for enlistment are only required to be retained for two years, and are not available.<sup>10</sup> Therefore, it is not possible to determine what details regarding Alexis’ arrest for Malicious Mischief in Seattle on June 4, 2004, were collected at enlistment.



Based on available documentation, Navy Recruiting District New York and Commander, Navy Recruiting Command followed enlistment procedures when determining Alexis' suitability for military service.<sup>11</sup>

### **Eligibility Determination for Access to Classified Information**

**Finding 3.1:** [Category B] Department of the Navy Central Adjudication Facility did not resolve important questions that arose from gaps and inconsistencies in the investigation report and failed to retain the required record of its adjudicative process. This hampered the investigation's ability to understand the factors that led to Department of the Navy Central Adjudication Facility's decision to grant Alexis a SECRET security clearance.

On August 28, 2007, Office of Personnel Management (OPM) completed a National Agency Check with Law and Credit (NACLC) background investigation to support DONCAF's determination of Alexis' eligibility to access classified information.<sup>12</sup> As noted in the timeline in Chapter 2, there were several notable discrepancies between the information Alexis provided and the information that became available during the OPM investigation. Alexis failed to make required disclosures concerning:

- A June 2004 Malicious Mischief arrest;
- Three traffic citations with fines greater than \$150; and
- Debts he was late in paying or which had been assigned to collection agencies.

OPM's investigation included a personal interview of Alexis, as required by investigative standards.<sup>13</sup> While OPM did obtain Alexis' account of the Malicious Mischief charge and discuss his indebtedness, the investigation did not verify:

- The specific details surrounding Alexis' account of the Malicious Mischief arrest – specifically the information that the arrest involved discharging a firearm in anger in a public place;

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- Sources of Alexis' income for the years 2003 through 2007, during which he had reported being unemployed; and
- Three unreported traffic citations for which Alexis was fined greater than \$150.<sup>14</sup>

In March of 2008,<sup>15</sup> six months after the OPM report was completed, DONCAF discovered through an updated credit report additional unreported and unaddressed debts and collection accounts.<sup>16</sup> DONCAF granted the security clearance with the following issues insufficiently resolved:

- Details of arrest not independently verified – specifically the information that the arrest involved discharging a firearm in anger in a public place;
- Sources of income for last four years not identified;
- Additional financial irresponsibility unaddressed; and
- Unlisted traffic citations not addressed.

Alexis' repeated false, misleading or contradictory statements on the Electronic Personnel Security Questionnaire (EPSQ), the omissions in the OPM's personnel security investigation, and additional adverse information discovered by DONCAF concerning Alexis' financial condition warranted further action. At a minimum, as required by SECNAV M-5510.30, DONCAF should have withheld an eligibility determination and requested OPM to do additional investigation to address the gaps in the original investigation and the new information from the more recent credit report.

SECNAV M-5510.30 and DONCAF's Standard Operating Procedure, applicable at the time of Alexis' adjudication, required DONCAF to maintain in a readily retrievable system the rationale underlying favorable determinations when substantive derogatory information was known and mitigated.<sup>17</sup> DoDCAF representatives were unable to locate this record, hampering this investigation's ability to understand the information and

factors considered by DONCAF in its favorable eligibility determination in Alexis' case.<sup>18</sup>

**Continuous Evaluation by Fleet Logistics Support Squadron FOUR SIX (VR 46)**

Alexis reported to VR 46 on December 15, 2007, and was determined eligible for a Secret security clearance on March 11, 2008.<sup>19</sup> He was granted access to classified information on August 28, 2008. He now entered the continuous evaluation phase of PSP.

**Finding 3.2: [Category B]** Fleet Logistics Support Squadron FOUR SIX did not properly continuously evaluate Alexis and report adverse information to Department of the Navy Central Adjudication Facility, as required by SECNAV M-5510.30.

On August 10, 2008, Alexis was arrested for Disorderly Conduct in DeKalb County, Georgia.<sup>20</sup> On September 4, 2010, Alexis was arrested for discharging a weapon in Fort Worth, Texas.<sup>21</sup> These arrests met the threshold of adverse information, specifically criminal conduct, and should have been reported to DONCAF even though the charges were eventually dropped.<sup>22</sup> No reports were made.<sup>23</sup>

On May 17, 2009, while on liberty Alexis consumed several alcoholic drinks and jumped from a set of stairs fracturing his right ankle.<sup>24</sup> While not clearly required to report this event to DONCAF, VR 46 could have reported it as adverse behavior related to alcohol abuse but did not.<sup>25</sup>

Interviews with former command members and residual paperwork from VR 46 indicate Alexis had several disciplinary actions that resulted in counseling and extra military instruction. None of these events met the requirements to be reported to DONCAF and none were reported.

Alexis had access to classified information while at VR 46 but his daily duties did not involve the use of it.<sup>26</sup> This created complacency in reporting disciplinary issues to the adjudicating authority. When

disciplinary actions were considered, the principal focus of the command was Alexis' continued suitability for service in the Navy; his continued eligibility to access classified information was a secondary consideration.<sup>27</sup>

Alexis' final evaluation at VR 46, which included the statement "AE3 Alexis will be a valuable asset to any civilian organization," contained no adverse information and had a recommendation for retention. Based on Alexis' consistent poor performance, including multiple arrests and drunken behavior, it was within the discretion of the command to not have recommended him for reenlistment, to have assigned him a less favorable reentry code, and to recommend that his security clearance be removed.

### **Suitability and Eligibility Determination, and Continuous Evaluation of Alexis by The Experts**

Alexis was judged to be suitable for employment by The Experts based on his skills relative to the work he would be doing. He was judged to be eligible for access to classified information based on the fact that his prior SECRET security clearance from his time in the Navy was still valid after his discharge. With these two judgments in place, Alexis entered the continuous evaluation phase of PSP as a subcontractor.<sup>28</sup>

**Finding 3.3: [Category A]** Senior managers at the information technology company "The Experts," a subcontractor to HP Enterprise Services, LLC, for the Navy Marine Corps Intranet Continuity of Services Contract, failed to meet their contractually-required responsibility to continuously evaluate their employee Alexis and report adverse information to Department of Defense Central Adjudication Facility and U.S. Navy installation commanders. Specifically, the company leadership decided not to inform the government of adverse information concerning Alexis' emotional, mental, or personality condition, even when they had concerns that Alexis may cause harm to others, as required by the National Industrial Security Program Operating Manual.

The Experts conducted the pre-employment suitability background investigation on Alexis that HPES required in its contract with The Experts.

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The investigation for Alexis' first period of employment was completed after he started work; however, this deviation was approved by HPES.

While The Experts was not aware of all available information concerning Alexis' behavior in early August 2013 at Newport, Rhode Island, The Experts was aware that Alexis believed he had been followed by people from Norfolk, Virginia and that those people were:

- Speaking to him through the walls;
- Using a machine to pin him to the bed; and
- Changing hotels each time Alexis did to escape from them.

The Experts also knew Alexis had experienced previous episodes of paranoia and records reflect The Experts was concerned Alexis could present a risk of harm to others.

3.3.1: The Experts failed to report information concerning Alexis to U.S. Navy installation commanders to prevent access to Naval Station Newport and Naval Undersea Warfare Center (NUWC) as required by the NISPOM. The Experts had collected sufficient credible information that Alexis was experiencing an adverse emotional, mental, or personality event meeting reporting criteria.<sup>29</sup>

3.3.2: The Experts failed to report information about Alexis through JPAS to DoDCAF or Defense Security Service, the Cognizant Security Agency, to allow assessment of Alexis' continued eligibility for access to classified information.<sup>30</sup> Instead, The Experts only took an administrative action to cancel Alexis' visit request to NUWC. This was insufficient and based on an inaccurate assumption that NUWC access control processes would prevent entry after this administrative action.

3.3.3: In response to its concerns, The Experts used administrative removal, locally adjudicated that Alexis was suitable, and administratively reinstated his access. The actions to administratively debrief him, and then administratively reverse the action two days later by indoctrinating

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Alexis, were inappropriate given the circumstances known at the time. Instead, circumstances required an adverse information report and effective action to preclude Alexis' access to government facilities, including retrieving Alexis' government-issued credentials.

**Finding 3.4:** [Category A] HP Enterprise Services, LLC, the prime contractor for the Navy Marine Corps Intranet Continuity of Services Contract, failed to meet their contractually-required responsibility to continuously evaluate Alexis and report adverse information to Department of Defense Central Adjudication Facility and U.S. Navy installation commanders. Specifically, HP Enterprise Services, LLC, did not inform the government of adverse information concerning Alexis' emotional, mental, or personality condition, as was required by the National Industrial Security Program Operating Manual.

3.4.1: HPES failed to report information concerning Alexis to U.S. Navy installation commanders to prevent access to Naval Station Newport and NUWC as required by the NISPOM. Instead, Alexis' unusual behavior was discussed among three HPES employees at Newport.

3.4.2: HPES failed to report information about Alexis through JPAS to DoDCAF or Defense Security Service, the Cognizant Security Agency, to allow assessment of Alexis' continued eligibility for access to classified information.

The HPES FSO was at first unable to say definitively whether Alexis' behavior should have been reported. However, the FSO eventually concluded that an HPES employee did not need to report such behavior if the employee believed it was a "one time" event.<sup>31</sup> This is incorrect.

By letter dated October 18, 2013, the manager of HPES' Industrial Security Office (ISO), who oversees HPES FSOs, stated he had replaced and assumed the duties of the HPES FSO responsible for the Continuity of Services Contract (CoSC), and advised that the information known to the HPES employees:

*raised serious questions concerning Mr. Alexis' state of mind, constituting the kind of 'bizarre behavior' that HPES expects its employees to report to the ISO for follow up investigation...HPES expects its employees to report any incident that calls into question the trustworthiness of cleared employees, and this incident met that threshold.<sup>32</sup>*

The ISO manager said if the HPES employees had reported this information to HPES' ISO, he would have insisted The Experts file an incident report on Alexis in accordance with the NISPOM and, if The Experts refused, he would have directed the HPES FSO to submit a report. The ISO manager said that whichever way the report was submitted to the government, HPES would have denied Alexis access to classified information and facilities until HPES could fully understand Alexis' condition.<sup>33</sup>

### **Commentary on Naval Station Newport Actions**

When the Naval Station Newport Police Department responded to complaints made by and about Alexis, its personnel evaluated Alexis' behavior pursuant to Rhode Island law. Trained under that standard, Naval Station Newport Police Department personnel could have taken action to deny Alexis access to the base, and to have Alexis evaluated by a mental health professional if the officers thought Alexis presented a risk of immediate danger to himself or others. The responding officers concluded Alexis' behavior did not meet that standard. Naval Station Newport Police Department personnel viewed their interactions with Alexis solely through the lens of Rhode Island law. Since they were not trained to consider or report interactions with Alexis through the lens of the continuous evaluation of the PSP, it was not reported.<sup>34</sup> On a separate occasion at the Marriot Hotel, the City of Newport Police Department evaluated Alexis and similarly concluded he was not an immediate danger to himself or others. The Newport Police shared its report with Naval Station Police as part of routine law enforcement community interactions.

## Government Oversight of CoSC

**Finding 3.5: [Category B]** The Navy's Space and Naval Warfare Systems Command, Program Executive Office for Enterprise Information Systems, and Naval Enterprise Networks Program Manager, Warfare, did not exercise effective oversight of personnel security-related aspects of contractor performance for the Navy Marine Corps Intranet Continuity of Services Contract.

SPAWAR is responsible for CoSC administration and supports Program Executive Office for Enterprise Information Systems (PEO EIS) and Naval Enterprise Networks Program Manager, Warfare (PMW 205).<sup>35</sup> PEO EIS and PMW 205 are responsible for program management of the NMCI/CoSC program.<sup>36</sup>

3.5.1: The NMCI/CoSC program lacks well-defined roles and responsibilities with regard to responsibility for and oversight over personnel security practices of HPES and its subcontractors,<sup>37</sup> and does not perform quality assurance as authorized by Federal Acquisition Regulation (FAR) Part 46 (Quality Assurance).<sup>38</sup>

SPAWAR, PEO EIS and PMW 205, responsible for the NMCI/CoSC program, have provided no information indicating they perform quality assurance with respect to personnel security. There is no quality assurance plan for the CoSC.<sup>39</sup> There is also no internal audit program for the CoSC, and the Contracting Office does not do auditing for personnel security-related matters.<sup>40</sup>

3.5.2: SPAWAR, PEO EIS, and PMW 205, relied on HPES and The Experts to self-report critical security information and did not perform the required government verification.

