Report by AR 15-6 Investigating Officer on Shooting Death of Iraqi Detainee, FOB Packhorse, Tikrit Iraq, 11 Sep 03

Narrative: On 11 Sep 03, 1LT [redacted] SPC [redacted] and SPC [redacted] were performing guard duty at the FOB Packhorse detention facility. 1LT [redacted] the Officer of the Guard, was standing less than twenty feet away from SPC [redacted] in the breezeway portion of the facility facing into the facility's back yard when he heard a shot fired (Exhibit A). SPC [redacted] a member of the guard force, was standing between 1LT [redacted] and SPC [redacted] when the shot was fired. SPC [redacted] was standing in the hallway of the isolation cell portion of the facility. At some point, SPC [redacted] looked away from the detainees in isolation in order to speak to SPC [redacted] (Exhibit B). Within a few seconds of turning back to see the detainees, SPC [redacted] raised his rifle, placed the selector on fire, and shot [redacted] (Exhibit C). [redacted] was handcuffed with plastic "flexicuffs" at the time he was shot. Neither 1LT [redacted] nor SPC [redacted] saw [redacted] pull the trigger. They were not in a position to see [redacted] activity. The other detainee in the isolation cell, [redacted] ([redacted]'s brother), saw SPC [redacted] fire his weapon, but did not see [redacted]'s activity either (Exhibit D). Upon hearing the shot, 1LT [redacted] moved to SPC [redacted] to assess the situation. According to 1LT [redacted] [redacted] stated, "He was standing right up next to the wire." Initially, 1LT [redacted] did not see any blood on the fallen [redacted], and asked [redacted] if he had indeed shot the detainee. SPC [redacted] stated again that he had shot [redacted] because he was standing next to the wire (Exhibit A). When 1LT [redacted] noticed that [redacted] was bleeding, he moved to the radio in the breezeway and called the 4th FSB TOC (Packhorse Mike) for assistance. SPC [redacted], who was guarding prisoners at a building directly across from the detention facility entrance, left his position to assess the situation at the main detention facility. Upon arriving at the scene, SPC [redacted] asked for a combat lifesaver's bag and SPC [redacted] went to the storage closet in the interview office to retrieve it (Exhibit E). SPC [redacted] and SPC [redacted] performed first aid on [redacted] at this time. SPC [redacted] went into the interview office and sat down. At around 2320, SSG [redacted] and SGT [redacted], medics, arrived. They assessed [redacted]'s condition and transported him by ambulance to the aid station (Exhibit F). Upon [redacted] arrival at the aid station, more life-saving steps were taken. 1LT [redacted] the physician's assistant on duty at the time, declared [redacted] dead at approximately 2330 hrs (Exhibit G). The body was photographed by CPT [redacted] with 1LT [redacted] assisting, as part of the 4th FSB's initial inquiry.

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Facts.

a. [redacted] was a detainee at the FOB Ironhorse Detention Facility when he died of a gunshot wound to the abdomen on 11 Sep 01 at approximately 2315 hours. He had turned himself at FOB Arrow on 02 Sep 03 upon learning that he was a targeted individual from Operation Arrow Sky, conducted by TF 4-42 (Exhibit H). He and his brother, [redacted] were in separate isolation cells at the detention facility. [redacted] had been incarcerated in the isolation cell since 8 Sep 03. [redacted] had been seen by

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medics earlier in the day on 11 Sep. He had complained of joint and back pain and couldn't sleep. The medics advised the guards, SPC [redacted] included, that the detainee should be allowed to get up and walk around in order to reduce his back and joint pain. Furthermore, the detainees in isolation had been told not to speak and to stay away from the concertina wire or they would be shot. According to 1LT [redacted] he did not see any indication that the concertina wire had been moved at the time of the shooting. According to INTSUM reporting, the brothers were alleged Saddam loyalists (Exhibit H).

b. SPC [redacted] D Co., 4th FSB, shot [redacted] nce when he observed [redacted] standing and touching the single strand concertina wire at his cell. SPC [redacted] did not give a verbal warning prior to firing his weapon. A round had already been chambered in the weapon. SPC [redacted] was aware that the medics had suggested that [redacted] be allowed to stand and walk around in his cell in order relieve some of the joint and shoulder pain [redacted] had been experiencing while being held in the cell (Exhibits A and B).

