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# **JAGMAN**

# **Investigations**

# **Handbook**

# Report Documentation Page

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## INTRODUCTION

Almost every naval officer will have contact with an administrative investigation (commonly referred to as a "JAGMAN" investigation) during their military career, either as an investigating officer or as a convening authority. The basic regulations governing such investigations are contained in the *Manual of the Judge Advocate General* (JAGMAN). The primary purpose of an administrative investigation is to provide the convening authority and reviewing authorities with information regarding a specific incident which occurs in the Department of the Navy. These officials will then make decisions and take appropriate action based upon the information contained within the investigative report.

Incidents investigated pursuant to the JAGMAN often provide the basis for a later claim against the Navy. This claim may even evolve into a lawsuit. When a suit is filed, the first document that is requested by both the attorneys representing the Navy and attorneys on the other side is the JAGMAN investigation. **There is nothing that will serve and protect the Navy's interest more effectively than a thorough, comprehensive and properly documented investigation.** Once a lawsuit is filed, it is likely the investigating officer will have been transferred and witnesses will have left the area. It is time-consuming, frustrating, and often counter-productive to try to reconstruct an incident or correct a slipshod investigation after months or years have passed. The key, then, is a thorough investigation conducted as soon after the incident as possible.

This handbook is designed to assist commanding officers and investigating officers with the administrative investigation process. There is no substitute for a working knowledge of Chapter II of the JAGMAN; this handbook is **not** designed to replace reference to, and study of, the source document. Rather, this publication gives you a simplified "nuts and bolts" summary to initially orient your approach to the investigative process.

The organizational approach to this handbook is to discuss how an investigating officer (IO) goes about conducting a Preliminary Inquiry, Command Investigation, or Litigation Report Investigation<sup>1</sup>. Sample forms and report formats are provided. The checklists contained in this handbook will be particularly useful to both the IO and the convening authority (CA) in ensuring that the investigative report includes all necessary information and enclosures. The IO should review the checklists contained herein **prior** to initiating his/her investigative effort to see if there are specific informational requirements given the nature of the incident under investigation.

Additional information is provided regarding Line of Duty/Misconduct determinations and special considerations that apply in death cases. A discussion of command endorsements is also included.

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<sup>1</sup> Courts and Boards of Inquiry are not addressed - refer to JAGMAN, Chapter II, and JAGINST 5830.1A for procedures applicable to these more formal investigations.

Should you have any questions regarding JAGMAN investigations that are not answered in this handbook, you are encouraged to contact your station or staff judge advocate or the nearest Regional Legal Service Office/Marine Law Center. Questions may also be directed to the Civil Law Department, Naval Justice School, DSN 948-3800, COMM (401) 841-3800.

## PRELIMINARY INQUIRY

The preliminary inquiry (PI) is a quick and informal investigative tool that can be used to determine initially whether a particular incident is serious enough to warrant some form of JAGMAN investigation. A PI is not necessarily required; however, it is "advised" for all incidents potentially warranting an investigation.

**Method of inquiry.** The convening authority (CA) may conduct a PI personally or appoint a member of the command to do so. There are no requirements or restrictions governing how the inquiry is to be accomplished. The goal is to take a "quick look" at a particular incident (e.g., a minor fender-bender), and gather enough information so that an informed decision can be made by the CA regarding whether some sort of JAGMAN investigation is truly necessary. Generally, the PI should not take any longer than three (3) working days. If more time is required it generally means that the inquiry officer is attempting to do too much or has not been sufficiently instructed as to what issue(s) is to be addressed (see page II-3 for a PI checklist).

Upon completion of the PI, a report is tendered to the CA. The PI report need not be in writing, but some form of limited documentation is advisable (see page II-5 for a sample PI report). JAGMAN 0203.

**Command options.** Upon reviewing the results of the PI, the CA should take one of the following actions:

(1) Take no further action. Where further investigation would serve no useful purpose, there is no need to convene a JAGMAN investigation. This is an appropriate course where the PI reveals that the incident is likely to be of little interest to anyone outside the immediate command or that the event will be adequately investigated under some other procedure (e.g., NCIS investigation, MLSR/survey procedure, etc.). JAGMAN 0204(b)(1). As a matter of practice, documentation of the PI and the command decision is advisable.

(2) Conduct a command investigation. JAGMAN 0204(b)(3), 0209.

(3) –Convene a litigation-report investigation if a claim or civil litigation may be filed against the DON/USG, or may be asserted on behalf of the DON/USG. **Consultation with the "cognizant judge advocate" is required.** JAGMAN 0204(b)(4), 0210.

(4) Convene a court or board of inquiry. In the event of a "major incident," if the CA is not a general court-martial convening authority (GCMCA) and therefore not empowered to convene a court or board of inquiry, the officer exercising general GCMCA over the command involved or general officer in the chain-of-command, or any superior flag or general officer **will** immediately take cognizance over the case as the CA.. JAGMAN 0203(b)(2). If the CA concludes that the incident is not in fact a "major incident" or concludes that a court or board of inquiry is not warranted, then the CA shall report such conclusion to the next superior in the chain-of-command before convening another type of investigation.

**NOTE:** Whenever a question exists about how a particular incident or event should be



investigated, a commander should discuss the matter with a judge advocate. JAGMAN 0203.

***Reporting the results of PIs.*** After deciding which of the command options to exercise, the CA is to report that decision to his/her immediate superior in the chain-of-command (ISIC) pursuant to standing ISIC guidance. This does **not** require a special, stand-alone report; command decisions on PIs are to be relayed in the context of existing situational reporting systems. You should determine if your ISIC has issued guidance on what types of incidents should be or should not be reported and the manner of report.

***Review of command decision.*** The initial determination of which option to exercise is a matter of command discretion. Superiors in the chain-of-command may direct that an option be reconsidered or that a particular course of action be taken. For example, a superior may feel that a litigation-report investigation may be the preferred method of investigating and documenting a particular incident and direct that a subordinate convene such an investigation rather than a command investigation. JAGMAN 0204(e).

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**PRELIMINARY INQUIRY CHECKLIST**

- \_\_\_ CA appoints a preliminary inquiry officer.
- \_\_\_ Begin work on the inquiry immediately upon hearing that you are to be appointed, whether or not you have received an appointing order in writing.
- \_\_\_ Decide what the purpose and methodology of your inquiry will be.
- \_\_\_ Can this preliminary inquiry be completed in three working days? If not, you may be trying to do too much. Further clarification from the CA may be necessary.
- \_\_\_ Has this incident involved a member of the command and/or occurred within the command? If not, are you the appropriate command to conduct the preliminary inquiry and/or any administrative investigation?
- \_\_\_ Is this incident under investigation by NCIS, the FBI, or local civilian law enforcement agencies? (If yes, refer to JAGMAN 0201(d)).
- \_\_\_ Could this be considered a "major" incident? (Refer to JAGMAN Appendix A-2-a for a definition of a "major" incident.)
  - \_\_\_ If believed to be a "major" incident, refer to JAGMAN 0203(b)(2), (f), 0204(b)(5), 0210(a)(1).
- \_\_\_ Obtain any available documentation pertaining to the inquiry, i.e. copies of rules and regulations, instructions, correspondence and messages, logs, standard operating procedures, personnel records, medical records, official reports, vehicle accident report forms, etc.
- \_\_\_ Locate, preserve and secure evidence, i.e. real objects (logs, firearms, bullets, etc.) and note physical locations (accident sites, etc.)
  - \_\_\_ Draw up a list of possible witnesses.
  - \_\_\_ Conduct an interview of any witness you deem relevant to your inquiry, in other words, those that will provide you with enough information to understand what occurred and enable you to make an informed recommendation to the CA on a future course of action.
  - \_\_\_ If a witness is not physically available, an interview may be conducted via telephone or message.
  - \_\_\_ **Advise any military witness who may be suspected of an offense, misconduct, or improper performance of duty, of his/her rights under Article 31, UCMJ.** (Refer to page IX-1 of this handbook for a sample form.)

- \_\_\_\_\_ Advise each witness prior to signing any statement relating to the origin, incident, or aggravation of any disease or injury that he/she has suffered, of his/her right not to sign such a statement. (Refer to page IX-2 of this handbook for a sample form). See JAGMAN 0212(c). NOTE: In any incident involving personal injury or a potential claim against the DON, no signed witness statements should be taken.
  
- \_\_\_\_\_ Is a Privacy Act statement required for any witness interviewed? JAGMAN 0207(e) requires that Privacy Act statements be obtained from each witness from whom personal information is taken. (Refer to page IX-3 of this handbook for a sample form.)
  
- \_\_\_\_\_ Does the CA desire/require the outcome to be documented in writing? (If yes, refer to page II-5 of this handbook for sample format.)
  
- \_\_\_\_\_ The preliminary inquiry officer drafts and makes his/her report to the CA.
  
- \_\_\_\_\_ Which of the command options does the CA choose in light of the preliminary inquiry?
  - \_\_\_\_\_ No further action.
  - \_\_\_\_\_ Command investigation.
  - \_\_\_\_\_ Litigation-report investigation.
  - \_\_\_\_\_ Line of Duty investigation.
  
- \_\_\_\_\_ Discuss the case immediately with the GCMCA or ISIC SJA if the case is a potential “major incident.”
  
- \_\_\_\_\_ CA reports the result of the PI to the ISIC, if required.
  
- \_\_\_\_\_ Preserve all evidence, witness statements, documentation gathered during the preliminary inquiry for possible use in any administrative investigation that may be subsequently convened based on the PI.