- IT Levels of Trust – Contrary to the CoSC (DD 254), the Government relies on HPES to determine what level of Information Technology (IT) Position of Trust is required for each type of work under the



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CoSC.<sup>41</sup> This assessment should be performed or concurred in by the government.

- Note: the Program Manager is taking steps to address this by putting a process into place to manage the designation and vetting of personnel in these positions.<sup>42</sup>
- Common Access Card (CAC) Requests – The responsible Contracting Officer’s Representative (COR) does not independently check JPAS codes supporting CAC requests from HPES, necessitating reliance upon HPES to have assigned the correct codes.<sup>43</sup>
- Adverse Information – According to HPES, it is not aware of The Experts ever reporting adverse information about an individual to HPES since the contractual relationship between the two companies began.<sup>44</sup> HPES in turn has never reported adverse information up to the Security COR or the SPAWAR Director of Security, and has never had one employee report information on another.<sup>45</sup> SPAWAR, PEO EIS and PMW 205 have no audits or oversight in this area.
- No evidence was provided that personnel security-related audits have been or were going to be accomplished.

3.5.3: Little has been done to address the problems identified in the May 26, 2011, Naval Audit Service (NAS) Audit Report – “Controls Over Navy Marine Corps Intranet Contractors and Subcontractors Accessing Department of the Navy Information.”<sup>46</sup>

The NAS’ key finding was that the NMCI program management office was overly reliant on the internal controls of the contractor and did not provide effective oversight. Specifically, the NMCI program management office was not performing periodic random inspections to ensure that the prime contractor and its subcontractors were complying with DON security and information technology access policies.<sup>47</sup> PEO EIS and PMW 205

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acknowledge they have done little to implement corrective actions in response to the 2011 NAS audit report.<sup>48</sup>

Furthermore, no quality assurance oversight was in place for contractor personnel security matters, including continuous evaluation and corresponding notification of adverse information.<sup>49</sup>

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<sup>1</sup> SECNAV M-5510.1-1.2, p. 1-1, Nov 2007.

<sup>2</sup> SECNAV M-5510.1-1.1, p. 1-1, Nov 2007.

<sup>3</sup> SECNAV M-5510.1-8.1, p. 1-10, Nov 2007.

<sup>4</sup> DoD 5220.22-M, 1-100, p. 1-1-1, 18 Mar 2011.

<sup>5</sup> SECNAV M-5510.30.5-4.3, p. 5-8, Jun 2006.

<sup>6</sup> SECNAV M-5510.30.5-4.4, p. 5-8, Jun 2006.

<sup>7</sup> SECNAV M-5510.30.10-1.1, p. 10-1, Jun 2006.

<sup>8</sup> SECNAV M-5510.30.2.a, b, c, p. 10-1, Jun 2006.

<sup>9</sup> SECNAV M-5510.30, Appendix E, E-1.1 & 2, p. E-1, Jun 2006.

<sup>10</sup> COMNAVCRUITCOMINST 1130.8G, Apr 2005; and Reference Document (RD) 3.1 Email from CDR (b) (6), Commanding Officer, Navy Recruiting District, New York, 2 Nov 2013.

<sup>11</sup> Program Review (PR) 3.1 Suitability at Enlistment.

<sup>12</sup> RD 3.2 OPM Federal Investigative Notice, 06-08, September 11, 2006, p. 3.

<sup>13</sup> RD 2.8 White House (Berger) Memorandum, Implementation of Executive Order 12968, 24 Mar 1997.

<sup>14</sup> RD 2.2 Aaron Alexis Report of Investigation, Office of Personnel Management (OPM), Case # 07Q87334.

<sup>15</sup> PR 3.2 Eligibility Determination for Access to Classified Information.

<sup>16</sup> RD 2.2 Aaron Alexis OPM Case # 07Q87334; and RD 2.9 Alexis' Trans Union Employment Credit Report, 6 Mar 2008.

<sup>17</sup> RD 3.10 Aaron Alexis Department of the Navy Central Adjudication (DONCAF) Facility Standard Operating Procedure, p. 51; RD 3.11 DONCAF Standard Operating Procedure, p. 50; and RD 3.12 DONCAF Standard Operating Procedure, p. 31 dated 2 Jan 2008.

<sup>18</sup> Summary of Interview (SI) 3.2 with (b) (6), Branch Chief Navy Division DoDCAF, conducted on 8 and 18 Oct 2013; and PR 3.2 Eligibility Determination for Access to Classified Information.

<sup>19</sup> RD 2.5 Alexis' Official Military Personnel File (OMPF): History of Assignments; and RD 2.10 DONCAF Security Eligibility Determination Ltr Ser 10FUH565, 11 Mar 2008.

<sup>20</sup> RD 2.12 State of Georgia Uniform Traffic Citation, Summons and Accusation, Citation Number 23852927, 10 Aug 2008.

<sup>21</sup> RD 2.19 Fort Worth Police Department Report 10-94577, dated 4 Sep 2010.

<sup>22</sup> SECNAV M5510.30, Exhibit 10A.

<sup>23</sup> RD 2.11 Alexis' JPAS Incident History Page printed on 7 Oct 2013; and PR 3.3 Continuous Evaluation by VR 46.

<sup>24</sup> RD 2.13 Aaron Alexis Report and Disposition of Offense(s), NAVPERS 1626/7 of 24 Jun 2009.

<sup>25</sup> RD 2.11 Alexis' JPAS Incident History Page printed on 7 Oct 2013.

<sup>26</sup> SI 2.12 with CAPT (b) (6), former Commanding Officer of VR 46, conducted on 4 Oct 2013.

<sup>27</sup> SI 2.12 with CAPT (b) (6), former Commanding Officer of VR 46, conducted on 4 Oct 2013; and SI 2.4 with CAPT (b) (6), former Commanding Officer of VR 46, conducted on 4 Oct 2013.

<sup>28</sup> PR 3.4 Suitability and Continuous Evaluation of Alexis by The Experts.

<sup>29</sup> NISPOM, Feb 2006 and JPAS Users Manual, Feb 2006.

<sup>30</sup> *Id.*

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- <sup>31</sup> SI 3.6 with (b) (6), HPES ISO, conducted on 14 Oct 2013.
- <sup>32</sup> RD 3.27 HPES Letter to (b) (6), 18 Oct 2013.
- <sup>33</sup> SI 3.5 with (b) (6), HPES ISO, conducted on 19 Oct 2013.
- <sup>34</sup> RD 3.34 Naval Station Newport Chronological Account dated 19 Sep 2013.
- <sup>35</sup> SPAWAR awarded CoSC (N00039-10-D-0010) on 8 Jul 2010.
- <sup>36</sup> www.public.navy.mil/spawar/peoeis/pages.
- <sup>37</sup> SI 3.8 with (b) (6), Deputy Program Manager, Warfare (PMW 205), conducted on 21 Oct 2013.
- <sup>38</sup> SI 3.8 with (b) (6), Deputy Program Manager Warfare (PMW 205), conducted on 21 Oct 2013; and SI 3.11 with (b) (6), Program Executive Officer for Enterprise Information Systems (EIS), conducted on 7 Oct 2013.
- <sup>39</sup> SI 3.15 with (b) (6), Procuring Contracting Officer (PCO) for the CoSC, conducted on 28 Oct 2013.
- <sup>40</sup> *Id.*
- <sup>41</sup> RD 3.36 Email from CDR (b) (6), SPAWAR Contracting Officer, to (b) (5), 28 Oct 2013.
- <sup>42</sup> *Id.*
- <sup>43</sup> SI 3.9 and SI 3.10 with (b) (6), NAVSEA CoSC COR, conducted on 9 and 18 Oct 2013.
- <sup>44</sup> SI 3.5 with (b) (6), HPES Industrial Security Office (ISO) Manager, conducted on 19 Oct 2013.
- <sup>45</sup> SI 3.6 with (b) (6), HPES Facility Security Officer (FSO), conducted on 14 Oct 2013.
- <sup>46</sup> SI 3.8 with (b) (6), Deputy Program Manager Warfare (PMW 205), conducted on 21 Oct 2013; and SI 3.11 with (b) (6), Program Executive Officer for Enterprise Information Systems (EIS), conducted on 7 Oct 2013.
- <sup>47</sup> RD 3.37 Naval Audit Service – Audit Report (N2011-0038) “Controls Over Navy Marine Corps Intranet Contractors and Subcontractors Accessing Department of the Navy Information” of 26 May 2011.
- <sup>48</sup> SI 3.8 with (b) (6), Deputy Program Manager Warfare (PMW 205), conducted on 21 Oct 2013; and SI 3.11 with (b) (6), Program Executive Officer for Enterprise Information Systems (EIS), conducted on 7 Oct 2013.
- <sup>49</sup> PR 3.5 - Contractual Personnel Security Requirements and Their Application.

## **Chapter 4 – Force Protection at the Washington Navy Yard**

The force protection mission is accomplished by employing the integrated implementation of programs such as antiterrorism (AT), physical security, law enforcement, and access control. The findings identified below present weaknesses that could impact the ability to deter, detect and deny unauthorized access or inappropriate actions on the WNY. For the findings relating to the conduct of force protection, even had proper procedures been followed, there would have been no direct impact on the chain of events that led to the WNY shooting incident on September 16, 2013. These findings still require correction to address critical performance gaps and improve the WNY's capability against a wide range of threats.

This chapter provides an assessment of the execution of and compliance with Department of Defense (DoD) and Department of the Navy (DON) force protection policies and procedures locally implemented at the WNY and NAVSEA Headquarters.

The Investigation Team examined the physical structures that establish the WNY boundary; the entry control points (ECPs) for pedestrian and vehicle entrance in the WNY; locally developed post orders, standard operating procedures (SOP) and pre-planned responses (PPR) developed by the Naval Support Activity Washington (NSAW); procedures that govern physical security and law enforcement operations and policy at the WNY; and a comparison of the NSAW Naval Security Force (NSF) current staffing compared to authorized and required staffing.

# Antiterrorism Programs at the Washington Navy Yard and Naval Sea Systems Command

## Regulatory Background

The regulatory basis for AT programs is found in DoDI 2000.12 (DoD Antiterrorism Program), and DoDI 2000.16 (DoD Antiterrorism Standards), both of which are implemented in SECNAVINST 3300.2B (Department of the Navy (DON) Antiterrorism Program); OPNAVINST F3300.53C (Navy Antiterrorism Program; Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.1, Antiterrorism); and USFF AT OPORD 3300-13 (Commander, United States Fleet Forces Command Antiterrorism Operations Order). The DoD and Navy instructions prescribe minimum program elements and require commands to establish an AT program tailored to the local mission, conditions, and terrorist threats.

## Fundamentals of AT Programs

OPNAVINST F3300.53C defines AT as defensive measures used to reduce the vulnerability of individuals and property to terrorist acts, including limited response and containment by local military and civilian forces. AT is a defensive component of force protection and stresses deterrence of terrorist incidents through preventive measures common to all combatant commands and services.<sup>1</sup>

NTTP 3-07.2.1 provides details on the elements of an AT program – risk management, planning, training and exercises, resource application, and comprehensive program review. These elements support the five goals of AT – deter, detect, defend against, mitigate and recover.<sup>2</sup>

Risk Management: AT risk management processes are designed to identify, assess, and control risks arising from terrorist activities and to assist in planning and conducting the force protection mission. The risk management process should be embedded into all operations and identified in respective protection plans.<sup>3</sup>

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Planning: The planning process provides the commander with a means to sequentially organize, plan, and execute operational activities. An integral element of an installation's AT plan is the implementation of random antiterrorism measures (RAM). RAMs are the random implementation of higher Force Protection Condition (FPCON) security measures and other physical security measures which present a robust security posture from which a terrorist cannot easily discern patterns and routines. The RAM program serves to deter, detect, and disrupt potential terrorist attacks.<sup>4</sup>

Training and Exercises: AT training includes formal schoolhouse training, drills and exercises, and internet-based individual training with the aim to develop the tactical capabilities to successfully execute the AT mission. The AT training and exercise programs serve to train and assess the command's ability to execute the AT mission.<sup>5</sup>

Resource Application: Resource application is the process of identifying and submitting requirements through existing planning, programming, budgeting, and execution processes to ensure sufficient funding for AT program elements.<sup>6</sup>

Program Review: AT vulnerability assessments provide a vulnerability based analysis of a command's AT program. The assessment validates the command's AT plans, identifies vulnerabilities that may be exploited, and suggests options that may eliminate or mitigate those vulnerabilities.<sup>7</sup>

**Finding 4.1**: **[Category C]** The Naval Support Activity Washington's Antiterrorism Program is deficient in several areas.