c. SPC [redacted] requested a lawyer before any questioning could be done. He provided a statement on DA Form 2823 during 4th FSB's initial inquiry, but he was not read his rights (Exhibit B). In that statement, SPC [redacted] stated that the detainee had been fidgeting with his handcuffs earlier in the day. Furthermore, the detainee had been told not to speak. According to the statement, at about 2315 hours, [redacted] said something in Arabic. SPC [redacted], who had been speaking with SPC [redacted], turned to look at the detainee and saw him standing near the wire and touching it. At that instant, SPC [redacted] raised his weapon and fired.

d. There are conflicting accounts about the training that the guards received prior to assuming their duties at the detention facility. SPC [redacted] and SPC [redacted] were on their second full day of detention guard duty. They had received a briefing from 1LT [redacted] on their duties, but SPC [redacted] did not recall any instructions with respect to graduated force IAW TF Ironhorse FRAGO 422 (Exhibit C). SPC [redacted] believed that they could shoot a detainee if the detainee approached the wire without permission. 1LT [redacted] stated that he gave that order but with the understanding that verbal warnings and other measures would first be considered before applying lethal force. No rehearsals or drills had been conducted.

e. The guard force had wooden clubs readily available in order to deal with belligerent detainees using less than lethal force (Exhibit J). Upon initial set-up of the detention facility, the guard force did not have weapons inside of the detention facility. At some point between the initial set-up of the facility and 11 Sep 03, the 1st BCT Commander instructed the 4th FSB to have guards carry weapons inside of the wire to ensure the presentation of authority (Exhibit K).

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f. The guard force has no written instructions and there is no written battalion guidance for the operation of the detention facility. Guards received their instructions verbally by the shift leader, in this case, 1LT [redacted] (Exhibit A).

g. TF Ironhorse FRAGO 422, Maintenance of Law and Order, dated 16 May 03, provides guidance for the use of graduated force and specifically identifies a "Shout, Show, Shove, Shoot, Shoot" methodology (Exhibit L).

h. Paragraph 3-2f, Army Regulation 190-14, The Carrying of Firearms by Law Enforcement Personnel and Personnel Performing Security Duties, states that, "Deadly force is justified only under conditions of extreme necessity and as a last resort when all lesser means have failed or cannot be reasonably employed." Furthermore, paragraph 3-2g requires that personnel give an order to halt before firing (Exhibit M).

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i. [redacted] the other isolated detainee in the detention facility, stated that he received no warnings about what would happen if he tried to escape. He stated that none of the other prisoners provided the information. One prisoner held in the general population cell, [redacted] stated he had received a briefing on what would happen if he tried to escape (Exhibit D). (b)(6)4

j. SPC [redacted] was described as overly aggressive by 1LT [redacted] The other guards, SPC [redacted] and PFC [redacted], described SPC [redacted] as being unnecessarily vulgar towards the detainees. Also, SPC [redacted] had banged wooden clubs on the cell doors unnecessarily and had used vulgar language toward the prisoners on 10 Sep. 1LT [redacted] had corrected that behavior (Exhibits A, E, and N).

k. There is no indication that the detainee had been physically abused prior to being fatally shot. He had adequate medical attention for his aching back and joints; the guards understood that the detainees could stand up and stretch in order to relieve some of the discomfort. Adequate food and water had been given to the detainee (Exhibit G and O).

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Findings: The convergence of several conditions resulted in the shooting of [redacted] on the evening of 11 Sep 03.

a. Statements reveal that there is sufficient cause to believe that SPC [redacted] knowingly or not, was in violation of Army use of force policy and TF Ironhorse directives governing the use of deadly force. No verbal warning was given, and no lesser means of force was considered before applying deadly force. Furthermore, the fact that [redacted] was handcuffed and his position on the floor in his cell once he was shot provide sufficient doubt about [redacted] intent to escape (Exhibits A, B, C, and V).