**SAMPLE PRELIMINARY INQUIRY APPOINTING ORDER**

(Date)

From: (Title of authority ordering preliminary inquiry)

To: (Name and rank of individual conducting preliminary inquiry)

Subj: PRELIMINARY INQUIRY INTO (DESCRIPTION OF INCIDENT)

Ref: (a) JAGMAN Section 0203

1. This appoints you, per reference (a), to inquire into the facts and circumstances surrounding (description of incident).
2. Inquire into the facts and circumstances surrounding (description of incident). Report personnel contacted, all materials reviewed and their custodian, and then make a recommendation on subsequent command action in writing, for example: consult a Judge Advocate, no further investigation warranted, conduct a command investigation, conduct a litigation report, or order a board or court of inquiry.
3. Your report is to be complete in letter form by (3 days later) 20 \_\_\_\_, unless an extension of time is granted. If you have not previously done so, read chapter II of reference (a) in its entirety before beginning your inquiry.
4. You may seek legal advice from the Staff Judge Advocate, (name and contact information), during the course of your inquiry.

\_\_\_\_\_  
Name, rank, unit, telephone

## SAMPLE PRELIMINARY INQUIRY REPORT

(Date)

From: (Name and rank of individual conducting preliminary inquiry)

To: (Title of authority ordering preliminary inquiry)

Subj: PRELIMINARY INQUIRY INTO (DESCRIPTION OF INCIDENT)

Ref: (a) JAGMAN Section 0203

1. This reports completion of the preliminary inquiry conducted in accordance with reference (a) into (description of incident).
2. Personnel contacted: (List individuals with name, rank, title, unit, and telephone number).
3. Materials reviewed: (List documents, objects, materials, tangibles reviewed and, if of probable evidentiary value, where stored together with name of the custodian of such material and that person's phone number).
4. Summary of findings: (The inquiring official should provide a brief summary of their findings to the commander. While the summary need not extend beyond one paragraph, it should be as long as required to provide the commander with a reasonably good picture of what occurred and should support the recommendations provided below. In addition, it should document what is not known about the event in question).
5. Recommendation: (The inquiring official should provide a recommendation on subsequent command action: consult a judge advocate; no further investigation warranted; command investigation; litigation-report investigation; board of inquiry; or court of inquiry. If the inquiring official: concludes that any injuries may result in a finding of "not in the line of duty" or "misconduct," then it must be accompanied by a recommendation to convene a formal investigation; or, recommends disciplinary action, then such a recommendation should be followed by a recommendation to conduct a formal investigation or a Preliminary Inquiry pursuant to Rule for Courts-Martial 303.

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Name, rank, unit, telephone

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FIRST ENDORSEMENT

\_\_\_\_\_ Concur with recommendation

\_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Name, rank, unit, telephone

(Note: attachments may be added to the report as desired.)

## COMMAND INVESTIGATIONS

By far the most common administrative investigation is the Command Investigation. The Command Investigation (CI) functions to search out, develop, assemble, analyze, and record all available information relative to the incident under investigation. The findings of fact, opinions and recommendations developed may provide the basis for various actions designed to improve command management and administration, publish "lessons learned" to the fleet, and allow for fully informed administrative determinations.

**When required.** CIs are likely to be the appropriate investigative tool for incidents involving: aircraft mishaps; explosions; ship stranding or flooding; fires; loss of government funds or property; firearm accidents; security violations; injury to servicemembers, where such injury is incurred while "not in the line of duty"; and deaths of servicemembers where there is a "nexus," or connection, to naval service.

A CI would **not** be used for the following: "Major" incidents, (*see* JAGMAN Appendix A-2-a for definition); incidents that have resulted or are likely to result in claims or litigation against or for the Navy or the United States; and incidents which have the potential for causing significant damage to the environment (a litigation-report investigation should be conducted instead). If a "major" incident, the GCMCA will assume cognizance of the case and decide whether to convene a court or board of inquiry. If a claim or litigation issue appears to be the *primary purpose* for the investigation, then a litigation-report investigation is required.

**Rules on Convening.** A CI will be convened, in writing, by the CA (*see* page III-3 for a sample convening order). When the CA feels that the investigation of an incident is impractical or inappropriate for the command to investigate, another command may be requested to conduct the investigation. *See* JAGMAN 0205(b). When circumstances do not allow for completion of an investigation, (e.g., deployments), requests for assistance may be directed to superiors in the chain-of-command. When more than one command is involved, a single investigation should be conducted and coordination/cooperation is required. Special convening rules for incidents involving injuries to Marine Corps personnel are contained in JAGMAN 0205(e).

**Time Periods.** The CA will prescribe when the report is due, normally 30 days from the date of the convening order. The CA may grant extensions as needed. Requests and authorizations for extensions need not be in writing, but must be noted in the preliminary statement of the final report.

**Conducting the Investigation: Helpful Hints.** The general goal is to find out who, what, when, where, how and why an incident occurred. The IO should decide what the purpose and methodology of his/her investigation is **before** starting to collect evidence. The IO should review **all** applicable checklists contained in Part G of JAGMAN chapter II and sections IX and X of this handbook to determine what specific informational requirements exist.

One of the principle advantages of the CI is that the IO is **not** bound by formal rules of evidence: the IO may collect, consider and include in the record any matter relevant to the investigation that is believable and authentic. Photographs, maps, sketches, etc., are always helpful to reviewing authorities in understanding what has occurred. So too are present sense impressions (e.g., noise, texture, smell, observations) that are not adequately portrayed in other evidence. The IO may record these impressions in a simple memorandum for inclusion in the CI record.

In handling witnesses, there are several things to keep in mind. The IO may obtain information by personal interview, correspondence, or telephone inquiry. If a witness is unable to review and/or sign a statement, the IO may simply make a summary of the conversation and certify it to be accurate. Before interviewing witnesses, it is important to understand when and what rights advisements may be required: if the military member is suspected to have committed a criminal offense, Article 31, UCMJ, warnings are required; when interviewing a service member concerning the incurring of an injury, a warning under JAGMAN 0212(c) is required; if the IO is asking for personal information (as opposed to information related to performance of duty), Privacy Act advice is necessary. Refer to section IX of this handbook for forms.

Each witness should be interviewed separately. Let the witness tell what happened; don't ask questions that suggest answers. Ask for clarification if the witness is speaking in broad or vague terms (e.g., "He was drunk"; "What gave you that impression?"; "He had an odor of alcohol about him, his eyes were bloodshot, he was slurring his speech and unable to maintain his balance"). Try to obtain as much information during the interview as possible; the relevance of a particular fact may not become clear until later in the investigation. A good practice is to conclude the interview with "is there anything else you would like to tell me, or think I should know".

A checklist to help you conduct the CI is contained on page III-4.

***Writing the Investigation: Helpful Hints.*** The key to writing a good CI is **organization**. The IO must take the time to reconstruct the incident in their mind, pulling together all the evidence. The incident must then be documented in a **readable** fashion. Remember, the CA and reviewing authorities will want to understand the incident from a reading of the facts. Often a recitation of the facts in chronological, step-by-step form is easiest to follow; however, the complexity of the incident may dictate other form and format. Keep findings of fact as clear and concise as possible.

In drafting opinions and recommendations, the IO should address responsibility and accountability. All other areas directed by the CA and in the opinion of the IO which need corrective action must also be addressed.

A checklist to help you prepare the CI report is contained on page III-8.



**SAMPLE COMMAND INVESTIGATION CONVENING ORDER (USN or USMC)**

5800  
Ser Info  
Date

From: Commanding Officer, Headquarters Battalion, Marine Corps Base,  
Camp Pendleton, CA

To: Captain \_\_\_\_\_, USMC

Subj: COMMAND INVESTIGATION OF THE FIRE THAT OCCURRED AT \_\_\_\_\_ ON  
\_\_\_\_\_ AUGUST 20\_\_\_\_

Ref: (a) JAGMAN, Chapter II

1. This appoints you, per chapter II of reference (a), to inquire into the facts and circumstances surrounding the fire that occurred at \_\_\_\_\_ on \_ August 20\_.
2. Investigate the cause of the fire, resulting injuries and damages, and any fault, neglect, or responsibility therefor, and recommend appropriate administrative or disciplinary action. Report your findings of fact, opinions, and recommendations in letter form by \_ September 20\_, unless an extension of time is granted. If you have not previously done so, read chapter II of reference (a) in its entirety before beginning your investigation.
3. You may seek legal advice from \_\_\_\_\_ during the course of your investigation.
4. By copy of this appointing order, Commanding Officer, Headquarters Company, is directed to furnish necessary clerical assistance.

Colonel, U.S. Marine Corps

Copy to:  
CG, MCB CamPen, CA  
CO, HQCo, HQBn, MCB, CamPen, CA

## THE COMMAND INVESTIGATION CHECKLIST

### I. GETTING STARTED

- \_\_\_ CA appoints an investigating officer (IO) in writing.
- \_\_\_ Begin work on the investigation immediately upon hearing that you are to be appointed, whether or not you have received a convening order in writing.
- \_\_\_ Carefully examine the convening order to determine the scope of your investigation.
- \_\_\_ Determine when the investigative report is due to the CA.
  - \_\_\_ If you can not reach that deadline, request an extension.
- \_\_\_ Review all relevant instructions on your investigation, i.e. JAGMAN Chapter 2, etc.
- \_\_\_ Determine which checklists may apply to your investigation and review them carefully to determine what information is required. Refer to sections IX and X of this handbook.
- \_\_\_ Decide what the purpose and methodology of your investigation will be.
  - \_\_\_ Where is evidence likely to be located?
  - \_\_\_ How can such evidence best be obtained and preserved?
- \_\_\_ Has this incident involved a member of the command and/or occurred within the command? If not, are you the appropriate command to conduct the investigation?
- \_\_\_ Is this incident under investigation by NCIS, the FBI, or local civilian law enforcement agencies? (If yes, refer to JAGMAN 0201(d)).
- \_\_\_ Is this incident under a safety investigation? (If yes, refer to JAGMAN 0201(d)).
- \_\_\_ Is this considered a "major" incident? (Refer to JAGMAN Appendix A-2-a for definition.)
  - \_\_\_ If believed to be a "major" incident, refer to JAGMAN 0203(b)(2), (f), 0204(b)(5), 0210(a)(1).
- \_\_\_ Is this investigation likely to require access to and inclusion of classified material? (If yes refer to JAGMAN 0208(b) and contact a Judge Advocate).
- \_\_\_ Does the investigation require travel and/or other time consuming administrative action? (If yes, begin working soonest).