The deficiencies noted below limit NSAW's ability to deter potential threats or to interdict a terrorist event or other act of violence. Noteworthy deficiencies are provided below with additional deficiencies included in Appendix F.

4.1.1: (b) (7)(E) [REDACTED]

(b) (7)(E) [Redacted]  
[Redacted] (b) (7)(E) [Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

[Redacted]  
[Redacted]  
[Redacted]

4.1.2: Antiterrorism Training: NSAW has not conducted all annual exercises and assessments required by USFF OPORD 3300-13 to evaluate the AT plan; to evaluate the AT program training effectiveness, efficiency and readiness; and to provide feedback to improve training and supporting doctrine.<sup>10</sup>

Contrary to OPNAVINST F3300.53C, NAVSEA has not conducted annual AT Level 1 awareness refresher training for all personnel. However, NAVSEA does ensure personnel travelling overseas receive AT training.<sup>11</sup>

The Navy AT Level 1 Awareness Training (Course CENSECFOR CANSF-ATFP-CONUS-1.0) currently found on Navy Knowledge Online does not incorporate lessons learned from Fort Hood contrary to the Secretary of Defense memo. Specifically, there is no current training on insider threats, recognizing mental instability, or responding to an active shooter scenario.

4.1.3: Vulnerability Assessments: (b) (7)(E) [Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

(b) (7)(E)

.<sup>12</sup>

4.1.4: Oversight: Contrary to OPNAVINST F3300.53C, oversight of the installation AT program by Commander, Navy Installations Command (CNIC) and Naval District Washington (NDW) is not evident. (b) (7)(E)

.<sup>13</sup>

Additionally, NSAW has not held tenant commands accountable for required AT program elements. Specifically, most tenant commands, including NAVSEA, have not provided required annexes to the installation AT plan.<sup>14</sup>

## Physical Security and Law Enforcement

### Regulatory Background

The regulatory basis for physical security and law enforcement on DoD installations is found in 18 U.S. Code § 930; DoDI 5200.08 (Security of Department of Defense (DoD) Installations and Resources, DoD Physical Security Review Board (PSRB)); and DoD 5200.08R (Physical Security Program).

OPNAVINST 5530.14E (Navy Physical Security and Law Enforcement Programs) implements DoD physical security and law enforcement policy, and requires installation commanding officers to establish and maintain a Navy Security Program that implements higher headquarters requirements. SECNAVINST 5500.29C (Use of Deadly Force and the Carrying of Firearms by Personnel of the Department of the Navy in Conjunction with Law Enforcement, Security Duties and Personal Protection) implements DoDD 5210.56 (Use of Deadly Force and the Carrying of Firearms by DoD Personnel Engaged in Law Enforcement and



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Security Duties) and establishes policy for the carrying of firearms and the use of deadly force. CNICINST 5530.14A (CNIC Ashore Protection Program) implements the OPNAV physical security and law enforcement requirements for all Navy installations. USFF AT OPOD 3300-13 (Commander, United States Fleet Forces Command Antiterrorism Operations Order) provides reporting requirements.

Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.3 (Law Enforcement and Physical Security) provides DON tactics, techniques, and procedures governing the conduct of physical security and law enforcement. OPNAVINST 3591.1F (Small Arms Training and Qualification) provides firearms training requirements.

Unified Facilities Criteria (UFC) provide DoD requirements for planning, design, construction, sustainment, restoration, and modernization criteria pertaining to physical structures on Naval installations. UFC 4-022-01 (Security Engineering: Entry Control Facilities/Access Control Points) and UFC 4-022-03 (Security Engineering: Fences, Gates, and Guard Facilities) are applicable to physical security standards.

OPNAVINST 5530.13C (Department of the Navy Physical Security Instruction for Conventional Arms, Ammunition and Explosives (AA&E)) provides safety, security, and accountability requirements to any command handling or storing AA&E.

### **Fundamentals of Physical Security and Law Enforcement**

Physical security and law enforcement programs safeguard personnel, property and material by enforcing rules, regulations, and law at Navy installations and activities. OPNAVINST 5530.14E defines and describes key elements of these programs:<sup>15</sup>

Physical Security: Physical security measures protect personnel; prevent unauthorized access to installations and assets; and safeguard against espionage, sabotage, damage, and theft by means of physical measures.

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Physical security plans include elements of physical security, antiterrorism, and law enforcement as part of an integrated system. NTTP are used in physical security plans and in development of security procedures.<sup>16</sup>

Physical Security Surveys, Inspections, and Assessments: Each command's review and assessment program includes physical security surveys, inspections, and assessments. These products are used to guide commanders in determining what assets require protection, what security measures are in effect, where improvement is needed, and in setting security priorities.<sup>17</sup>

Entry Control Points: Installation ECPs are designated areas where pedestrian and vehicular access to the installation is permitted. ECP design elements are specified in UFC and include specific requirements for guard protection and control of vehicles entering the installation. Vehicle ECPs must include barriers which provide the capability to stop unauthorized vehicle entry to the installation.<sup>18</sup>

Mission Profile Validation – Protection: The Mission Profile Validation – Protection (MPV-P) is the Navy's tool for determining NSF manpower requirements and is managed by CNIC. The MPV-P is based on actual observation of operations and validates security force manpower requirements based on the installation's size, number of ECPs, physical configuration, and assets to be protected. The total number of NSF personnel required at a given installation is that which is required to man all validated posts and all additional support personnel such as trainers, administrators, and armory personnel.<sup>19</sup>

Law Enforcement Procedures: Navy law enforcement personnel conduct operations using three types of procedures:

- Post orders that provide guidance for standing a given post or watch;
- SOPs that establish how routine operations are conducted; and



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and ensure an annual review of post orders as required by NTTP 3-07.2.3. The post orders do not include required elements. Additionally, post orders and standard operating procedures contain differing and incorrect rules for the use of deadly force that are not in compliance with SECNAVINST 5500.29C. Finally, post orders and pre-planned responses lack clear guidance for routine and emergency situations.<sup>23</sup>

4.2.3: NSAW Physical Security, Facilities, and Entry Control Points: (b) (7) (E)

[REDACTED] Additionally, NSAW did not (b) (7)(E) [REDACTED] to NDW and USFF as required by USFF AT OPOD 3300-13.<sup>24</sup> Contrary to OPNAVINST 5530.14E, (b) (7)(E) [REDACTED]

[REDACTED]<sup>25</sup>  
Finally, the WNY entry control points are not posted with specific language prohibiting base entry with dangerous weapons as required by 18 U.S. Code § 930.<sup>26</sup>

4.2.4: NAVSEA Physical Security: Contrary to OPNAVINST 5530.14E, NAVSEA does not have an approved physical security plan, has not properly designated and marked restricted areas, and has not performed required physical security surveys or inspections. A Naval Criminal Investigative Service report provided to NAVSEA 09P (Office of Security Programs and Continuity Planning) on August 25, 2009, listed a number of observations and recommendations for Building 197 physical security which NAVSEA has not corrected.<sup>27</sup>

4.2.5: NAVSEA Contracted Security Guards: Contract security guards are provided for NAVSEA buildings 104, 176, 197, and 201 by HBC Management. The contract security guards are not part of the NSAW NSF and are prohibited from performing law enforcement functions. The security guard contract, signed and administered by Naval Facilities Engineering Command (NAVFAC) to provide services to NAVSEA, has numerous deficiencies. (b) (7)(E) [REDACTED]

(b) (7)(E) [Redacted]

[Redacted] Additionally, there is not a memorandum of agreement that defines the responsibilities and coordinates the contract guard force with the NSAW NSF as required. The presence of two separate but uncoordinated armed security forces on the installation risks blue-on-blue incidents between the two forces.

(b) (7)(E) [Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]

The contractor is not compliant with current Navy firearms training requirements as specified in OPNAVINST 3591.1F. NTTP 3-07.2.3 requires that the contractor certify that armed guards are qualified to Navy standards. The contract currently specifies OPNAVINST 3591.1D as the standard for weapons training for the security guards. OPNAVINST 3591.1F was issued in August 2009, well before the current contract was implemented on April 1, 2012. Additionally, contrary to NAVSEAINST 8370.2D, non-government ammunition is being used in Government weapons. Finally, NAVSEA has not appointed an AA&E accountability officer as required by OPNAVINST 5530.13C.

A number of performance problems associated with security guard watchstanding and weapons handling were identified as detailed in Appendix F. The number of deficiencies identified indicates that NAVSEA and NAVFAC headquarters have not provided effective oversight of the contract security guard force to ensure compliance with the scope of work specified by the contract.<sup>28</sup>

Navy Physical Security Assessment Report: The Navy physical security "Quick Look" conducted by Commander, U.S. Fleet Forces Command as requested by SECNAV concluded that existing directives and policies are adequate, and that the Navy is in compliance with physical security

protection standards set by DoD, DON, Service and Geographic Combatant Commander guidance and directives.<sup>29</sup> This “Quick Look” reviewed policy and existing reports.

The findings of this investigation support the “Quick Look” assessment that Navy physical security policy is sound, but this investigation concludes execution of and compliance with that policy is deficient at NSAW.

## **Access Controls at the Washington Navy Yard and Naval Sea Systems Command**

### **Regulatory Background**

The basis for access control on DoD installations is Homeland Security Presidential Directive 12 (HSPD-12) and DoD Directive-Type Memorandum 09-012 (DTM 09-012) (Interim Policy Guidance for DoD Physical Access Control), which implements the requirements of HSPD-12. CNICINST 5530.14A (CNIC Ashore Protection Program) implements DoD access control requirements and promulgates access control standards for all Navy installations.

NSAW has established local access control requirements in NSAW 5560.1A (Naval Support Activity Washington Traffic Policy); NSAW 5530 Ltr Ser N00/126 (Access Control Changes Effective July 1, 2011); and NSAWINST 5532.1 (Procedures for Vetting Visitors to Navy Museum on the Washington Navy Yard).

The regulatory basis for contractor access to classified information is DoD 5220.22-R (Industrial Security Regulation). NAVSEAINST 5510.2C (NAVSEA Access and Movement Control) establishes local requirements for visitor access to NAVSEA facilities and classified information.

## Fundamentals of Access Control

The objective of access control is to restrict and control entrance to installations only to authorized individuals. These objectives are accomplished by ensuring all unescorted persons entering DoD installations have a valid purpose to enter and their identity is verified and vetted.

Personnel with Common Access Cards: Military, civilian, and contractors possessing DoD-issued Common Access Cards (CAC) have their identity verified at the card issuance site and vetted according to applicable DoD personnel security standards. As such, military, civilian, and contractors possessing a CAC can properly gain access to installations via either an electronic physical access control system or through a manned security post.<sup>30</sup>

Personnel without Common Access Cards: Visitors who do not possess a CAC have their identity verified and vetted at the Pass Office prior to being issued an unescorted installation pass. Visitors must provide an authorized form of identification. Their need for access is validated by Pass Office personnel, who also vet visitors by using an authorized data source (The National Crime Information Center database (NCIC)) to perform a criminal background check.<sup>31</sup>

Personnel with Navy Commercial Access Control System Cards: Contractors and vendors who do not possess a DoD CAC may participate in the Navy Commercial Access Control System (NCACS) to enable routine access for up to one year. NCACS participants have their identity verified by the Pass Office and are vetted by a CNIC authorized contractor (EID Passport) prior to being issued an NCACS identification card that can be scanned to verify access privileges at manned security posts.<sup>32</sup>

Personnel Debarment Process: Installation Commanding Officers can debar individuals and have their credentials confiscated as a result of inappropriate behavior. Installations use the Navy's Consolidated Law

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Enforcement Operations Center (CLEOC) database to document individuals who have been debarred from an installation. Prior to granting entry, installations use CLEOC to ensure personnel requesting installation entry have not been debarred.<sup>33</sup>

Personnel Access to Classified Material: Individuals are granted access to classified information after the host organization verifies identity, need to know, and a valid security clearance via Joint Personnel Adjudication System (JPAS).