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b. There are insufficient instructions for guards in performing their duties. There are no written SOPs or post instructions for guards (Exhibits A and K). Instructions are given verbally by the shift leader, and the guards on-duty that evening had a different understanding of their responsibilities. For example, SPC [redacted] and PFC [redacted] did not have a round chambered in their weapons prior to the shooting—even though they were guarding isolated detainees—while SPC [redacted] and SPC [redacted] did. 1LT [redacted] did not have a round chambered in his weapon, either. SPC [redacted] and PFC [redacted] had an understanding of the use of force as it applied to the application of deadly force (Exhibit E and N). SPC [redacted] had not heard of graduated force or differing levels of force, nor did he remember receiving a briefing which covered verbal warnings prior to shooting an escaping detainee (Exhibit C).

c. The combination of loaded weapons within the confines of the detention facility, in addition to the inadequate number of guards on duty, created an environment conducive for the quick escalation to the use of deadly force. There were plenty of wooden clubs available to use in applying less than deadly force. SPC [redacted] had used a club before in order to rattle the cage doors. b)(2)3 There were [redacted] guards on duty at two different buildings with 56 detainees on 11 September. While the majority of detainees were in the general population, incarcerated in a large open room, there were eight others held in isolation cells who required increased visual surveillance. It is difficult for guards to maintain adequate situational awareness over such a dispersed operation. Furthermore, [redacted] (b)(2)3

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d. The isolation cells in which the [redacted] brothers were held were unkempt and had [redacted] barriers. There were full MRE boxes in the cells which could provide materials for [redacted] (b)(2)3 Furthermore, [redacted] used as the barrier in place of the cell doors could have been improved, thus making it more difficult for detainees to move or negotiate, and making it clearer for guards to determine a detainee's intent to escape. Without a witness who might have seen [redacted]'s actions which caused SPC [redacted] to shoot, it is difficult to determine [redacted]'s intent with respect to crossing the wire on the evening of the shooting. (b)(6)4

e. Based on comments by the interviewees, the detention facility had been visited on numerous occasions by leaders in the chain of command. Shift leaders were either a senior NCO or an officer. The officer in charge of detainee operations was on site daily. The battalion commander had inspected on numerous occasions. The brigade commander had inspected the facility and provided guidance in handling the detainees. Detainees were adequately fed, had plenty of water, and received adequate medical attention. Detainees were allowed to conduct hygiene and had access to latrines.

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Recommendations:

a. A criminal investigation should be initiated immediately in order to determine possible violations of the UCMJ by SPC [redacted] Statements from 1LT [redacted], SPC [redacted], and PFC [redacted] indicate that SPC [redacted] exhibited overly aggressive behavior when around the detainees. [redacted] was handcuffed when he was shot, and SPC [redacted] did not apply graduated force IAW established regulations and orders. (b)(6)4

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c. [redacted] (b)(2)3

d. Clear the facility, especially holding cells, of MRE boxes, equipment, etc., that can be used as weapons or projectiles.

e. Improve the barrier system for the isolation cells. Two stacked strands of concertina wire would allow guards to better determine a detainee's intent to breach the wire and escape.

f. Improve the facility's wire perimeter entrance to ensure that the entrance is closed off when not in use.

g. Develop a written SOP and provide guards with post instructions to ensure that guards are aware of approved procedures for the use of force, detainee handling, briefing procedures, and security of special population/isolated detainees.

h. Train the guard force on the SOP and ensure that rehearsals and drills are conducted to deal with special situations, such as medical emergencies, attempted escapes, and fights between prisoners.

FRANK Y. RANGEL, JR.
MAJ, MP
Investigating Officer

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SECTION VI - AUTHENTICATION *(para 3-17, AR 15-6)*

THIS REPORT OF PROCEEDINGS IS COMPLETE AND ACCURATE. *(If any voting member or the recorder fails to sign here or in Section VII below, indicate the reason in the space where his signature should appear.)*

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[redacted] JR, MAJ, MP

(Recorder)

(Investigating Officer) ~~(President)~~

(Member)

(Member)

(Member)

(Member)

SECTION VII - MINORITY REPORT *(para 3-13, AR 15-6)*

To the extent indicated in Inclosure _____, the undersigned do(es) not concur in the findings and recommendations of the board. *(In the inclosure, identify by number each finding and/or recommendation in which the dissenting member(s) do(es) not concur. State the reasons for disagreement. Additional/substitute findings and/or recommendations may be included in the inclosure.)*

(Member)

(Member)

SECTION VIII - ACTION BY APPOINTING AUTHORITY *(para 2-3, AR 15-6)*

The findings and recommendations of the *(investigating officer) (board)* are *(approved) (disapproved) (approved with following exceptions/ substitutions). (If the appointing authority returns the proceedings to the investigating officer or board for further proceedings or corrective action, attach that correspondence (or a summary, if oral) as a numbered inclosure.)*

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