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## II. HANDLING WITNESSES

(NOTE: You may wish to gather and review other types of evidence before interviewing any or all witnesses.)

\_\_\_\_\_ Draw up a list, to be supplemented as the investigation progresses, of all possible witnesses.

\_\_\_\_\_ Determine if witnesses are transferring, going on leave, hospitalized, etc., which might take them out of the area before review of the investigation is completed.

\_\_\_\_\_ Inform the CA, orally, with confirmation in writing, immediately upon learning that a material witness might leave the area before review of the investigation is completed.

\_\_\_\_\_ Conduct an intensive interview of each witness, i.e. names, places, dates, and events that are relevant.

\_\_\_\_\_ Witness statements should be as factual in content as possible. If a witness makes a vague statement ("he was drunk"), try to pin down the actual facts.

\_\_\_\_\_ If a witness is not physically available for an interview, attempt to conduct it via telephone, mail or message.

\_\_\_\_\_ Advise any military witness who may be suspected of an offense, misconduct, or improper performance of duty, of his/her rights under Article 31(b) UCMJ. Ordinarily, an investigation should collect relevant information from all other sources before interviewing a suspect. *See* JAGMAN 0207(c)(2) (Refer to page IX-1 of this handbook for a sample form.)

\_\_\_\_\_ Advise each witness prior to signing any statement relating to the origin, incident, or aggravation of any disease or injury that he/she has suffered, of his/her right not to sign such a statement. (Refer to page IX-2 of this handbook for a sample form). *See* JAGMAN 0212(c).

\_\_\_\_\_ Is a Privacy Act statement required for the witness interviewed? JAGMAN 0207(e) requires that Privacy Act statements be obtained from each witness from whom personal information is taken. (Refer to page IX-3 of this handbook for a sample form.)

\_\_\_\_\_ Record the interview of each witness in detailed notes or by mechanical means. If you record the interview, be sure to state the time, date and location. Summarize what action has been taken before the interview, i.e. 31(b) rights administered, and get witness to affirm summary on record. Be conscious of the fact that you may solicit classified information during the interview and take steps to secure the notes/recording at the conclusion, or discuss with the witness the intent to remain "UNCLASS" during the interview, if applicable.

- \_\_\_\_\_ Reduce each witness' statement to a complete and accurate narrative statement.
- \_\_\_\_\_ If possible, obtain the signature of each witness, under oath and witnessed, on the narrative statement of his/her interview. If not possible, indicate on the narrative statement that it represents either an accurate summary, or verbatim transcript, of oral statements made by the witness.
- \_\_\_\_\_ Direct witnesses subject to naval authority not to discuss their statements. Witnesses not subject to naval authority may be requested not to discuss their statements. Let them know you may have follow-up questions.
- \_\_\_\_\_ Review your list of possible witnesses to ensure that you have interviewed all such witnesses and make sure you have followed up and asked any lingering or additional questions.

### **III. DOCUMENTARY EVIDENCE**

- \_\_\_\_\_ Make a list, to be supplemented as the investigation proceeds, of all possible documents, to include:
  - \_\_\_\_\_ Copies of relevant rules, regulations, instructions, standard operating procedures;
  - \_\_\_\_\_ Relevant correspondence and messages;
  - \_\_\_\_\_ Personnel records;
  - \_\_\_\_\_ Medical records (clinical and hospital records, death certificates, autopsy reports, etc.);
  - \_\_\_\_\_ Official logs and reports; and
  - \_\_\_\_\_ Required forms (personnel injury forms, vehicle accident reports, etc.).
- \_\_\_\_\_ Examine your list of possible documents to ensure that you have obtained all such documents available to you.
- \_\_\_\_\_ If unable to obtain a certain document, attempt to obtain it via fax, message, telephone, or mail.
- \_\_\_\_\_ Obtain originals or certified true copies of all documents available to you.

#### IV. OTHER EVIDENCE

- \_\_\_\_\_ Make a list of any other information which may be of assistance to reviewing authorities in understanding the incident investigated (real objects, physical locations, maps, charts, photographs, your personal observations, etc.).
- \_\_\_\_\_ Examine your list of possible information to ensure that you have obtained all such information personally available to you.
- \_\_\_\_\_ If unable to obtain certain information, attempt to obtain it via fax, message, telephone, or mail.
- \_\_\_\_\_ Attempt to reduce such information to a form, such as photographs or sketches, which can be conveniently included in your investigative report.
- \_\_\_\_\_ Take all steps possible to insure that any evidence not an enclosure to the investigative report will be kept in an identified place, safe from tampering, loss, theft, and damage, pending review of the investigation.
- \_\_\_\_\_ Take pictures, if possible.

## **DRAFTING THE CI REPORT**

**(NOTE: REFER TO PAGE III-12 OF THIS HANDBOOK FOR SAMPLE FORMAT)**

- \_\_\_\_\_ Classification of the report, (secret, confidential, etc.). Omit classified information unless absolutely essential (*see* JAGMAN 0208(b)).
  
- \_\_\_\_\_ A good practice tip is not to number your enclosures as you draft the report, rather cite them by name and wait until the report is finalized to change the names into numbers so that if a fact or series of facts are moved within the report it does not impact the enclosure numbers (especially with auto format).

## **PRELIMINARY STATEMENT**

- \_\_\_\_\_ State that all reasonably available evidence was collected or is forthcoming and that each directive of the CA has been met.
  
- \_\_\_\_\_ Set forth the nature of the investigation.
  
- \_\_\_\_\_ Relate any delays or difficulties encountered, including non-availability of evidence or failure to interview relevant witnesses.
  
- \_\_\_\_\_ Explain any conflicts in evidence, which evidence is considered more reliable, and why.
  
- \_\_\_\_\_ Note any requests for extensions, whether granted or denied.
  
- \_\_\_\_\_ Note the limited participation by any member or advisor, i.e. witness elected to not to waive 31(b) rights and make a statement.
  
- \_\_\_\_\_ State if social security numbers contained in the report were obtained from sources other than the individual (i.e., from service records). If social security numbers are obtained from the individual, a Privacy Act statement should be signed by the individual and included as an enclosure.
  
- \_\_\_\_\_ Indicate where original items of evidence are maintained, how they are being safeguarded, and the name and phone number of the responsible custodian.
  
- \_\_\_\_\_ Any other information necessary for a complete understanding of the case.

**FINDINGS OF FACT.** A fact is something that is or happens.

- \_\_\_\_\_ Distinguish in your own mind the differences between the terms "fact", "opinion", and "recommendation".
  
- \_\_\_\_\_ Conduct an evaluation of the evidence or lack of evidence.

- \_\_\_ Review any special fact-finding requirements pertaining to the specific incident in the JAGMAN checklists.
- \_\_\_ When drafting the findings of fact, be specific as to persons, times, places, and events.
- \_\_\_ Reference after each finding of fact, the enclosures to the report that support the finding of fact in order. This enables the CA to easily and efficiently review the enclosures while reading the report. (See note above about numbering).
- \_\_\_ Identify by grade or rate, service number, organization, occupation or business, and residence person(s) connected with the incident. A practice tip is to establish patterns of citation, especially in the background sections of the findings of fact. For example, as each member of an aircrew is addressed in the findings of fact, reference their designation letters, then their flight up-chit (medical clearance), then their log book, then their orders. By using this routine for every member of the crew, it addresses the same relevant facts with each, and assures that nothing is overlooked or inadvertently not included in the enclosures.
- \_\_\_ Make appropriate findings of fact for all relevant facts, including information already stated in the preliminary statement. The preliminary statement is not a substitute for findings of fact.
- \_\_\_ Place findings of fact in chronological and/or logical order.
- \_\_\_ Ask is each fact a separate finding?
- \_\_\_ Ask is each finding of fact supported by an enclosure?
- \_\_\_ Are all enclosures used? (if not used and not critical, delete the enclosure.)
- \_\_\_ Ensure that when read together, the findings of fact tell the whole story of the incident without having to refer back to the enclosures.
- \_\_\_ Does the story flow? Is it readable?

**OPINIONS** are reasonable evaluations, inferences, or conclusions based on the facts found. Opinions are value judgements.

- \_\_\_ Ensure that each of your opinions are exactly that, not findings of fact or recommendations.
- \_\_\_ Ensure that each opinion references the finding(s) of fact that support it.
- \_\_\_ Ensure that you have rendered those opinions required by the convening order, as well as any others you feel are appropriate.

**RECOMMENDATIONS** are proposals made on the basis of the opinions.

- \_\_\_\_\_ Ensure that each of your recommendations are exactly that, not findings of fact or opinions.
- \_\_\_\_\_ Ensure that each recommendation is logical and consistent with the findings of fact and opinions.
- \_\_\_\_\_ Address those recommendations specifically required by the convening order and any others considered appropriate. As IO, you have been tasked based on your ability, experience, etc. The CA is expecting you to exercise it. Feel free to make recommendations for the service, if required.
- \_\_\_\_\_ Recommend any appropriate corrective, disciplinary, or administrative action. Practice tip: be specific. Don't just recommend "disciplinary action". Provide forum and suggested charges, but not specific punishments.
- \_\_\_\_\_ Enclose a draft of a punitive letter of reprimand if recommending such action.
- \_\_\_\_\_ Draft and send, under separate cover, a non-punitive letter of caution if recommending such action.

## **SIGNING**

- \_\_\_\_\_ Sign your report.

## **ENCLOSURES**

- \_\_\_\_\_ The first enclosure is the convening order.
- \_\_\_\_\_ All evidence in logical order, tracking with the findings of fact.
- \_\_\_\_\_ Is each statement, affidavit, transcript or summary of testimony, photograph, map, chart, document, or other exhibit, a separate enclosure? *See* JAGMAN, 0208(g)(1).
  - \_\_\_\_\_ Are any reproduced documents certified to be true copies?
  - \_\_\_\_\_ Have you complied with the special marking requirements applicable to photographs? *See* JAGMAN, 0207(b)(4).
- \_\_\_\_\_ Are enclosures listed in the order in which they are cited in the body of the investigation?
- \_\_\_\_\_ Ensure that you do not have inappropriate material in the investigation: NCIS reports of



investigations; aircraft mishap reports; Inspector General reports; polygraph examinations; medical quality assurance investigations.