**Finding 4.3: [Category C]** The access control methods and practices employed by Naval Support Activity Washington and Naval Sea Systems Command to vet unescorted visitors do not comply with local, Department of the Navy, and Department of Defense instructions.

Noteworthy deficiencies are provided below with additional deficiencies included in Appendix F.

4.3.1: WNY Access Control: (b) (7)(E) [Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

(b) (7)(E) [Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

[Redacted] (b) (7)(E) [Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]

<sup>36</sup>



(b) (7)(E) [Redacted]  
[Redacted]  
[Redacted].<sup>37</sup>

(b) (7)(E) [Redacted]  
[Redacted]  
[Redacted]  
[Redacted].<sup>38</sup>

4.3.2: NAVSEA Access Control: There are inadequate or incomplete procedures concerning NAVSEA access control. There is also a lack of compliance with existing procedures and a lack of government oversight to ensure that access controls are properly executed. (b) (7)(E) [Redacted]

[Redacted]  
[Redacted]  
[Redacted].

4.3.2.1: Inadequate NAVSEA Access Instruction: NAVSEAINST 5510.2C, NAVSEA Access and Movement Control, does not provide guidance for determining need-to-know as required by SECNAV M-5510.30, DON Personnel Security Program Manual.<sup>39</sup> SECNAV M-5510.30 requires that individual commands establish procedures that at a minimum will include verification of identity, validation of personnel security clearance eligibility and access, and a need-to-know determination.

4.3.2.2: Deficient Implementation of NAVSEA Access Instruction: The NAVSEA instruction is not being followed and, in some cases, personnel are using informal guidance and (b) (7)(E) [Redacted]

[Redacted]  
[Redacted].<sup>40</sup>

NAVSEA did not follow NAVSEAINST 5510.2C and SM-3 (Naval Nuclear Propulsion Program Headquarters Security Manual) to grant HP Enterprise Services, LLC (HPES) and The Experts, Inc. (The

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Experts) including Alexis, access to Buildings 197, 201, and 104. Specifically, a visit request was not reviewed prior to granting access to Building 104 and Alexis' clearance was not verified in JPAS prior to granting access to Building 197. HPES and The Experts personnel were subsequently confirmed to have proper credentials.<sup>41</sup>

4.3.2.3: Visitor Control Center Operations in Building 197: The Visitor Control Center informally controls visitor access based on verbal directions and emails instead of approved SOP that link back to higher authority guidance and requirements. For example, NAVSEA 09P provided an unsigned "procedure" given to Visitor Control Center contractor staff that allows issuing an unescorted access badge to an individual with unadjudicated JPAS security events without assessment by NAVSEA 09P.<sup>42</sup>

4.3.2.4: NAVSEA FORM 5510/9 (Badge Request Form): Deficiencies were identified on 29 of 250 (~11%) forms reviewed and included missed NAVSEA Administrative Officer or Contracting Officer Representative's signatures, incomplete investigation dates, and incorrect access authorization dates. Additionally, based on interviews with NAVSEA 09P managers, NAVSEA is not retaining visitor access records for two years as required by SECNAV M-5210.1 (Department of the Navy Records Management Manual).<sup>43</sup>

In summary, the weaknesses identified above with the implementation of key antiterrorism, physical security and access control programs at the WNY present vulnerabilities that unless corrected, will in the future reduce the ability to deter, detect, and deny unauthorized access or inappropriate actions.

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<sup>1</sup> OPNAVINST F3300.53C (Navy Antiterrorism Program).

<sup>2</sup> NTTP 3-07.2.1, Antiterrorism of June 2010.

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

<sup>5</sup> OPNAVINST F3300.53C (Navy Antiterrorism Program).

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- <sup>6</sup> DoDI 2000.12, DoD Antiterrorism (AT) Program with Change 1.
- <sup>7</sup> NTTP 3-07.2.1, Antiterrorism of June 2010.
- <sup>8</sup> Program Review (PR) 4.1 NSAW Antiterrorism Program Review; Summary of Interview (SI) 4.1 with Mr. (b) (6), NSAW Antiterrorism Officer conducted on 8 Oct 2013.
- <sup>9</sup> SI 4.1 with Mr. (b) (6), NSAW Antiterrorism Officer conducted on 8 Oct 2013; SI 4.2 with Mr. (b) (6), NAVSEA 09P, Antiterrorism Training Officer conducted on 9 Oct 2013; PR 4.1 – NSAW Antiterrorism Program; PR 4.2 – NAVSEA Antiterrorism Program.
- <sup>10</sup> PR 4.3 NSAW Antiterrorism Training Program; SI 4.1 with Mr. (b) (6), NSAW Antiterrorism Officer conducted on 8 Oct 2013; SI 4.3 Ms. (b) (6), NSAW Installation Training Officer (ITO) conducted on 8 Oct 2013.
- <sup>11</sup> SI 4.4 with Mr. (b) (6), NAVSEA 09P, Antiterrorism Training Officer conducted on 18 Oct 2013; PR 4.4 – Antiterrorism Level 1 Training Program.
- <sup>12</sup> SI 4.5 with Mr. (b) (6), Naval District Washington (NDW) Regional Security Officer (N3AT), conducted on 9 Oct 2013; SI 4.1 with Mr. (b) (6), NSAW Antiterrorism Officer conducted on 08 Oct 2013; PR 4.1 – NSAW Antiterrorism Program.
- <sup>13</sup> SI 4.5 with Mr. (b) (6), Naval District Washington (NDW) Regional Security Officer (N3AT), conducted on 9 Oct 2013; SI 4.1 with Mr. (b) (6), NSAW Antiterrorism Officer conducted on 08 Oct 2013; PR 4.1 – NSAW Antiterrorism Program.
- <sup>14</sup> SI 4.1 with Mr. (b) (6), NSAW Antiterrorism Officer conducted on 08 Oct 2013; PR 4.1 – NSAW Antiterrorism Program.
- <sup>15</sup> OPNAVINST 5530.14E (Navy Physical Security and Law Enforcement Program).
- <sup>16</sup> *Id.*
- <sup>17</sup> *Id.*
- <sup>18</sup> UFC 4-022-01 (Unified Facilities Criteria for Security Engineering: Entry Control Facilities and Access Control Points).
- <sup>19</sup> OPNAVINST 5530.14E (Navy Physical Security and Law Enforcement Program).
- <sup>20</sup> *Id.*
- <sup>21</sup> *Id.*
- <sup>22</sup> SI 4.6 with Colonel (b) (6), NSAW Chief of Police conducted on 7 Oct 2013 and 9 Oct 2013; PR 4.5 – NSAW Law Enforcement Program.
- <sup>23</sup> PR 4.5 – NSAW Law Enforcement Program.
- <sup>24</sup> Field Observation on 3 Oct 2013 (Classified); PR 4.6 – NSAW Physical Security Program; SI 4.7 with Mr. (b) (6), Naval District Washington (NDW) Regional Security Officer (N3AT), conducted on 3 Oct 2013; Reference Document (RD) 4.1 Letter from Mr. (b) (6) concerning Washington Navy Yard vehicle barriers (undated, but provided on 3 Oct 2013).
- <sup>25</sup> Summary of Field Observation (SFO) 4.1 – Field Inspection of Washington Navy Yard Perimeter Boundary Structures conducted on 7 Oct 2013.
- <sup>26</sup> Field Observation conducted on 3 Oct 2013 (Classified).
- <sup>27</sup> PR 4.7 NAVSEA Physical Security Program; SI 4.8 with Mr. (b) (6), NAVSEA 09P, Director of Security conducted on 7 Oct 2013; SFO 4.2 – Field Inspection of Building 197 Main Entrance, Visitor Control Center and Alarm Control Center conducted on 7 Oct 13; RD 4.2 – Naval Criminal Investigation Service Physical Security Assist Visit Report of 25 Aug 2009.
- <sup>28</sup> SI 4.2 with Mr. (b) (6), NAVSEA 09P, Antiterrorism Training Officer conducted on 9 Oct 2013; SI 4.8 with Mr. (b) (6), NAVSEA 09P, Director of Security conducted on 7 Oct 2013; SI 4.9 with Mr. (b) (6), NAVSEA 09P, Division Head, Security Operations conducted on 8 Oct 2013; SFO 4.3 – Field Inspection of Building 197 Alarm Control Center conducted on 11 Oct 2013; PR 4.8 – NAVSEA Security Guards Program.
- <sup>29</sup> RD 4.3 USFF and COMMARFORCOM Base, Station and Installation Physical Security Assessment Report of 27 Sep 2013.
- <sup>30</sup> DTM 09-012, DoD Directive-Type Memorandum 09-012, Interim Policy Guidance for DoD Physical Access Control.
- <sup>31</sup> *Id.*
- <sup>32</sup> CNICINST 5530.14A (CNIC Ashore Protection Program).

<sup>33</sup> *Id.*

<sup>34</sup> Program Review (PR) 4.9 – NSAW Access Control Program.

<sup>35</sup> PR 4.9 – NSAW Access Control Program.

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

<sup>38</sup> Field Observation conducted on 3 Oct 2013; SFO 4.4 of NSAW Pass Office conducted on 8 Oct 13; PR 4.9 – NSAW Access Control Program.

<sup>39</sup> NAVSEAINST 5510.2C (NAVSEA Access and Movement Control); SM-3 (Naval Nuclear Propulsion Program Headquarters Security Manual).

<sup>40</sup> PR 4.10 – NAVSEA (Headquarters and 08) Access Control Program.

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

## **Chapter 5 – Incident Response and Emergency Management**

If physical security or the personnel security program (PSP) fails, a response force is required to contain and neutralize the threat. A response force consists of indigenous capability supported by outside agencies to augment as needed. The Navy relies on a comprehensive emergency management program to coordinate this response. Washington Navy Yard (WNY) Naval Support Activity Washington (NSAW) Naval Security Forces (NSF) and Naval District Washington (NDW) Fire and Emergency Services quickly responded to the incident on September 16, 2013, and effectively integrated into the overall response. The emergency management programmatic weaknesses identified by the Investigation Team were evident but did not delay or impede the response. For the findings relating to the conduct emergency management, even had proper procedures been followed, there would have been no direct impact on the chain of events that led to the WNY shooting incident on September 16, 2013. These findings still require correction to address critical performance gaps and improve the WNY's capability against a wide range of threats.

This chapter examines the execution of emergency response actions in response to the shooting on September 16, 2013. The detailed tactical responses of outside law enforcement or actions of the NSAW NSF and contract guard force inside Building 197 were not investigated. This chapter also presents an assessment of the emergency management programs in place at the NSAW and the NDW command levels and their compliance with higher order requirements.

The Investigation Team sought to determine which agencies responded to the incident, how they organized into an overall emergency response structure, and then assessed the Navy's role in the overall response.

## Regulatory Background

The regulatory basis for emergency management programs is defined in DoDI 6055.17 (DoD Installation Emergency Management (IEM) Program), which is implemented in OPNAVINST 3440.17 (Navy Installation Emergency Management Program), and CNIINST 3440.17 (Navy Installation Emergency Management Program Manual). The DoD and Navy instructions prescribe minimum program elements and require commands to establish an emergency management program tailored to the local mission, conditions, and hazards.

SECNAVINST 5720.44C (Department of the Navy Public Affairs Policy and Regulations) provides requirements and guidance on Navy Public Affairs Matters, including release authority and message criteria.

## Fundamentals of Emergency Management

OPNAVINST 3440.17 requires the development of an effective emergency management program to implement key principles, coordinate responsibilities, and establish structure for delivering the core capability to respond to all-hazards emergencies ranging from small-scale local emergencies to large-scale natural disasters and violent criminal activity.<sup>1</sup> The National Incident Management System (NIMS)<sup>2</sup> principles below are invoked by OPNAVINST 3440.17.