### CONCLUDING ACTION

- \_\_\_\_\_ Have you stretched your imagination to the utmost in gathering and recording all possible information on the incident investigated?
- \_\_\_\_\_ Have you checked and double-checked to ensure that your findings of fact, opinions, recommendations, and enclosures are in proper order?
- \_\_\_\_\_ Have you carefully proofread your Investigative Report to guard against embarrassing clerical errors?
- \_\_\_\_\_ Have you signed your Investigative Report?

**SAMPLE COMMAND INVESTIGATION REPORT (USN/USMC)**

Ser Info  
Date

From: Captain \_\_\_\_\_, USMC  
To: Commanding Officer, Headquarters Battalion, Marine Corps Base, Camp Pendleton, CA  
Subj: SAME AS SUBJECT ON CONVENING ORDER

- Encl: (1) Convening order and modifications thereto (if any were issued)  
(2) Summary (or verbatim) of sworn (or unsworn) testimony of \_\_\_\_\_ (a witness)  
(3) Summary (or verbatim) of sworn (or unsworn) testimony of \_\_\_\_\_ (a witness)  
(4) Statement of \_\_\_\_\_, signed by witness  
(5) Description of \_\_\_\_\_ (evidence found at scene of the accident)  
(6) Photograph of \_\_\_\_\_ depicting \_\_\_\_\_  
\_\_\_\_\_

**NOTE: Testimony of each witness, observations of the investigator, photographs, diagrams, and suitable reproductions of tangible evidence should be listed and attached as enclosures to the investigative report. The location of all original evidence, such as logs, charts, tangible items, and so forth, and the name and phone number of the official responsible for its safekeeping must be stated in the report, either on each enclosure or in the preliminary statement.**

Preliminary Statement

1. Paragraph 1 of an investigative report must contain information in the form of a "preliminary statement." Contents may require continuation in one or more additional paragraphs. In general, *see* JAGMAN 0208(c) for required contents. Where applicable, an investigating officer should indicate the name and organization of any judge advocate consulted. Extensions of time to complete the report should be noted here. Also state in appropriate cases that the matter was first referred to NCIS and NCIS expressed no objection to proceeding with the investigation.

Findings of Fact

1. \_\_\_\_\_ [encls ( ), ( )]
2. \_\_\_\_\_ [encls ( ), ( )]
3. \_\_\_\_\_ [encls ( ), ( )]

**Note: Findings of fact constitute an investigating officer’s description of details of events based on evidence. Findings must be as specific as possible about time, places, and persons involved. Each fact may be made a separate finding. An investigating officer may determine the most effective presentation for a particular case. Each fact must be supported by testimony of a witness, statement of the investigative officer, documentary evidence, or tangible (real) evidence attached to the investigative report as an enclosure. Each finding of fact must reference each enclosure that supports it in order.**

Opinions

1. \_\_\_\_\_ [FF ( )]
2. \_\_\_\_\_ [FF ( )]
3. \_\_\_\_\_ [FF ( )]

Note: An opinion is a reasonable evaluation, reference, or conclusion based on facts found. Each opinion must be supported by findings of fact. Determination of line of duty and misconduct is properly stated as an opinion.

Recommendations

- 1.
- 2.
- 3.

Note: If an investigating officer recommends trial by court-martial, a charge sheet drafted by the investigating officer may be prepared and submitted to the convening authority with the investigative report. See R.C.M. 307, MCM 2008. **The charge sheet should not be signed; i.e., charges should not be preferred since preferral starts the “speedy trial clock” running. Before preferring charges, the local trial service office or staff judge advocate should be consulted.** Unless specifically directed by proper authority, an investigating officer must not notify an accused of charges. Notification is the responsibility of the commanding officer of an accused. See R.C.M. 308 and 707, MCM 2008. If a punitive letter of reprimand or admonition is recommended, a draft of the recommended letter must be prepared and forwarded with the investigative report. Proposed non-punitive letters of caution must not be forwarded with the report. See section 0209(f).

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(SIGNATURE OF INVESTIGATING OFFICER)

## RETENTION AND RELEASE OF COMMAND INVESTIGATIONS

The GCMCA to whom the CI is ultimately forwarded is the authority who decides whether release under the Freedom of Information Act (FOIA) or Privacy Act (PA) will be made. While FOIA/PA releases are nothing new to fleet units, the release of JAGMAN investigations is new. SECNAVINST 5720.42 (series) and SECNAVINST 5211.5 (series) and a Judge Advocate should be consulted before releasing a CI. Guidance for all types of investigations, except for litigation reports, may be obtained from Office of the Judge Advocate General (OJAG), Administrative Law Division (Code 13) at (703) 604-8228 (commercial) or 664-8228 (DSN).

***Release of litigation-report investigations.*** OJAG (Code 15) is the custodian and the sole release authority for litigation-report investigations. FOIA/PA requests must be forwarded to Code 15 for action and the requester informed. (see JAGMAN 0210(h)). NOTE: Documents do not become privileged solely by virtue of their inclusion as enclosures to a litigation report. While a litigation report is never released, enclosures may be disclosed as documents prepared in the ordinary course of business that are otherwise releasable under FOIA, PA, civil procedure discovery statutes, or other statutes, rules, or regulations. Any request for such documents should be forwarded to the release authority of the particular record in question. If released, any notation that the document was contained in the litigation report should be removed because that fact is protected by the attorney work product doctrine.

***Release of CI's.*** Investigative reports, evidence, and documents compiled by investigating officials cannot be released until the report is final. The GCMCA to whom the report is forwarded, is the release authority. Each custodian with release authority will either release the record in its entirety or, if necessary forward it to the cognizant Initial Denial Authority (IDA) recommending withholding some or all of the record. Normally, except for an official release (e.g. responding to a Congressional Inquiry, a Federal Court Order, or to another Federal Agency) something is withheld from every investigation rendering the release a partial denial. Even withholding one social security number or home address requires forwarding the record to an IDA for release. The same is true for a total denial. Check with your ISIC and their Judge Advocate for more specific guidance.

Frequent communication with the requester is important. Keep them informed of their request's status. Remember FOIA is a *release statute* and it is DoN's policy to release as much as the rules allow. Where the requested investigation is not complete, keep the requester informed as to its progress and estimated release date.

While each CI must be completely reviewed, the following are normally withheld: social security numbers, home addresses, and telephone numbers (including home E-mail addresses), dates of birth, names of certain officials (NCIS, FBI, CIA agents, and confidential informants/sources), state/local civilian law enforcement material, military death certificates, descriptions of injuries of others, medical records of a living individual, medical boards, medical specialty reviews and peer reviews, alcohol and /or drug classes for living individuals, embarrassing items, names on rosters (also plans of the day) of deployable units, fitness reports and evaluations (including NATOPS, training records, grades, and class status), references to

disciplinary/administrative actions being taken or contemplated (e.g. NJP, letters of reprimand, non-punitive letters, etc.), motor vehicle citations and criminal charges (unless convicted), disapproved findings of fact, opinions, or recommendations (or all findings of fact, opinions, and recommendations where they relate to claims or potential litigation), classified material, trade secrets, and certain terms (e.g. "FOR OFFICIAL USE ONLY," "CONFIDENTIAL NOT FOR RELEASE," and "PERSONAL FOR"). The terms listed need not be cited in the cover letter but should be redacted so the requester does not believe he is getting something in violation of law. This list is only a general guide and is not exhaustive. Consult a Judge Advocate.

The following are normally released: BAC results, article 31(b) warning forms, and non-adverse Line of Duty determinations (which are released if the requester is the subject of the report). For military personnel: name, rank, date of rank, gross salary, past duty assignments, office/duty telephone numbers (including office E-mail), source of commission, promotion sequence number, awards and decorations, attendance at professional and military schools, and duty status. For civilians: name, grade, position, date of grade, gross salary, present and past assignments, and office telephone number (including office E-mail).

***Time Limit.*** Under FOIA/PA the recipient of the request has 20 working days to initially respond (e.g. grant or deny the request, provide an interim response, or refer the request to the proper records custodian). Under FOIA, this limit can be extended through either formal or informal means. Extension beyond 30 days of PA requests is difficult and is discouraged.

***Death Cases.*** The timing and substance of releasing death case records depends on the identity of the requester. Next-of-kin (NOK) are entitled to a copy of the investigation by federal law. Navy practice is to release an advance copy, upon request, to the NOK as soon as it has been reviewed by a flag officer. Grieving family members should not be further aggravated by obstructing their access to information concerning the member's death. The FOIA/PA 'first in/first out' processing rules do not apply to NOK releases which should be given priority. Consideration must be given to the potential impact of such a report. When practical, releasing authorities should ensure hand delivery of the report by someone who can discuss it with the family. Normally this will be the CACO but another appropriate person can be assigned (e.g. a family/personal friend or technical expert). Extreme caution must be taken with regard to release of autopsy reports and other graphic materials. These should be segregated under separate cover and sealed in an envelope with a warning attached. NOK should be advised that they can request the DoD Inspector General (IG) review any military investigation into a death from a self-inflicted cause.

Release to non-NOK requesters is more restrictive. Autopsy reports, graphic materials, and other sensitive items (e.g. suicide notes, last words, highly personal or embarrassing information) are normally *not* released. Although the privacy rights of a deceased are extinguished, remaining family members have a privacy interest where release of the information would cause unreasonable embarrassment or distress to the family.

Copies of all death investigations must be routed to the Naval Safety Center. In cases involving Naval personnel, a copy of the LOD determination shall be made in writing and forwarded to the Chief of Naval Personnel (PERS-62); if involving Marines, Headquarters, U.S. Marine Corps

(MMSR-6). For adverse determinations, a complete copy of the investigation shall be forwarded. *See* JAGMAN 0225, 0229(d).

***Retention of investigations.*** The CA must maintain a copy of all CI's for a minimum of 2 years, including litigation reports. Refer to JAGMAN Chapter II for specific retention policies based on the type of investigation.

## LITIGATION-REPORT INVESTIGATIONS

A litigation-report investigation is used to investigate an incident or event that may result in claims or civil litigation against the DON for damage to personal property, personal injury, or death, caused by Navy personnel, or on behalf of the DON as an affirmative claim for damage caused to DON property by non-DON personnel. Its *primary purpose* is to prepare to defend the legal interests of the DON and United States in claims proceedings or civil litigation. While closely resembling the command investigation in method of evidence collection and report preparation, there are special rules for the litigation-report investigation.

***Special Requirements.*** A litigation-report investigation must be: (1) convened only after consultation with a “cognizant judge advocate” (*see* JAGMAN, Appendix A-2-a for definition); (2) conducted under the direction and supervision of a judge advocate; (3) protected from disclosure to anyone who does not have an official need to know; and (4) ultimately forwarded to the Judge Advocate General.

**NOTE: When investigations are conducted in anticipation of litigation but are not conducted under the direction and supervision of a judge advocate or are handled carelessly, they cannot be legally protected from disclosure to parties whose litigation interests may be adverse to the litigation interests of the United States. It is imperative that the rules of JAGMAN section 0210 be followed to avoid compromising this defense.**

***When a Litigation-Report Investigation is Inappropriate.*** A litigation-report investigation should not be conducted into incidents involving the death of an active duty service member or a civilian whose death occurred when accompanying military personnel in the field or as a result of military-related actions. Further, a litigation-report investigation may not be appropriate to investigate “major incidents” (as defined in JAGMAN, Appendix A-2-a) which generally involve significant public press and congressional interest and attention; however, it may be appropriate in conjunction with other investigations into “major incidents”.

**NOTE: Litigation reports may not be required for motor vehicle accidents involving less than \$5,000 of property damage or minor personal injuries. In this case, completion of Standard Form 91 may be adequate to document the incident. HOWEVER, the potential for a serious claim is not always immediately evident. If in doubt, err on the side of caution and conduct a litigation report investigation. See JAGMAN Appendix, A-2-u for additional information on investigations involving motor vehicle accidents.**

***Conducting the Investigation: Helpful Hints.*** As with the command investigation, the general goal of the litigation-report investigation is to document who, what, when, where, how, and why an incident occurred. “How?” and “why?” may be the most important questions: they require critical thinking in gathering and analyzing information. **The Investigating Officer (IO) must consult with the supervising judge advocate and decide what the purpose and methodology of his/her investigation is before starting to collect evidence.** The IO should review the appendix to Chapter II of the JAGMAN, as well as the checklists contained in section X of this handbook to determine what specific informational requirements exist for particular

types of incidents (motor vehicle accidents, explosions, fires, health care incidents, etc.)

The IO is not bound by formal rules of evidence in gathering information but may collect, consider, and include in the record any matter relevant to the investigation that is believable and authentic. You may obtain information by personal interview, correspondence, or telephone inquiry. The IO should **never** obtain signed or sworn statements during the course of a litigation report investigation **unless** he/she has consulted with the supervising judge advocate before obtaining the sworn statement; See JAGMAN 0201d.(2). Photographs, maps, sketches, etc., are always helpful to reviewing authorities in understanding what occurred. So, too, are present sense impressions (e.g., noise, texture, and smell observations) that are not adequately portrayed in other evidence. You may record these impressions in a simple memorandum for inclusion as an enclosure to the litigation report. The report should state the source for any physical evidence included as an enclosure, as well as any special instructions for disclosure. (*See also* JAGMAN 0210(e)(3) for additional documentation required for all photographs included in the litigation report.) Further, for all original evidence, such as logs, charts, tangible items, etc., the name and phone number of the official responsible for the evidence's safekeeping must be stated in the report, either on each enclosure or in the preliminary statement. In handling witnesses, there are several things to keep in mind.

Before interviewing witnesses, know when and what rights advisements may be required: if you suspect a military member has committed a criminal offense, Article 31, UCMJ, warnings are required; when interviewing a service member concerning the incurring of injury, warning under JAGMAN 0212(c) is required; if you are asking for personal information (as opposed to information pertaining to performance of duty), Privacy Act advice is necessary. Refer to section IX of this handbook for forms.

Fully identify all witnesses, including their full names, job titles, and how they were involved in the incident. Provide full locating information for all witnesses, including command, work and home addresses, telephone numbers (work, home, and cell), and email addresses. If a witness is likely to transfer or leave the military in the foreseeable future, provide a timeframe and future contact information, if available. Each witness should be interviewed separately. Let the witness tell what happened; don't ask questions that suggest answers. Ask for clarification if the witness is speaking in broad or vague terms (e.g., "He was drunk"; "What gave you that impression?"; "He had an odor of alcohol about him, his eyes were bloodshot, he was slurring his speech and unable to maintain his balance"). Try to obtain as much information during the interview as possible; the relevance of a particular fact may not become clear until later in the investigation. After the interview, the IO should summarize the interview as completely and accurately as possible and sign the summary for inclusion in the litigation report.

See pages V-5 through V-12 for checklists to help you conduct the litigation-report investigation.

***Writing the Investigation Report: Helpful Hints.*** The key to writing a litigation-report investigation report is **organization**. IOs must take the time to reconstruct the incident in their mind, pulling together all the evidence. They must then document the incident in a **readable** fashion. Remember, the CA and reviewing authorities will want to understand the incident from a reading of the facts. Often a recitation of the facts in chronological, step-by-step form is easiest



to follow. Findings of fact should be as clear and concise as possible and reference each enclosure that supports it. There is no need to discuss state specific law or legal theories; if a claim is filed in the future the Tort Claims Unit (TCU) will research applicable law.

The IO must **not** draft opinions or recommendations unless specifically directed to by the CA or the supervising judge advocate. Any direction for, or authorization to, the IO to express an opinion and/or recommendation should be clear and specific.

See page V-8 for a checklist to help you prepare the litigation report.

**Protection.** The IO must clearly mark the top center of each page of the litigation report “FOR OFFICIAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT”. *See* JAGMAN 0210(e)(5). Copies of the report and any of the working notes of the IO must be maintained in files also marked “FOR OFFICIAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT” and safeguarded against improper disclosure. OJAG Code 15 is the sole release authority for litigation-report investigations and should be consulted before the report, or any portion thereof, is released to anyone. NOTE: The protection of the privileged nature of litigation report investigations is CRITICAL, and these instructions must be followed to maintain and protect that privilege.

**Review by Supervisory Judge Advocate.** After completion of the investigation by the IO, the supervisory judge advocate should review the litigation report for accuracy and thoroughness. The supervisory judge advocate should also coordinate with the Tort Claims Unit in Norfolk to ensure that the report is sufficient to allow for adjudication of any pending or potential claims.

**Forwarding.** Once the IO and the supervisory judge advocate have completed and signed the litigation-report investigation, an advanced copy of the report must be sent to: OJAG Code 15, Investigations Branch, 1322 Patterson Avenue SE, Suite 3000, Washington Navy Yard, DC 20374-5066. When a claim is filed, the assigned adjudicator can then check the Code 15 Investigations database and determine whether or not a litigation report investigation has been completed. After the litigation-report investigation process has been thoroughly completed and the litigation report endorsed by the CA, the original report and one copy should be sent to OJAG Code 15 at the same address.

**SAMPLE LITIGATION-REPORT INVESTIGATION APPOINTING ORDER**

5800  
Ser Info  
Date

From: Commanding Officer, Naval Submarine Base New London  
To: Lieutenant \_\_\_\_\_, USN

Subj: LITIGATION REPORT INVESTIGATION OF THE FIRE THAT OCCURRED AT  
QUARTERS XYZ, NAVSUBBASE NLON, ON 14 AUGUST 2008

Ref: (a) JAGMAN, Chapter II

1. Per reference (a), you are hereby appointed to investigate the circumstances surrounding the fire that occurred at Quarters XYZ, Naval Submarine Base, on 14 August 2008, and to prepare the related litigation report. During the investigation, you will be under the direction and supervision of LCDR \_\_\_\_\_, JAGC, USN, [\_\_\_\_\_(contact information)\_\_\_\_\_]. Consult LCDR \_\_\_\_\_ before beginning your inquiry or collecting any evidence. If you have not already done so, you should read chapter II of reference (a) in its entirety before consulting LCDR \_\_\_\_\_.
2. This investigation is being convened and your report is being prepared in contemplation of litigation and for the express purpose of assisting attorneys representing the interests of the United States in this matter. As such, it is privileged and should be discussed only with personnel who have an official need to know of its progress or results. If you have any doubt about the propriety of discussing the investigation with any particular individual, then you should seek guidance from LCDR \_\_\_\_\_ before doing so.
3. Investigate all facts and circumstances surrounding the fire, including the cause of the fire, resulting injuries and damage, and any fault, neglect, or responsibility therefore. Report your findings to LCDR \_\_\_\_\_ by (date) unless an extension of time is granted. Do not express any opinions or recommendations unless LCDR \_\_\_\_\_ directs you to do so. Label your report **“FOR OFFICIAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT”** and take appropriate measures to safeguard it.

(Signature of CA)

Copy to:  
COMSUBGRU TWO

## THE LITIGATION-REPORT INVESTIGATION CHECKLIST

### PRELIMINARY QUESTIONS

\_\_\_\_\_ Did the incident involve a member of the command and/or occurred within the command.

\_\_\_\_\_ If not, are you the appropriate command to conduct the investigation?

\_\_\_\_\_ Is this incident under investigation by NCIS, the FBI, or local civilian law enforcement agencies? (If yes, refer to JAGMAN 0201(d).

\_\_\_\_\_ Is this considered a “major” incident? (Refer to JAGMAN Appendix A-2-a for definition.)