Command and Control: Command and control is the element that allows the commander to coordinate and adapt the overall response, including situations beyond the planned responses. Command and control establishes the response structure including trained responders, resources, effective communications, and information management. Unified Command provides guidelines to enable agencies with different legal, geographic, and functional responsibilities to coordinate, plan, and interact effectively.<sup>3</sup>

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Planning: The planning processes organize and develop risk-based pre-planned procedures, including the integration of outside agencies through memoranda of agreement, to address all-hazards emergencies.

Training and Exercises: The training and exercise program including pre-planned responses enables emergency responders to validate readiness to respond to a range of all-hazards emergencies.

Communications Management: The communication capabilities are designed to integrate all responding indigenous and external agencies to facilitate command and control.

Equipment: Essential facilities and assets are established and maintained to enable a quick and effective response during an emergency.

Public Information: Unified Commands use a Joint Information Center, working in close coordination with the responding agencies, to determine relevant information and dissemination priorities. Navy public affairs is required to communicate relevant timely and accurate information to the public, news media, military members, civilian personnel and Congress. In order to communicate effectively, public affairs develops themes and messages, as well as identifying and utilizing the appropriate communication vehicles to support efficient communication to internal and external audiences.

Program Oversight: Emergency management oversight ensures the emergency management program remains flexible and capable to adapt to changes in risk posture and threat assessment.

## **Incident Response on September 16, 2013**

**Finding 5.1: [Category C]** The Naval Support Activity Washington Naval Security Forces and Naval District Washington Fire and Emergency Services' response was swift and heroic. At the operational level, Naval Support Activity Washington and Naval District Washington Operations Centers did not effectively

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communicate and coordinate actions with the Metropolitan Police Department Unified Command until after the threat had been neutralized. As such, Navy Command and Control assets did not play a meaningful role in the initial incident response.

5.1.1: Command and Control: The Metropolitan Police Department (MPD) Unified Command exercised overall command of the emergency response from all agencies, including on-scene tactical leadership, medical care and evacuation, establishing a Joint Information Center, and implementing a process for egress of WNY tenant personnel.<sup>4</sup> NSAW and NDW did not effectively integrate with external agencies using the command and control construct of NIMS as required by OPNAVINST 3440.17. NSAW and NDW did not establish an appropriate interface with MPD Unified Command. As a result, the Unified Commander relied on Naval Criminal Investigative Service personnel, who were not WNY subject matter experts. This approach slowed actions in support of Unified Command priorities. For instance, the Unified Commander was not made aware of the video monitoring system capability on the WNY and in Building 197, could not readily identify a responsible Navy authority to establish the plan to egress personnel sheltering-in-place and unite them with their families, and could not quickly obtain Building 197 floor plans.<sup>5</sup>

The lack of integrated communications between fire and emergency services and Unified Command resulted in the NDW Medical Command Post having an incomplete operational picture. For example, the Medical Command Post Commander was not aware of law enforcement actions or of a triage area in the Building 28 garage.<sup>6</sup> This did not impact the Unified Command management of resources.

5.1.2: Planning: The lack of pre-planned response plans and mutual aid agreements, required by OPNAVINST 3440.17, contributed to the poor integration into the Unified Command. NDW incorrectly considered sections of the Washington D.C. Code to eliminate the need to develop



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mutual aid agreements. While the D.C. law allows for support, it does not provide any details on how that support will be provided or conducted at the WNY.

5.1.3: Communication with WNY Personnel: Initial mass warning notifications were not initiated within the 5 minute requirement for emergency personnel and 10 minute requirement for all personnel as required by OPNAVINST 3440.17. The initial notification was 18 minutes following the initial active shooter report.<sup>7</sup>

5.1.4: Communications with Emergency Responders: NDW Fire and Emergency Services and NSAW NSF did not establish inter-department or interagency radio communications following the initial security response to the active shooter as required by CNICINST 3440.18 (Region Dispatch Centers) and NTTP 3-07.2.3 (Navy Techniques Tactics and Procedures, External Entry Control and Restricted Area Access).<sup>8</sup> This failure was the result of incorrect equipment programming and operators having incomplete knowledge of equipment capabilities.<sup>9</sup> While on-scene Navy radios were not appropriately programmed to communicate with other agencies, NDW Region Dispatch Center (RDC) had the capability to patch radio communications between agencies if requested.<sup>10</sup> No requests were made during the response.<sup>11</sup> Similar communications deficiencies during an NDW Fire and Emergency Services-led response, such as a building fire, could result in degraded response capability.

5.1.5: Public Affairs: Contrary to SECNAVINST 5720.44C (Public Affairs Regulations), the regulating document for Navy public affairs, the initial Navy Chief of Information, NDW, and CNIC public affairs response lacked coordination between themselves and with the Unified Commander.<sup>12</sup> As such, some of the initial releases of information were inaccurate with respect to on-going response actions, injuries, and fatalities.<sup>13</sup> Authority for the release of public statements was not clear.<sup>14</sup> This did not hamper incident response.<sup>15</sup>

## Emergency Management Program

**Finding 5.2: [Category C]** Naval Support Activity Washington and Naval District Washington did not have effective emergency management programs. Oversight of emergency management by Naval District Washington and Commander, Navy Installations Command did not identify the deficiencies.

Noteworthy deficiencies are provided below with additional deficiencies noted in Appendix G.

5.2.1: NSAW Emergency Management Program: NSAW lacks a comprehensive emergency management program.<sup>16</sup> Many of the missing program elements were identified in previous external emergency management program reviews dating back to 2007.<sup>17</sup>

5.2.1.1: NSAW Planning: NSAW did not have an emergency management plan on September 16, 2013, as required by OPNAVINST 3440.17.<sup>18</sup> The implementation of an emergency management plan was a recommendation from the Fort Hood follow-on review.<sup>19</sup> NSAW issued an emergency management plan on October 17, 2013. This instruction does not include all required elements, such as mutual aid agreements and hazard-specific appendices. Further, NSAW does not have memoranda of understanding with WNY tenant commands, for example the WNY Branch Health Clinic,<sup>20</sup> as required by OPNAVINST 3440.17.<sup>21</sup>

5.2.1.2: NSAW Training: NSAW has not developed emergency response training requirements or a training plan,<sup>22</sup> and no assessment program is in place.<sup>23</sup> In particular, the incorporation of active shooter training was a recommendation from the Fort Hood follow-on review.<sup>24</sup>

5.2.1.3: NSAW Manning: The NSAW EOC Manager and the NSAW Emergency Management Officer, key emergency management organization positions identified in CNIINST 3440.17, are not filled.

The EOC Manager position is not a funded billet and the Emergency Management Officer position is funded, but vacant.<sup>25</sup> Additionally, all critical response personnel are not designated in writing, ensuring they are aware of their responsibilities.<sup>26</sup> Unresolved manning shortfalls jeopardize NSAW's readiness and emergency response capability.

5.2.1.4: NSAW Equipment: The mass notification system does not have the required two control consoles, including at least one located in a manned space to alert all personnel within 10 minutes as required by Unified Facilities Criteria (UFC) 4-021-1 (Design, Operations, and Maintenance: Mass Notification Systems). Additionally, the EOC does not have emergency backup power capability to sustain emergency response.<sup>27</sup> Finally, several material deficiencies<sup>28</sup> were identified that prevent fire alarms from alerting at the RDC.<sup>29</sup> A mass notification system using loud speakers and prerecorded messages, and electronic, computer and cellular telephone communications was a recommendation of the Fort Hood follow-on review.<sup>30</sup>

5.2.2: NDW Emergency Management Program: The NDW emergency management program is deficient in organization, manning, equipment, and training.

5.2.2.1: NDW Planning: NDW has not established mutual aid agreements with civil and emergency responders, including local emergency management agencies, as required by CNIINST 3440.17.<sup>31</sup> Specifically, NDW only has one prearranged agreement, executed in 1990, which does not include all applicable agencies.<sup>32</sup> Additionally, the NDW Emergency Manager was not aware that CNIINST 3440.17 required for both NDW and NSAW Commanders to develop mutual aid agreements and obtain his specific review and approval.<sup>33</sup> The implementation of mutual aid agreements was a recommendation from the Fort Hood follow-on review.<sup>34</sup>

5.2.2.2: NDW Manning: The NDW emergency management program is not manned to the requirements of an operational level response capability to effectively respond to and contain the effects of a natural or manmade emergency (Group 2) as required by CNIINST 3440.17 and CNICINST 3440.18. Specifically, the Regional Operations Center (ROC) Manager and five of eight RDC supervisory positions, including the RDC Manager, RDC Operations Manager, two Dispatch Supervisors, and a RDC Instructor, are vacant.<sup>35</sup> Despite these shortfalls, on September 16, 2013, incoming calls were managed sufficiently to provide timely notification of first responders.<sup>36</sup>

5.2.2.3: NDW Training: NDW's compliance with CNIINST 3440.17 training requirements is deficient. NDW has not established the required emergency management training program including initial and recurring training for critical operations personnel.<sup>37</sup>

5.2.2.4: NDW Equipment: The Regional emergency management program communication equipment is not being maintained to ensure radio compatibility with responding agencies as required by NTTP 3-07.2.3 and CNIINST 3440.18. Additionally, communication problems noted include poor reception and transmission inside buildings, incomplete programming of multi-channel radios for interoperability, and missing communications interface adapters.<sup>38</sup> Further, the incident command post emergency communication package required to facilitate emergency relocation of the ROC is not available,<sup>39</sup> emergency response vehicle automatic vehicle locator and mobile data terminals have not been implemented,<sup>40</sup> and the mobile command vehicle is not being utilized.<sup>41</sup> These deficiencies hinder command and control during emergency response.

5.2.2.5: NDW Assessment: NDW's emergency management assessment programs, required by OPNAVINST 3440.17, are deficient and provide minimal value. The last annual<sup>42</sup> emergency

management program capability assessment was conducted on July 24, 2009.<sup>43</sup>

5.2.2.6: NDW Oversight: There is no program to develop, execute, and track an emergency management training plan for either the NDW and NSAW emergency management programs.<sup>44</sup> Therefore, compliance reviews are not being performed.<sup>45</sup> Further, the emergency management deficiencies identified in independent vulnerability assessments and assist visits<sup>46</sup> were not being corrected and actively tracked.<sup>47</sup>

5.2.3: CNIC: CNIC is deficient in emergency management program budgeting and management oversight.

5.2.3.1: CNIC Funding: Since Fiscal Year 2011, CNIC identified that the Navy-wide emergency management program has been funded to 60% of minimum requirements to support base level of planning, training, assessment, and staffing.<sup>48</sup> As a mitigating action, CNIC direction to the regional commander was to “take additional risk in programs that can expand the use of mutual aid and community support.”<sup>49</sup> As noted, there are no effective mutual aid agreements in place applicable to WNY emergency management for law enforcement and medical response.

5.2.3.2: CNIC Management: CNIC oversight of NDW and NSAW emergency management programs did not detect and correct or mitigate longstanding deficiencies and known risks. CNIC is not tracking and managing deficiencies in the NDW and NSAW emergency management programs.<sup>50</sup> Additionally, CNIC actions to verify compliance with requirements consist mainly of semi-annual “data calls” with no follow-up action to address areas of known non-compliance.<sup>51</sup> Further, longstanding emergency management deficiencies identified in independent vulnerability assessments and assist visits<sup>52</sup> were not being actively tracked and corrected.<sup>53</sup>

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The weaknesses identified above with key emergency management programs at NSAW and NDW present vulnerabilities that, unless corrected, will impact the ability to respond to all-hazards emergencies ranging from small-scale local emergencies to large-scale disasters and violent criminal activity. Notwithstanding these weaknesses, because of the swift tactical response by NSAW NSF, reinforced by the swift and overwhelming support from local law enforcement, fire, and emergency services, the deficiencies noted did not impact the effectiveness of the incident response on September 16, 2013.

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<sup>1</sup> National Response Framework Second Edition dated May 2013.

<sup>2</sup> National Incident Management System dated December 2008 adopted by the Department of Defense in Deputy Secretary of Defense Memorandum to Military Secretaries dated 29 Nov 2005.

<sup>3</sup> *Id.*

<sup>4</sup> Summary of Interview (SI) 5.1 with MPD Chief of Police Cathy Lanier and (b) (6), conducted on 29 Oct 2013; SI 5.2 (b) (6) and (b) (6), Special Agents, National Capital Response Squad, FBI Washington Field Office, conducted on 11 Oct 2013.

<sup>5</sup> SI 5.1 with MPD Chief of Police Cathy Lanier and (b) (6), conducted on 29 Oct 2013; SI 5.3 with (b) (6), conducted on 1 Nov 2013.

<sup>6</sup> SI 5.4 with Battalion Chief (b) (6), conducted on 9 Oct 2013.

<sup>7</sup> Giant Voice System Automated Log alarm number 0020604 from SFO with ETC (b) (6), conducted on 3 Oct 2013; Reference Document (RD) 5.1 NDW WAAN Use in support of WNY Active Shooter Incident (16-17 Sep 2013).

<sup>8</sup> SI 5.4 with Battalion Chief (b) (6), conducted on 9 Oct 2013; SI 5.5 Colonel (b) (6), conducted on 7 and 9 Oct 2013.

<sup>9</sup> Summary of Field Observation (SFO) 5.1 of Communications Equipment Field Test conducted on 15 Oct 2013.

<sup>10</sup> SFO 5.1 of Communications Equipment Field Test, conducted on 15 Oct 2013.

<sup>11</sup> SFO 5.2 of Enterprise Land Mobile Radio System, conducted on 11-15 Oct 2013.

<sup>12</sup> SI 5.3 with (b) (6), conducted on 1 Nov 2013.

<sup>13</sup> RD 5.5 Timeline of External and Internal Communication provided by CNIC on 10 Oct 2013.

<sup>14</sup> SI 5.8 with CDR (b) (6) on 17 Oct 2013. Only the Navy Chief of Information was authorized to release details of the ongoing active shooting incident; however, several additional public affairs officers, including NSAW, Commander Naval Installation Command, and NAVSEA released information. RD 5.5 Timeline of External and Internal Communication provided by CNIC on 10 Oct 2013;

<sup>15</sup> SI 5.1 with MPD Chief of Police Cathy Lanier and (b) (6), conducted on 29 Oct 2013.

<sup>16</sup> OPNAVINST 3440.17 paragraph 6.e defines the required Emergency Management minimum capabilities.

<sup>17</sup> 2011 Chief of Naval Operations Integrated Vulnerability Assessment (classified); NCIS Security Training, Assistance and Assessment Team Physical Security Assist Visit 12AUG13-2AZL-0011-9Y04/C (classified).

<sup>18</sup> Required by DoDI 6055.17, OPNAVINST 3440.17, and CNIINST 3440.17.

<sup>19</sup> RD 5.2 Final recommendation of the Fort Hood follow-on review, recommendation 4.6 dated 18 Aug 2010.

<sup>20</sup> SI 5.6 with LCDR (b) (6), conducted on 9 Oct 2013.

- <sup>21</sup> SFO 5.4 of Memorandums of Agreement (MOAs), Memorandums of Understanding (MOUs), Mutual Aid Agreements (MAAs), and Inter-Service Support Agreements (ISSAs), conducted on 23 Oct 2013.
- <sup>22</sup> SFO 5.3 with (b) (6), conducted on 8 Oct 2013 regarding implementation of training required by OPNAVINST 3440.17, DoDI 6055.17 and CNIINST 3000.1.
- <sup>23</sup> Required by OPNAVINST 3440.17 and SFO 5.3 with (b) (6), conducted on 8 Oct 2013.
- <sup>24</sup> RD 5.2 Final recommendation of the Fort Hood follow-on review, recommendation 4.6 dated 18 Aug 2010.
- <sup>25</sup> SFO 5.5 with (b) (6) and ETC (b) (6) conducted on 3 Oct 2013; RD 5.3 Commanding Officer, NSAW Ltr 5800 Ser N00/340 of 17 Oct 2013.
- <sup>26</sup> CNIINST 3440.17 standard 2 (Personnel Categorization.); SFO 5.5 Interview with (b) (6) and ETC (b) (6), conducted on 3 Oct 2013.
- <sup>27</sup> SFO 5.6 with (b) (6), conducted on 9 Oct 2013.
- <sup>28</sup> SFO 5.7 of Tour with Fire Inspector (b) (6), conducted on 16 Oct 2013.
- <sup>29</sup> NFPA 72, Public Emergency Alarm Reporting Systems.
- <sup>30</sup> RD 5.2 Final recommendation of the Fort Hood follow-on review, recommendation 4.4 dated 18 Aug 2010.
- <sup>31</sup> CNIINST 3440.17 requires the Mutual Aid Agreements outlining cooperative measures where the Navy and the civilian community may provide mutual assistance in response to natural and man-made emergencies. SFO 5.4 Memorandums of Agreement (MOAs), Memorandums of Understanding (MOUs), Mutual Aid Agreements (MAAs), and Inter-Service Support Agreements (ISSAs), conducted on 23 Oct 2013.
- <sup>32</sup> SFO 5.4 Memorandums of Agreement (MOAs), Memorandums of Understanding (MOUs), Mutual Aid Agreements (MAAs), and Inter-Service Support Agreements (ISSAs), conducted on 23 Oct 2013.
- <sup>33</sup> SFO 5.8 with (b) (6), conducted on 7 Oct 2013.
- <sup>34</sup> RD 5.2 Final recommendation of the Fort Hood follow-on review, Recommendation 4.7 dated 18 Aug 2010.
- <sup>35</sup> SFO 5.9 with (b) (6), conducted on 3 Oct 2013.
- <sup>36</sup> SFO 5.10 of Region Dispatch Center Operations, conducted on 1 Nov 2013.
- <sup>37</sup> SFO 5.9 with (b) (6), conducted on 3 Oct 2013; OPNAVINST 3440.17.
- <sup>38</sup> SFO 5.1 of Communications Equipment Field Test conducted on 15 Oct 2013.
- <sup>39</sup> SI 5.7 with (b) (6) and (b) (6), conducted on 4 Oct 2013.
- <sup>40</sup> SFO 5.11 with (b) (6) on 10 Oct 2013.
- <sup>41</sup> The NDW Mobile Command Vehicle, which can provide ROC video feeds to Unified Command, was available, but not used on 16 September 2016.
- <sup>42</sup> OPNAVINST 3440.17.
- <sup>43</sup> RD 5.4 NDWINST 3440.17B, NDW Emergency Management Capability Assessment, Appendix T-6, dated 24 Jul 2009.
- <sup>44</sup> SFO 5.13 with (b) (6), conducted on 8 Oct 2013.
- <sup>45</sup> *Id.*
- <sup>46</sup> 2011 Chief of Naval Operations Integrated Vulnerability Assessment (classified); NCIS Security Training, Assistance and Assessment Team Physical Security Assist Visit 12AUG13-2AZL-0011-9Y04/C (classified).
- <sup>47</sup> SFO 5.13 with (b) (6) and (b) (6), conducted on 8 Oct 2013; SFO 5.9 with (b) (6), conducted on 3 Oct 2013.
- <sup>48</sup> CNIC response to Investigation Team Request for Information of 17 Oct 2013, which included RD 5.6 CNIC Navy Shore Guidance and History with emergency management (EM) Special Interest Codes; RD 5.7 Historical Navy Shore Resourcing for Force Protection, Fire and Emergency Services, Emergency Management, and Training and Readiness; SFO 5.12 CAPT (b) (6), CNIC N3 Operations, conducted on 25 Oct 2013.
- <sup>49</sup> CNIC response to Investigation Team Request for Information of 17 Oct 2013, which included RD 5.6 CNIC Navy Shore Guidance and History and emergency management (EM) Special

Interest Codes; RD 5.8 through 5.10, CNIC FY12-14 Operational Plans and the CNIC Emergency Management Requirement, Budget and Execution.

<sup>50</sup> SFO 5.13 with (b) (6), conducted on 8 Oct 2013.

<sup>51</sup> *Id.*

<sup>52</sup> 2011 Chief of Naval Operations Integrated Vulnerability Assessment (classified); NCIS Security Training, Assistance and Assessment Team Physical Security Assist Visit 12AUG13-2AZL-0011-9Y04/C (classified).

<sup>53</sup> SFO 5.13 with (b) (6) and (b) (6), conducted on 8 Oct 2013; SFO 5.9 with (b) (6), conducted on 3 Oct 2013.



## Chapter 6 – Post-Incident Response

Post-incident response entails actions necessary to provide support to affected personnel and restore mission capability after the initial response force has contained or eliminated the threat. The Investigation Team assessed the overall post-incident response was timely, plentiful, and responsive to the needs of those affected by the incident.

This chapter provides an assessment of the Navy's execution of, and compliance with, Department of Defense (DoD) and Department of the Navy (DON) policies and procedures pertaining to post-incident response, including medical response, support to victims and their families, mission continuity, and communication. Victim support actions for the three week period following the September 16, 2013, incident were reviewed.

### Regulatory Background

DoDI 1342 (Military Family Readiness) establishes policy, assigns responsibilities, establishes procedures for the provision of military family readiness services, and sets requirements for providing Emergency Family Assistance (EFA). The requirements governing EFA have been updated in the Navy's Fleet and Family Support Center (FFSC) Emergency Family Assistance Center (EFAC) Desk Guide, issued by Commander, Navy Installations Command (CNIC).

DoDI 1300.18 (Department of Defense Personnel Casualty Matters, Policies, and Procedures) assigns responsibilities and establishes uniform personnel policies and procedures across DoD components for reporting, recording, notifying, and assisting the next-of-kin whenever DoD casualties – deceased, missing, ill, or injured – are sustained. OPNAVINST 1770.1A (Casualty Assistance Calls and Funeral Honors Support (CAC/FHS) Program Coordination) establishes Navy requirements for providing and coordinating casualty assistance and funeral honors support for active duty and retired military members and their families.

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BUMEDINST 3440.10 (Navy Medicine Force Health Protection Emergency Management Program) provides policy, operational structure, and responsibilities for a comprehensive force health protection emergency management program at all Navy Medicine activities.

BUMEDINST 6440.6 (Mobile Medical Augmentation Readiness Team (MMART) Manual) establishes a deployable Navy Medicine Special Psychiatric Rapid Intervention Team (SPRINT) to provide psychiatric support in response to mass casualty events.

SECNAVINST 5720.44C (Department of the Navy Public Affairs Policy and Regulations) provides requirements and guidance on Navy Public Affairs Matters.

OPNAVINST 3030.5B (Navy Continuity of Operations Program and Policy) implements policy, assigns responsibility, and provides instructions to develop a plan for continuity of operations for U.S. Navy Echelon 1 through 6 commands.

OPNAVINST 3006.1 (Personnel Accountability in Conjunction with Catastrophic Events) provides requirements for reporting the status and location of personnel following catastrophic events, and implements the Navy Family Accountability and Assessment System.

### **Fundamentals of Post-Incident Response**

Post-incident response entails actions necessary to provide support to affected personnel, including medical support during the incident, and to restore mission capability after the initial response force has contained or eliminated the threat.

Emergency Medical Response: The immediate actions taken in response to an emergency include an assessment of the scene to ensure the health and safety of all first responders. In addition to neutralizing the threat, law enforcement will coordinate with other emergency responders, including medical responders, allowing access to the scene to address other hazards and injuries as conditions permit.<sup>1</sup>

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Post-Incident Care of Personnel and Families: Current Navy instructions provide requirements for the care and support of the families of active duty members who have died or become severely injured in the line of duty. A team consisting of a naval officer and Navy chaplain provide assistance with grief counseling, funeral arrangements, and benefits. The Navy has also established organizations and military units that provide support to families and communities following incidents that result in the death or injury.

Continuity of Operations: Presidential Directives, promulgated through departmental instructions, require Federal agencies to develop and maintain Continuity of Operations (COOP) Plans in the event of a natural or man-made disaster which has the potential to significantly disrupt government operations.<sup>2</sup> COOP Plans require Federal agencies to identify mission essential functions which support national essential functions, as well as key personnel to carry out mission essential functions, relocation plans and resources, and procedures for delegation of authority and devolution of command and control.