\_\_\_\_\_ If believed to be a “major” incident, refer to JAGMAN 0203(b)(2), (f), 0204(b)(5), and 0210(a)(1) and consult a judge advocate.

### I. GETTING STARTED

\_\_\_\_\_ Convening Authority (CA) consults with cognizant judge advocate.

\_\_\_\_\_ CA appoints an investigating officer (IO) in writing, identifying the judge advocate under whose direction and supervision the investigation will be conducted.

\_\_\_\_\_ The IO must consult with the assigned judge advocate **before** beginning the investigation.

\_\_\_\_\_ Carefully examine the convening order to determine the scope of your investigation.

\_\_\_\_\_ Determine when the investigative report is due to the CA.

\_\_\_\_\_ If you cannot reach that deadline, request an extension.

\_\_\_\_\_ Review all relevant instructions on your investigation (e.g., the convening order, JAGMAN chapter II, etc.)

\_\_\_\_\_ Determine which checklists may apply to your investigation and review them carefully to determine what information is required. Refer to section X of this handbook.

\_\_\_\_\_ Decide what the purpose and methodology of your investigation will be.

\_\_\_\_\_ Where is evidence likely to be located?

\_\_\_\_\_ How can such evidence best be obtained and preserved?

\_\_\_\_\_ Contemplate whether there will be any need for classified information or handling of classified information. If so, consult the cognizant judge advocate.

**PRIOR TO OBTAINING ANY OF THE BELOW INFORMATION, CONSULT WITH THE ASSIGNED JUDGE ADVOCATE.**

**II. HANDLING WITNESSES**

(NOTE: You may wish to gather and review other types of evidence before interviewing any or all witnesses)

- \_\_\_\_\_ Draw up a list, to be supplemented as the investigation progresses, of all possible witnesses.
- \_\_\_\_\_ Determine if witnesses are transferring, going on leave, hospitalized, etc., such as might take them out of the area before review of the investigation is completed.
  - \_\_\_\_\_ Inform the CA orally, with confirmation in writing, immediately upon learning that a material witness might leave the area before review of the investigation is completed.
- \_\_\_\_\_ Determine what rights advisements may apply to your prospective witnesses and prepare the appropriate forms. Refer to section IX of this handbook.
  - \_\_\_\_\_ Advise any military witness who may be suspected of an offense misconduct, or improper performance of a duty, of his/her rights under Article 31, UCMJ. (Refer to page IX-1 of this handbook for a sample “Rights Advisement Form”.)
  - \_\_\_\_\_ Advise each witness prior to signing any statement relating to the origin, incident, or aggravation of any disease or injury that he/she has suffered of his/her right not to sign such a statement. *See* JAGMAN 0212(c). (Refer to page IX-2 of this handbook for a sample “Warning Advisement about Statements Regarding Origin of Disease/Injury”).
- \_\_\_\_\_ Is a Privacy Act statement required for the witness interviewed? JAGMAN 0207(e) requires that Privacy Act statements be obtained from each witness from whom personal information is taken. (Refer to page IX-3 of this handbook for a sample “Privacy Act Statement”.)
- \_\_\_\_\_ Conduct an intensive interview of each witness, obtaining names, places, dates, events, and observations that may be relevant.
  - \_\_\_\_\_ Witness statements should be as objective and factual in content as possible. If a witness makes a vague statement (e.g., “he was drunk”), try to pin down the objective facts.
- \_\_\_\_\_ If a witness is not physically available for an interview, attempt to conduct it via telephone, mail, or message.

- \_\_\_\_\_ Record the interview with each witness in detailed notes.
- \_\_\_\_\_ Reduce each witness' statement to a complete and accurate narrative statement.
- \_\_\_\_\_ Witnesses will not, in most cases, be asked to make a written statement or to sign a statement that the investigator has prepared. **DO NOT attach signed witness statements as enclosures to the investigation unless the supervising judge advocate so directs.**
- \_\_\_\_\_ Indicate on the narrative statement that it represents an accurate summary of the oral statement made by the witness and authenticate the statement with your signature.
- \_\_\_\_\_ Review your list of possible witnesses to ensure that you have interviewed all available witnesses.

**PRIOR TO OBTAINING ANY OF THE BELOW INFORMATION, CONSULT WITH THE ASSIGNED JUDGE ADVOCATE.**

### **III. DOCUMENTARY EVIDENCE**

- \_\_\_\_\_ Make a list, to be supplemented as the investigation proceeds, of all possible documents, to include:
  - \_\_\_\_\_ Copies of relevant rules, regulations, instructions, standard operating procedures;
  - \_\_\_\_\_ Relevant correspondence and messages;
  - \_\_\_\_\_ Personnel records;
  - \_\_\_\_\_ Medical records (clinical and hospital records, death certificates, autopsy reports, etc.);
  - \_\_\_\_\_ Official logs and reports; and
  - \_\_\_\_\_ Required forms (personal injury forms, vehicle accident reports, etc.)
- \_\_\_\_\_ Examine your list of possible documents to ensure that you have obtained all such documents personally available to you.
- \_\_\_\_\_ If unable to obtain a certain document, attempt to obtain it via fax, message, telephone, or mail.
- \_\_\_\_\_ Obtain originals or certified true copies of all documents available to you.

\_\_\_\_\_ For all documentary evidence, include the source and any specific restrictions on disclosure to 3<sup>rd</sup> parties.

#### **IV. OTHER EVIDENCE**

\_\_\_\_\_ Make a list of any other information which may be of assistance to reviewing authorities in understanding the incident investigated (real objects, physical locations, maps, charts, photographs, your personal observations, etc.).

\_\_\_\_\_ Examine your list of possible information to ensure that you have obtained all such information personally available to you.

\_\_\_\_\_ If unable to obtain certain information, attempt to obtain them via fax, message, telephone, or mail.

\_\_\_\_\_ Attempt to reduce such information to a form, such as photographs or sketches, which can be conveniently included in your investigative report.

\_\_\_\_\_ Take all steps possible to ensure that any physical evidence be kept in an identified place, safe from tampering, loss, and damage pending review of the investigation.

\_\_\_\_\_ Ensure that all photographs and videos are labeled in accordance with the section 0210(e) of the JAGMAN.

### **DRAFTING THE LITIGATION REPORT (REFER TO PAGE V-13 OF THIS HANDBOOK FOR SAMPLE FORMAT)**

#### **I. PRELIMINARY STATEMENT**

\_\_\_\_\_ Include this statement: “This report was prepared under the supervision of a judge advocate in contemplation of litigation by or against the United States.”

\_\_\_\_\_ State that all reasonably available evidence was collected or is forthcoming and that each directive of the CA has been met.

\_\_\_\_\_ Set forth the nature of the investigation.

\_\_\_\_\_ Relate any delays or difficulties encountered, including non-availability of evidence or inability to interview relevant witnesses.

\_\_\_\_\_ Explain any conflicts in evidence and whether certain evidence is considered more reliable and why.

\_\_\_\_\_ Note any extensions requested, whether granted or denied.

\_\_\_\_\_ Note the limited participation by any member or advisor.

\_\_\_\_\_ If social security numbers contained in the report were obtained from sources other than the individual (e.g., from service records), so state. If social security numbers are obtained from the individual, a Privacy Act statement should be signed by the individual and included as an enclosure.

\_\_\_\_\_ Indicate where original items of evidence are maintained, how they are safeguarded, and the name and phone number of the responsible custodian.

\_\_\_\_\_ Include any other information necessary for a complete understanding of the case.

**II. FINDINGS OF FACT.** A fact is something that is or happens.

\_\_\_\_\_ Distinguish in your own mind the differences among the terms “fact”, “opinion”, and “recommendation”.

\_\_\_\_\_ Conduct an evaluation of the evidence or lack of evidence.

\_\_\_\_\_ Review any special fact-finding requirements pertaining to the specific incident in the JAGMAN checklists (refer to chapter X of this handbook).

\_\_\_\_\_ When drafting the findings of fact, be specific as to persons, times, places, and events.

\_\_\_\_\_ After each finding of fact, reference the enclosures to the report which support that finding of fact.

\_\_\_\_\_ Identify by full name, grade or rate, service number, organization, occupation or business, and residence all persons connected with the incident.

\_\_\_\_\_ Make appropriate findings of facts for all relevant facts, including information already stated in the preliminary statement. The preliminary statement is not a substitute for findings of fact.

\_\_\_\_\_ Place findings of fact in chronological and/or logical order.

\_\_\_\_\_ Is each finding of fact supported by an enclosure?

\_\_\_\_\_ Is every enclosure referenced in at least one finding of fact? Ensure that, when read together, the findings of fact tell the whole story of the incident without having to refer back to the enclosures.

\_\_\_\_\_ Does the story flow? Is it readable? Does it make sense?

\_\_\_\_\_ Make sure abbreviations and acronyms are adequately explained the first time they appear in the investigation (the final report will be read by persons far removed from and unfamiliar with the originating command).

**NOTE: OPINIONS AND RECOMMENDATIONS ARE NOT TO BE MADE BY THE IO UNLESS DIRECTED BY THE SUPERVISORY JUDGE ADVOCATE.**

**III. OPINIONS.** Reasonable evaluations, inferences, or conclusions based on the facts found. Opinions are valuable judgments.

\_\_\_\_\_ Ensure that each of your opinions are exactly that, not findings of fact or recommendations.

\_\_\_\_\_ Ensure that each opinion references the findings of fact that support it.

\_\_\_\_\_ The IO should discuss each opinion with the supervising judge advocate.

\_\_\_\_\_ The supervisory judge advocate should include an opinion regarding the scope of the employment of any government employee whose alleged actions may be the basis for a claim or litigation.

**IV. RECOMMENDATIONS.** Proposals made on the basis of opinions.

\_\_\_\_\_ Ensure that each of your recommendations are exactly that, not findings of fact or opinions.

\_\_\_\_\_ Ensure that each recommendation is logical and consistent with the findings of fact and opinions.

\_\_\_\_\_ Recommend any appropriate corrective, disciplinary, or administrative action.