Personnel Accountability: The purpose of personnel accountability is to rapidly identify the location of personnel following any man-made or natural disaster, so that resources and aid can be supplied to personnel in need.

Public Affairs: Navy public affairs communicates relevant, timely, and accurate information to the public, news media, military members, civilian personnel and Congress. In order to communicate effectively, public affairs develops themes and messages, as well as identify and use appropriate communication vehicles to support efficient communication to internal and external audiences.

**Finding 6.1: [Category C]** Department of the Navy leadership proactively executed highly effective post-incident actions. Some areas for improvement were identified.

Response efforts were prioritized to support victims and their families, as well as to ensure the physical and mental well-being of all affected personnel. The EFAC at Joint Base Anacostia-Bolling (JBAB) and the counseling center aboard the Washington Navy Yard (WNY) were rapidly established and fully resourced to meet the demand. All of the shooting victims were provided Casualty

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Assistance Calls Officer (CACO) services with the exception of the wounded D.C. Metropolitan Police Department (MPD) Police Officer, who had an existing support network. The Naval Sea Systems Command (NAVSEA) effectively executed its COOP Plan, and by September 19, 2013, had reconstituted and restored its capability to execute all mission essential functions.

6.1.1: Medical Response: The Naval District Washington (NDW) Fire and Emergency Services responded as required by quickly requesting emergency medical services from external agencies and coordinating the establishment of a triage area at 11<sup>th</sup> and O Streets. Due to the continued threat of an active shooter, NDW Fire and Emergency Services followed standard protocol and did not send emergency medical technicians into the immediate area of the shooting without a law enforcement escort. Based on the possibility of a second shooter, entry into Building 197 by emergency medical technicians did not occur. By the time Building 197 transitioned from an active threat situation to a crime scene, all personnel in need of immediate medical care were being treated. The lead law enforcement agencies at the Unified Command assessed that the nature of the wounds for fatalities did not appear to be survivable.<sup>3</sup>

The WNY Branch Health Clinic is a Tier 4 facility, which by definition has minimal response capabilities and is not equipped to provide emergency medical services.<sup>4</sup> The WNY Branch Health Clinic has not been integrated into the Naval Support Activity Washington (NSAW) emergency management program as required by DoDI 6055.17 (DoD Installation Emergency Management (IEM) Program).<sup>5</sup> Despite the lack of integration, the WNY Branch Health Clinic provided limited emergency medical treatment to one of the shooting victims who had evacuated from Building 197 to the Clinic, and supplied six hospital corpsmen to the triage area in Building 28.<sup>6</sup> Due to the extended length of the shelter-in-place order, several other medical issues arose as the incident was unfolding. The triage areas and the WNY Branch Health Clinic treated several personnel for non life-threatening issues, including assisting two pregnant females,<sup>7</sup> three personnel experiencing diabetic emergencies, and several minor injuries.<sup>8</sup>

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6.1.2: Next-of-Kin Notifications: Notification provided to the families of victims resulted in all notifications being reported complete at 0020 on September 17, 2013.<sup>9</sup> The Federal Bureau of Investigation (FBI), as Lead Federal Agency, took charge of next-of-kin notifications. Next-of-kin of six of the victims were notified at Nationals Park by an FBI Agent, an FBI grief counselor, and a Navy chaplain. Two of the notifications were made at hospitals by the FBI alone.<sup>10</sup> Teams consisting of an FBI Agent, an FBI grief counselor, a MPD police officer, and a Navy chaplain made the remaining notifications.<sup>11</sup> Although this effort was not led by the Navy, the timeliness of notifications met the intent of DoD instructions to notify next-of-kin as soon as practicable after the circumstances surrounding the casualty are known.<sup>12</sup>

6.1.3: Casualty Assistance Calls: OPNAVINST 1770.1A does not apply to civilian and contractor personnel. Despite this, NAVSEA leadership provided CACO services to the families of government civilian and contractor victims.<sup>13</sup> These actions were effective and demonstrated a high level of support for the victims and their families. Incorporation of casualty support requirements applicable to private citizens who become casualties on a military installation within the Continental United States was a recommendation from the Ft. Hood follow-on review.<sup>14</sup>

6.1.4: Support for Victims and their Families: The Navy's support to affected personnel and their families was comprehensive and effective, and adapted quickly to meet the demands of the incident. Senior DON Leadership, including the Secretary of the Navy, Assistant Secretary of the Navy (Manpower and Reserve Affairs), Vice Chief of Naval Operations (VCNO), CNIC, and Commander, NAVSEA had daily discussions regarding victim support efforts and met with victims and other affected personnel.

As discussed in Chapter 5, there was a lack of integration of Navy personnel into the Unified Command.<sup>15</sup> Due to the lack of integration, MPD took the lead for the reunification effort of WNY personnel with friends and family at Nationals Park. However, once Navy support organizations became aware of the reunification plan, they provided four Navy Chaplains, three clinical social workers, and two Public Affairs Officers to provide support to friends and family of the victims.<sup>16</sup>

The NDW Regional Operations Center (ROC) also arranged for meals, a processing area to support personnel egress, and provided Navy bus service to transport WNY personnel to Nationals Park.<sup>17</sup>

Additional follow-on support efforts were effectively coordinated. For example, CNIC stood up an Emergency Family Assistance Center (EFAC) at JBAB that was prepared to handle a mass casualty within hours of the event.<sup>18</sup> The EFAC was established using the Navy's FFSC EFAC Desk Guide, which is distributed by CNIC to all FFSCs worldwide.<sup>19</sup> The EFAC provided emotional and financial counseling services, assisted in coordinating charity and fundraising events, and provided referral services. Additionally, CNIC established an Emergency Support Counseling and Assistance Center (ESCAC) on the WNY on September 17, 2013.

On September 16, 2013, the VCNO directed CNIC to stand up an Emergency Family Support Task Force, and the Secretary of the Navy authorized the provision of medical care to all those wounded in the shooting and legal assistance to anyone affected by the shooting. The task force arranged for and coordinated services provided by the JAG Corps, Chaplain Corps, FBI grief counselors, American Red Cross, Hope Dogs, and other organizations which offered services.<sup>20</sup> The Navy Surgeon General ordered deployment of the SPRINT from Portsmouth Naval Hospital.<sup>21</sup>

By the time the Emergency Family Support Task Force began curtailing operations due to reduced demand on October 4, 2013, it had assisted almost 10,000 people, including over 8,000 people seen by the SPRINT.<sup>22</sup>

6.1.5: Personnel Accountability: WNY Commands were ordered to complete a muster of all personnel shortly after the shooting incident occurred on September 16, 2013.<sup>23</sup> Tenant commands, including NAVSEA, completed mustering their personnel later that day. A review of Navy policies on personnel accountability identified inconsistent applicability to contractors and dependents;<sup>24</sup> This gap was not a factor on September 16, 2013, due to the geographically localized nature of the shooting incident.

6.1.6: Mission Continuity: NAVSEA effectively implemented its COOP Plan. The events of September 16, 2013, required evacuation of non-essential personnel from the WNY for two days. Over the next several days, NAVSEA units relocated to multiple locations throughout the National Capital Region. Engineering personnel were relocated to Building 176; Corporate Operations (SEA 10) relocated to Building 111; Legal personnel relocated with the organizational components they support; Team Ships relocated to a contractor facility; the NAVSEA Inspector General (IG) relocated to the Navy IG's office; the Naval Surface Warfare Command relocated to its facility at Carderock; Security personnel went to Building 201; and the Science, Technology, and Intelligence Office went to Building 176.<sup>25</sup> The Chief of Staff, Strategy Office, and Support personnel remained at the Military Sealift Command (MSC) Emergency Operations Center. The fundamental elements contained within the NAVSEA COOP Plan – including defined mission essential functions, essential personnel, relocation plans, and communications protocols – were instrumental to NAVSEA's ability to promptly reconstitute itself.<sup>26</sup> Building 197 remains closed for damage assessment and repair.

The NDW ROC arranged for additional naval security force personnel from nearby installations to augment NSAW security forces to ensure long-term coverage of NSAW posts and post-incident security functions.

6.1.7: Public Communication: The Navy public affairs efforts transitioned quickly and effectively to providing accurate and timely information on services and support to employees and families in the post-incident scenario. The Secretary of the Navy, Navy Chief of Information, CNIC, NDW, and NAVSEA used distribution tools such as Twitter, Facebook postings, all-hands emails, blogs, navy.mil stories, interviews, press conferences, and internet videos to communicate information about the available medical and counseling services, the meeting point for families, base closure and reporting instructions, and locations for support services throughout the week.

Summary: The Navy's execution of the post-incident response was responsive and caring. Notwithstanding some minor compliance issues with DoD instructions and areas where DoD and DON guidance was absent, the Navy

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provided support to all affected personnel and restored mission capability quickly and effectively after the initial response force had eliminated the threat.

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<sup>1</sup> U.S. Fire Administration (an agency within FEMA), "Fire/Emergency Medical Services Department Operational Considerations and Guide for Active Shooter and Mass Casualty Incidents," September 2013; Joint Committee to Create a National Policy to Enhance Survivability From a Mass Casualty Shooting Events, Hartford Consensus II, July 11, 2013; Firefighter Life Safety Initiative 12, January 2013 ([www.lifesafetyinitiatives.com/12/FLSI12\\_FinalReport.pdf](http://www.lifesafetyinitiatives.com/12/FLSI12_FinalReport.pdf)); U.S. Fire Administration (an agency within FEMA), "EMS Safety Techniques and Applications," April 1994; [www.c-tecc.org](http://www.c-tecc.org).

<sup>2</sup> Directed by National Security Presidential Directive-51/Homeland Security Presidential Directive-20, dated 4 May 2007, and Federal Continuity Directive 1, dated October 2012. DoD and DON implemented these directives via DoD Directive 3020.26, dated 9 Jan 09, and SECNAVINST 3030.4C, dated 22 Jul 09.

<sup>3</sup> Summary of Interview (SI) 5.1 with MPD Chief of Police Cathy Lanier and (b) (6), conducted on 29 Oct 2013; SI 5.2 (b) (6) and (b) (6) Special Agents, National Capital Response Squad, FBI Washington Field Office, conducted on 11 Oct 2013.

<sup>4</sup> The WNY Branch Health Clinic is defined as a Tier 4 facility in BUMEDINST 3440.10 (Navy Medicine Force Health Protection Emergency Management Program).

<sup>5</sup> SI 5.6 LCDR (b) (6), Department Head, WNY Naval Health Clinic, conducted on 9 and 15 Oct 2013.

<sup>6</sup> SI 6.1 HMC (b) (6), Safety Manager, Naval History and Heritage Command, conducted on 9 Oct 2013; SI 5.6 LCDR (b) (6), Department Head, WNY Naval Health Clinic, conducted on 9 and 15 Oct 2013.

<sup>7</sup> SI 5.6 LCDR (b) (6) Department Head, WNY Naval Health Clinic, conducted on 9 and 15 Oct 2013.; SI 6.2 (b) (6), President, Physical Evaluation Board, and CAPT (b) (6), Medical Officer, Physical Evaluation Board, conducted on 21 Oct 2013.

<sup>8</sup> Reference Document (RD) 6.1 EOC Logs of 16 Sep 2013.

<sup>9</sup> RD 6.2 "Religious Ministry Metrics ISO Mass Casualty, 16 Sep 2013" document of CAPT (b) (6) Region Chaplain (undated).

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> See DoD Instruction 1300.18, dated January 8, 2008.

<sup>13</sup> SI 6.3 LT (b) (6), NAVSEA CACO Officer, conducted on 7 Oct 2013; SI 6.4 CDR (b) (6), NAVSEA Staff Judge Advocate, conducted on 6 Oct 2013.

<sup>14</sup> PR 6.1 Personnel Casualty Matters and Accountability. See also SFO 6.2 Emergency Management Policy; PR 6.3 Family Support Policy; PR 6.4 Medical Services.

<sup>15</sup> SI 5.1 with MPD Chief of Police Cathy Lanier and (b) (6), conducted on 29 Oct 2013.