\_\_\_\_\_ Enclose a draft of a punitive letter of reprimand if recommending such action.

\_\_\_\_\_ Draft and send under separate cover a non-punitive letter of caution if recommending such action.

\_\_\_\_\_ The IO should discuss each recommendation with the supervisory judge advocate.

**V. SIGNING**

\_\_\_\_\_ Is the report signed by the supervisory judge advocate?

\_\_\_\_\_ Is the report signed by the investigating officer?



## VI. ENCLOSURES

\_\_\_ Enclosure (1) will be the convening order.

\_\_\_ All evidence in logical order.

\_\_\_ Is each statement, affidavit, transcript or summary of testimony, photograph, map, chart, document, or other exhibit, a separate enclosure?

\_\_\_ Are all reproduced documents certified to be true copies?

\_\_\_ Have you complied with the special marking requirements applicable to photographs? *See* JAGMAN 0207(b)(4) and 0210(e).

\_\_\_ Are enclosures listed in the order in which they are cited in the body of the investigation?

\_\_\_ Ensure that you do not have inappropriate material in the investigation:

\_\_\_ Copies of safety investigations, aircraft mishap reports, Inspector General reports, polygraph examinations; and medical quality assurance investigations should never be included in the litigation-report investigation.

\_\_\_ NCIS investigations consist of the Report of Investigation (the narrative summary portion) and enclosures. Reports of Investigation should not be included in the litigation-report investigation. However, unless a local NCIS office indicates to the contrary, clearance is not required for including NCIS investigation **enclosures** in the litigation-report investigation.

\_\_\_ Sworn or signed witness statements should not be included as enclosures to the litigation-report investigation unless they have been approved by the supervisory judge advocate and are from a claimant or opposing party to the litigation.

## VII. CONCLUDING ACTION

\_\_\_ Is the report marked “**FOR OFFICAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT**” on the top center of each page?

\_\_\_ Have you stretched your imagination to the utmost in gathering and recording all possible information on the incident investigated?

\_\_\_ Have you checked and double-checked to ensure that your findings of fact, opinions,

recommendations, and enclosures are in proper order? Does the report make logical sense?

\_\_\_\_\_ Have you carefully proofread the report to guard against embarrassing clerical errors?

\_\_\_\_\_ Have you signed the report?

\_\_\_\_\_ Have you arranged for an advanced copy to be forwarded to OJAG Code 15?

**SAMPLE LITIGATION-REPORT INVESTIGATION**

**FOR OFFICIAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT**

5800  
Ser Info  
Date

From: Lieutenant Commander \_\_\_\_\_, JAGC, USN  
Lieutenant \_\_\_\_\_, USN

To: Commanding Officer, Naval Submarine Base New London

- Encl: (1) Convening order and modifications thereto (if any were issued)  
(2) Summary of statement of witness \_\_\_\_\_  
(3) Summary of statement of witness \_\_\_\_\_  
(4) Description of \_\_\_\_\_ [evidence found at scene of the fire]  
(5) Photograph of \_\_\_\_\_ [description of depicted object(s)]

**NOTE: Summarized statements of each witness, observation of the investigator, photographs, diagrams, and suitable reproductions of tangible evidence should be listed and attached as enclosures to the investigative report. The location of all original evidence, such as logs, charts, tangible items, and so forth, and the name and phone number of the official responsible for its safekeeping must be stated in the report, either on each enclosure or in the preliminary statement.**

**Preliminary Statement**

1. Paragraph 1 of a litigation-report must contain information in the form of a “preliminary statement.” Contents may require continuation in one or more additional paragraphs. In general, see section 0208(e) for required contents. The name and organization of the supervisory judge advocate should be listed and the following language must be included: **This investigation is being conducted and this report is being prepared in anticipation of litigation and for the express purpose of assisting attorneys representing the interests of the United States in this matter.”**

Findings of Fact

1. \_\_\_\_\_ [encls. ( ), ( )]
2. \_\_\_\_\_ [encl. ( ), ( )]
3. \_\_\_\_\_ [encl. ( ), ( )]

**FOR OFFICIAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT**

**NOTE: Findings of fact constitute an investigating officer's description of details of events based on evidence. Findings must be as specific as possible about time, place, and persons involved. Each fact may be made a separate finding. An investigating officer may determine the most effective presentation for a particular case. Each fact must be supported by the (unsigned, narrative) statement of a witness, statement of the investigating officer, documentary evidence, or tangible (real) evidence attached to the investigative report as an enclosure. Each finding of fact must reference each enclosure that supports it.**

**Opinions and Recommendations are not made by the investigating officer unless directed by the supervisory judge advocate.**

**(SIGNATURE OF INVESTIGATING OFFICER)**

**(SIGNATURE OF SUPERVISORY JUDGE ADVOCATE)**

## LINE OF DUTY / MISCONDUCT DETERMINATIONS

To assist in the administration of naval personnel issues, the commanding officer is required to inquire into certain cases of injury or disease incurred by members of his or her command. When these inquiries are conducted, the commanding officer is required to make what is referred to as a line of duty (LOD)/misconduct determination. As in most matters, the type of inquiry and the degree of formality of the report will depend upon the circumstances of the case.

***Reason for LOD/misconduct determinations.*** Adverse LOD/misconduct determinations can affect several benefits and/or rights administered by the Department of the Navy, including: extension of enlistment; withholding of longevity and retirement multipliers for the time missed, and; denial of disability retirement and/or severance pay.

***When LOD/misconduct determinations are required.*** Findings concerning LOD/misconduct must be made in every case in which a member of the naval service incurs a *disease or injury* that:

1. *Might* result in permanent disability; or
2. Results in the physical inability to perform duty for a period exceeding 24 hours (as distinguished from a period of hospitalization for evaluation or observation). *See*, JAGMAN 0212.
3. Death.

***What constitutes "line of duty?"*** Injury or disease incurred by naval personnel while on active duty service is presumed to have been incurred "in the line of duty" unless there is **clear and convincing** evidence that it was incurred:

1. As a result of the member's own "misconduct." There must be clear and convincing evidence that the injury was intentionally incurred or the result of willful neglect which demonstrates a reckless disregard for foreseeable and likely consequences.
2. While avoiding duty by deserting.
3. While absent without leave, and such absence materially interfered with the performance of required military duties (generally, in excess of 24 hours).
4. While confined under sentence of a court-martial that included an unremitted dishonorable discharge.
5. While confined under sentence of civil court following conviction of an offense that is defined as a felony by the law of the jurisdiction where convicted.

**Preliminary Inquiries (PI's).** Each injury or disease requiring LOD/misconduct determinations *must* at a minimum be reviewed through use of a PI. JAGMAN 0222(a)(1). Upon completion of the PI, the command is to report the results to the GCMCA through use of the Personnel Casualty Report system. JAGMAN 0222(b), MILPERSMAN 1770-010. A copy of the PI report is delivered to the appropriate medical department for review and notation in the health or dental record. If the medical officer and the commanding officer are of the opinion that the injury or disease was incurred "in the line of duty" and "not as a result of the member's own misconduct," then appropriate entries stating such are entered in the health record. **No further investigation** is required, unless directed by the GCMCA. JAGMAN 0222(c).

**Command Investigations (CI's).** As noted above, use of the PI and health record entries will provide sufficient documentation where injuries or disease are found to have occurred while in the line of duty, not due to misconduct. CI's are only required when:

1. The injury or disease was incurred in such a way that suggests a finding of "misconduct" or "not in line of duty" might result (JAGMAN 0222(d)(1), (2));
2. There is a reasonable chance of permanent disability and the CA considers an investigation essential to ensuring an adequate official record;
3. The injury involves a Naval or Marine Reservist and the CA considers an investigation essential to ensuring an adequate official record.

In endorsing a CI, the CA must specifically comment on the LOD/misconduct opinion and take one of the following actions:

1. If the CA concludes that the injury or disease was incurred "in the line of duty" and "not due to a member's own misconduct," that shall be expressed (regardless of whether it differs from or concurs with the IO's opinion). JAGMAN 0223(a)(1).
2. If, upon review of the report or record, the convening (or higher) authority believes the injury or disease was incurred *not* "in the line of duty" or "due to the member's own misconduct," the member *must* be informed of the preliminary determination and afforded an opportunity, not to exceed 10 days, to submit any desired information to try and convince the CA otherwise. The member may be permitted to review the investigative report before providing any information. If the member decides to present information, it shall be considered by the CA and appended to the record. If the member elects not to provide information, or the 10 day period lapses without submission, then such shall be noted in the endorsement. JAGMAN 0223(a)(2).

The CI is forwarded to a GCMCA with an assigned judge advocate. The GCMCA shall indicate approval, disapproval or modification of conclusions concerning misconduct and line of duty. A copy of such action will be returned to the CA so that appropriate entries may be made in the member's service and medical records. JAGMAN 0223(b)(1).

***Required warning.*** Any person in the Armed Forces, prior to being asked to make or sign any statement relating to the origin, incidence, or aggravation of any disease or injury that he or she has suffered, shall be advised of the right not to make such a statement. (Refer to page IX-2 of this handbook for a sample form).

***Mental responsibility.*** Suicide and a **bona-fide** suicide attempt, as distinguished from a suicide gesture, creates a strong inference of a lack of mental responsibility. As such, suicides or bona-fide suicide attempts are considered as acts committed in the line of duty/not due to the member's own misconduct in light of the fact that the member demonstrated a lack of mental responsibility, and is therefore not responsible for his or her actions. However, a self-inflicted injury, not prompted by a serious suicidal intent, is a suicidal gesture, and is deemed to be incurred as a result of the member's own misconduct, unless evidence establishes otherwise that the member lacked mental responsibility. JAGMAN 0218, 0222(d)(1)(c).

Refer to page VI-4 of this handbook for a checklist to assist you in preparing LOD/misconduct determinations.