<sup>16</sup> SI 6.5 (b) (6) and (b) (6), NDW Fleet and Family Services Program Managers, conducted on 8 Oct 2013; RD 6.2 Memo of CAPT (b) (6), Region Chaplain (undated); SI 5.8 with CDR (b) (6) Assistant Chief of Information (OI-3) conducted on 17 Oct 13.

<sup>17</sup> SI 6.9 CAPT (b) (6), Assistant Regional Engineer, Naval Facilities Engineering Command conducted on 8 Oct 2013.

<sup>18</sup> SI 6.5 (b) (6) and (b) (6), NDW Fleet and Family Services Program Managers, conducted on 8 Oct 2013; RD 6.3 SITREP 01, Emergency Family Support Task Force of 24 Sep 2013; RD 6.4 SITREP 02, Emergency Family Support Task Force of 26 Sep 2013; RD 6.5 SITREP 03, Emergency Family Support Task Force of 26 Sep 2013; RD 6.6 SITREP 04, Emergency Family Support Task Force of 27 Sep 2013; RD 6.7 SITREP 05, Emergency Family Support Task Force of 30 Sep 2013; RD 6.8 SITREP 06, Emergency Family Support Task Force of 1 Oct 2013; RD 6.9 SITREP 07, Emergency Family Support Task Force of 2 Oct 2013; RD 6.10 SITREP 08, Emergency Family Support Task Force of 3 Oct 2013; RD 6.11 SITREP 09, Emergency Family Support Task Force of 4 Oct 2013.

<sup>19</sup> Issued in March 2013.

<sup>20</sup> RD 6.12 Memorandum from the Vice Chief of Naval Operations to Commander, Navy Installations Command of 16 Sep 2013; RD 6.14 SECNAV memo to JAG dated 18 Sep 2013; RD 6.15 SECNAV memo to Surgeon General dated 17 Sep 2013.



<sup>21</sup> SI 6.6 CAPT (b) (6), Navy Medicine Psychiatry Specialty Leader, Navy Medicine East, conducted on 8 Oct 2013; SI 6.7 CDR (b) (6) Public Health Service, conducted on 8 Oct 2013.

<sup>22</sup> RD 6.11 SITREP 09, Emergency Family Support Task Force of 4 Oct 2013.

<sup>23</sup> RD 6.13 NDW WAAN Use in support of WNY Active Shooter Incident (16-17 Sep 2013).

<sup>24</sup> PR 6.1 Personnel Casualty Matters and Accountability.

<sup>25</sup> SI 6.8 (b) (6), Division Head, NAVSEA Continuity Planning, conducted on 7 Oct 2013.

<sup>26</sup> Review of NAVSEAINST 3730.1B (NAVSEA Continuity of Operations Policy) (classified); SI 6.8 (b) (6), Division Head, NAVSEA Continuity Planning, conducted on 7 Oct 2013. (6)

## Chapter 7 – Opinions and Recommendations

This investigation concluded that on September 16, 2013, Aaron Alexis was an insider threat. The Washington Navy Yard (WNY) shooting is the latest of several incidents involving insider threats, including Nadal Hassan (shooter at Fort Hood), Casey Fury (arson on USS MIAMI), Bradley Manning (source for Wikileaks), and Edward Snowden (source of leaks from the National Security Agency). Recognizing that the insider threat is particularly challenging and insidious, on August 8, 2013, the Secretary of the Navy promulgated “The Department of the Navy Insider Threat Program” (SECNAVINST 5510.37), which among other actions established a Senior Executive Board (SEB) to review insider threat program strategic goals, approve standardized procedures, and develop prioritized resource recommendations. The opinions and recommendations of this investigation may inform the SEB effort.

The insider threat obtains and uses valid credentials to do damage from inside the force protection defenses. Inside these defenses, the Department of the Navy (DON) works hard to build a climate of trust and teamwork. The insider threat uses that trust against the organization, exploiting the access they have. Defeating the insider threat will require an adjustment to behaviors and mindsets to not only trust, but verify.

On October 11, 2013, the Secretary of the Navy approved the recommendations from the rapid reviews conducted by the Assistant Secretary of the Navy (ASN) Manpower & Reserve Affairs (M&RA) and the General Counsel of the Navy. The findings of this report also support the findings and opinions of those rapid reviews.

To directly address the findings most relevant to improving the Navy’s capability against an insider threat (i.e., Category A and B findings), urgent actions to include improving compliance with the Personnel Security Program (PSP) by all DON organizations and contractors. This will require

improved training, assessments, and oversight of the PSP. On a less urgent timeframe, the current PSP should be evaluated for opportunities to make it stronger.

The Category C findings are just as important. They represent notable gaps in the force protection and emergency management programs on the WNY. Closing these gaps is critical to strengthening the WNY's capability in the future against a wide range of threats.

The following sections present recommendations to address Category A, B, and C findings.

## **7.1 Personnel Security Program**

In the case of Alexis, this investigation discovered that, in practice, several factors prevented an accurate assessment of his reliability, loyalty, and trustworthiness:

- Pertinent information about Alexis, available in accessible records, was not compiled by the Office of Personnel Management (OPM) and therefore was not considered by the Department of the Navy Central Adjudication Facility (DONCAF).
- The initial investigation was overly dependent on incomplete and inaccurate information self-reported by Alexis without sufficient independent validation by investigators.
- Instead of actual pertinent events, records considered by OPM and DONCAF consisted of "summary descriptions" of Alexis' adverse behavior made by local authorities. These summaries did not convey the more serious nature of the actual behavior.
- Adverse behavior was often judged by local authorities – Fleet Logistics Squadron FOUR SIX, The Experts, Inc., and HP Enterprise Services, LLC. These local dispositions, and subsequent failure to

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report actual adverse information as required, masked patterns of actual adverse behavior over time.

In summary, the picture that emerged from this investigation's review of Alexis' record of actual adverse behavior is much more alarming than the picture that resulted from the incomplete and filtered record compiled by OPM and adjudicated by DONCAF.

To be effective against the insider threat, compliance with the current requirements of the PSP must be quickly improved. It is recommended that the Secretary of the Navy:

7.1.1: Immediately and forcefully reinforce with DON leadership and DON contractors and subcontractors their responsibility to comply with existing PSP requirements as laid out in SECNAV M-5510.30, Department of the Navy PSP, and the National Industry Security Program Operating Manual (NISPOM) including prompt and accurate reporting of adverse information and removing access to secure assets when warranted.

7.1.2: Direct ASN (M&RA) and Deputy Under Secretary of the Navy for Plans, Policy, Oversight and Integration to develop DON training material, supplemented by a case study based on the WNY shooting incident, to train personnel on the principles of the PSP, the importance of compliance, and consequences of non-compliance. This material should be incorporated into leadership schools and civilian continuing training programs.

7.1.3: Direct CNO and CMC to order self-assessments, at the unit level, of compliance with the requirements of SECNAV M-5510.30, including security manager training, reporting of adverse information, commentary in performance evaluations regarding handling of classified material, and follow up of Department of Defense Central Adjudication Facility (DoDCAF) letters of concern.

7.1.4: Direct ASN Research, Development & Acquisition (RD&A) to clarify expectations for Program Executive Offices, Program Offices, Contracting

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Offices and Commands regarding oversight and administration of the security aspects of DON contracts. This should include audits of contractor compliance with PSP requirements. As part of this effort, ASN (RD&A) should validate that DON contracts include appropriate security clauses.

7.1.5: Direct ASN (M&RA) to require that all adverse information developed during investigations, deliberations, and formal adjudications, beginning with the recruitment process, be thoroughly documented, properly retained, and readily accessible by authorized personnel. This will help to provide a complete and detailed record to support future suitability and eligibility determinations.

The recommendations above are focused on complying with the current requirements of the PSP and should be executed as quickly as feasible. In support of a more deliberative assessment of the adequacy of the current PSP, it is further recommended:

7.1.6: That the Secretary of the Navy forward the findings and recommendations of this report to the Secretary of Defense for use in broader efforts to assess the effectiveness of the PSP. This assessment should also consider a program that includes the following attributes:

- That OPM's investigative techniques and methods serve to collect all pertinent information to support accurate suitability determinations and eligibility adjudications based on all available information.
- That new pertinent information entered into Joint Personnel Adjudication System or in criminal databases clearly alerts DoDCAF and all responsible commands or employers in near-real time, and remains available for future reference.
- Evaluating the adequacy of the threshold for granting access.
- Evaluating the adequacy of reporting thresholds for continuous evaluation.

- That when faced with potentially adverse information, leadership can effectively suspend an employee's access until the concern is investigated and adjudicated. This suspension should be non-punitive. This suspension fails safe for the organization in that the employee of concern is denied access to critical assets. This suspension also fails safe for the employee, in that they can obtain the help they may need to resolve their situation. Finally, if after investigation and adjudication the employee is cleared, the system should allow the leadership to quickly reinstate the employee's access as warranted.

## **7.2 Force Protection, Emergency Management, and Post-Incident Response**

This investigation concurs with the conclusions of the October 11, 2013 joint Navy and Marine Corps "Quick Look" assessment that DON force protection policies relevant to physical security, law enforcement, and antiterrorism programs are sound. This report concludes that compliance and execution of these policies is deficient in several areas at the WNY. Further, oversight by the chain of command was not fully effective in that it did not detect and correct these deficiencies.

More rigorous compliance with existing physical security, law enforcement, and antiterrorism program requirements is required. Accordingly, it is recommended that the Secretary of the Navy:

7.2.1: Immediately and forcefully reinforce with DON leadership their responsibility to oversee compliance with existing physical security, law enforcement, and antiterrorism program requirements.

7.2.2: Direct that ASN (M&RA) develop DON training material, supplemented by a case study based on the WNY shooting incident, to train personnel on the principles of force protection, the importance of compliance, and consequences of non-compliance. This material should

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be incorporated into leadership schools and civilian continuing training programs.

7.2.3: Direct Chief of Naval Operations (CNO) and Commandant of the Marine Corps (CMC) to update Antiterrorism Level 1 Awareness Training to include lessons learned from the Fort Hood incident and the WNY incident.

7.2.4: Direct the CNO and CMC to conduct a self-assessment of installation compliance with higher headquarters directives in force protection and emergency management. This assessment must focus on actual compliance at the installation, not a review of administration, and should include:

- Implementation of deadly force policy.
- Adequacy of program oversight.
- Adequacy of training and drill programs.
- Adequacy of resources.

Deficiencies should be reported up the chain of command and assessed for mitigation, as well as used to inform the longer-term action addressed above.

7.2.5: Direct the CNO and CMC to identify, prioritize and execute the most cost effective, high-impact actions that could mitigate known force protection and emergency management capability gaps. This should include effective use of random antiterrorism measures to deter, detect and disrupt potential attacks; revitalized training and drills, and the establishment and subsequent exercising of mutual aid agreements to enhance incident response.

7.2.6: Direct the CNO and CMC to conduct a review of DON requirements for force protection and emergency management as compared to the available resources and assess threat. This review should also address

how the operational commander and the resource provider reach agreement on the final resource distribution as balanced against the resultant risk.

7.2.7: Direct the ASN (M&RA) to address DON policy gaps for post-incident response in the areas of personnel casualty matters, family support programs, and the fleet and family support center program.

## **7.3 Towards a Comprehensive Approach**

Many of the findings in this report are similar to the findings from the Fort Hood investigation. Additionally, there have been other investigations that explored insider threat incidents. To ensure complete and lasting actions in efforts to defeat the insider threat, it is recommended that the Secretary of the Navy:

7.3.1: Recommend that the Secretary of Defense establish a single authority, who will report directly to him, to compile all recommendations and direction resulting from the investigations into the Fort Hood shooting, USS MIAMI fire, the release of information by Manning and Snowden, the WNY shooting, and other incidents that may be pertinent. An assessment should be done to determine which actions have been completed. Those recommendations that remain open should be prioritized and overseen to completion. A routine report to the Secretary of Defense should be made to formally record progress and completion of these actions.

## **7.4 Accountability**

7.4.1: It is recommended that the Secretary of the Navy refer this matter to the Chief of Naval Operations and the Assistant Secretary of the Navy (Research, Development & Acquisition) for review, consideration, further investigation, and action as appropriate.