**LINE OF DUTY/MISCONDUCT CHECKLIST**  
(JAGMAN 0212 - 0232)

- \_\_\_\_\_ Is a LOD/misconduct determination required?
  - \_\_\_\_\_ Possible permanent disability?
  - \_\_\_\_\_ Physical inability to perform duties for 24 hours or more?
- \_\_\_\_\_ A PI must be conducted.
  - \_\_\_\_\_ *See* Section II of this Handbook for considerations in carrying out a PI.
- \_\_\_\_\_ The results of the PI are reported to the GCMCA via the Personnel Casualty Report.
- \_\_\_\_\_ Ensure medical receives a copy of the PI.
- \_\_\_\_\_ If the CA determines this injury was incurred "in the line of duty, not due to misconduct," ensure medical record entries stating as such are made.
- \_\_\_\_\_ A command must convene a CI when:
  - \_\_\_\_\_ The results of the PI indicate that the injury was incurred under circumstances which suggest a finding of "misconduct" might result. These circumstances include, but are not limited to, all cases in which the injury was incurred:
    - \_\_\_\_\_ while the member was using illegal drugs;
    - \_\_\_\_\_ while the member's blood alcohol content was of .08 percent by volume or greater. This does not preclude the convening of an investigation if the blood-alcohol percentage is lower than .08, if the circumstances so indicate;
    - \_\_\_\_\_ as a result of a bona fide suicide attempt; or
    - \_\_\_\_\_ while the member was acting recklessly or with willful neglect of the *foreseeable* consequences of his/her actions.
  - \_\_\_\_\_ The results of the PI indicate that the injury was incurred under circumstances that suggest a finding of "not in line of duty" might result.
    - \_\_\_\_\_ Was the servicemember in a desertion status at the time of injury?
    - \_\_\_\_\_ Was the servicemember UA at the time of injury?
    - \_\_\_\_\_ Was the servicemember in the Brig with a dishonorable discharge at the time of the injury?



- \_\_\_\_\_ Was the servicemember in jail as a result of a civilian felony conviction at the time of the injury?
  
- \_\_\_\_\_ There is a reasonable chance of permanent disability and the commanding officer considers the convening of an investigation essential to ensure an adequate official record is made concerning the circumstances surrounding the incident.
  
- \_\_\_\_\_ The injured member is in the Naval Reserve or the Marine Corps Reserve and the commanding officer considers an investigation essential to ensure an adequate official record is made concerning the circumstances surround the incident.

If a CI is necessary, the following information must be included in the final report. The considerations contained in Section III of this Handbook also pertain.

- \_\_\_\_\_ Identifying data of all persons, military or civilian, killed or injured.
  - \_\_\_\_\_ Name, sex, age.
  - \_\_\_\_\_ Military grade or rate, regular or reserve, armed force, station or residence.
  - \_\_\_\_\_ Experience/expertise, where relevant.
  - \_\_\_\_\_ Civilian title, business or occupation, address.
  - \_\_\_\_\_ Experience/expertise, where relevant.
  
- \_\_\_\_\_ All relevant records must be obtained, including: military or civilian police accident reports, pertinent hospitalization or clinical records, death certificates, autopsy reports, records of coroners' inquest or medical examiners' reports, and pathological, histological, and toxicological studies.
  
- \_\_\_\_\_ Place of injury occurrence, the site and terrain, to include photographs, maps, charts, diagrams or other relevant exhibits.
  
- \_\_\_\_\_ Duty status of injured person: leave, liberty, unauthorized absence (UA), active duty, active duty for training, or inactive duty for training at time of injury.
  - \_\_\_\_\_ Whether any UA status at time of injury materially interfered with his/her military duty.
  
- \_\_\_\_\_ Nature/extent of injuries, including description of body parts injured.
  - \_\_\_\_\_ Extent of hospitalization.
  - \_\_\_\_\_ Cost from any civilian medical facilities.

- \_\_\_\_\_ Amount of time "lost."
- \_\_\_\_\_ Physical factors and impairment.
  - \_\_\_\_\_ Tired (working excessive hours), hungry, on medication (prescribed or unauthorized), ill or experiencing dizziness, headaches or nausea, exposed to severe environmental extremes.
  - \_\_\_\_\_ Any alcohol or habit-forming drug impairment.
    - \_\_\_\_\_ Individual's general appearance, behavior, rationality of speech, and muscular coordination.
    - \_\_\_\_\_ Quantity and nature of intoxicating agent used.
    - \_\_\_\_\_ Period of time in which consumed.
    - \_\_\_\_\_ Results of blood, breath, urine or tissue test for intoxicating agents.
    - \_\_\_\_\_ Lawfulness of intoxicating agent.
- \_\_\_\_\_ Mental factors.
  - \_\_\_\_\_ Emotionally upset (angry, depressed, moody, tense) and/or mentally preoccupied with unrelated matters.
  - \_\_\_\_\_ Motivation.
  - \_\_\_\_\_ Knowledge of/adherence to standard procedures.
  - \_\_\_\_\_ Attempted suicide (genuine intent to die v. gesture or malingering). *See* JAGMAN 0218.
  - \_\_\_\_\_ Mental disease or defect. Psychiatric evaluation warranted?
- \_\_\_\_\_ LOD Recommendation.
  - \_\_\_\_\_ Member was *in the line of duty and not due to misconduct*
  - \_\_\_\_\_ Member was *NOT in the line of duty and not due to misconduct*
  - \_\_\_\_\_ Member was *NOT in the line of duty and DUE to misconduct*

\_\_\_\_\_ **DO NOT RECOMMEND** member was *in the line of duty and DUE to misconduct*. If you have, you need to review and discuss further with a Judge Advocate.

**The CI must clearly document all facts leading up to and connected with the injury or death. Some of the information to be addressed might include:**

- \_\_\_\_\_ Training.
  - \_\_\_\_\_ Formal/on the job.
  - \_\_\_\_\_ Adequacy.
  - \_\_\_\_\_ Engaged in tasks different from those in which trained.
  - \_\_\_\_\_ Engaged in tasks too difficult for skill level.
- \_\_\_\_\_ Emergency responses/reaction time.
- \_\_\_\_\_ Supervision (adequate/lax/absent).
- \_\_\_\_\_ Design factors.
  - \_\_\_\_\_ Equipment's condition, working order.
  - \_\_\_\_\_ Operating unfamiliar equipment/controls.
  - \_\_\_\_\_ Operating equipment with controls that function differently than expected due to lack of standardization.
  - \_\_\_\_\_ Unable to reach all controls from his/her work station and see and hear all displays, signals, and communications.
  - \_\_\_\_\_ Provided insufficient support manuals.
  - \_\_\_\_\_ Using support equipment which was not clearly identified and likely to be confused with similar but non-compatible equipment.
- \_\_\_\_\_ Environmental factors.
  - \_\_\_\_\_ Harmful dusts, fumes, gases without proper ventilation.
  - \_\_\_\_\_ Working in a hazardous environment without personal protective equipment or a line-tender.
  - \_\_\_\_\_ Unable to hear and see all communications and signals.

- \_\_\_\_\_ Exposed to temperature extremes that could degrade efficiency, cause faintness, stroke or numbness.
- \_\_\_\_\_ Suffering from eye fatigue due to inadequate lighting or glare.
- \_\_\_\_\_ Visually restricted by dense fog, rain, smoke or snow.
- \_\_\_\_\_ Darkened ship lighting conditions.
- \_\_\_\_\_ Exposed to excessive noise/vibration levels.
- \_\_\_\_\_ Personnel protective equipment.
  - \_\_\_\_\_ Using required equipment for the job (e.g., seatbelts, safety glasses, hearing protectors).
  - \_\_\_\_\_ Not using proper equipment due to lack of availability (identify).
  - \_\_\_\_\_ Not using proper equipment due to lack of comfort or personal image (identify).
  - \_\_\_\_\_ Using protective equipment that failed and caused additional injuries (identify).
- \_\_\_\_\_ Hazardous conditions.
  - \_\_\_\_\_ Inadequate/missing guards, handrail, ladder treads, protective mats, safety devices/ switches, skid proofing.
  - \_\_\_\_\_ Jury-rigged equipment.
  - \_\_\_\_\_ Use of improper non-insulated tools.
  - \_\_\_\_\_ Incorrectly installed equipment.
  - \_\_\_\_\_ Defective/improperly maintained equipment.
  - \_\_\_\_\_ Slippery decks or ladders, obstructions.
  - \_\_\_\_\_ Improper clothing (leather heels, conventional shoes vice steel-toed shoes, loose-fitting clothes, no shirt, conventional eyeglasses vice safety glasses).

**Remember to consult other applicable checklists for information requirements. For example, if a sailor injured himself in a motor vehicle accident, the IO would also need to gather that information listed in JAGMAN A-2-u for inclusion in the final CI.**

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## SPECIAL CONSIDERATIONS IN DEATH CASES

The circumstances surrounding the death of naval personnel, or of civilian personnel at places under military control, may be recorded in a variety of ways, such as autopsy reports, battlefield reports, and medical reports. Investigations conducted pursuant to the JAGMAN may also focus on such deaths and may incorporate other official reports as enclosures. Since reports pertaining to deaths of military members are, by law, generally releasable to family members, and since the deceased cannot contribute to the investigation process, special considerations prevail in the investigation of death cases.

**NOTE: NCIS must be notified per SECNAVINST 5430.107 series on any death case involving actual or suspected criminal conduct.**

***Time limitations.*** Investigating Officers should complete an administrative investigation concerning death cases within 20 days from the date of the death or its discovery. The CA may extend the investigation for good cause. The CA and subsequent reviewers have 20 days to review and endorse the investigation. If a command does not comply with these time limits, the command must comment on this fact in its endorsement of the investigation. JAGMAN 0225(e)

***Preliminary Inquiry (PI).*** A PI should be conducted into the death of a member of the naval service or into the death of a civilian that occurs at a place under naval control. At the conclusion of the PI, the CA must determine which of the options listed in JAGMAN 0204 will be exercised, and report that decision to the next superior in the chain-of-command.

A command investigation under the JAGMAN will normally **not** be conducted if the PI shows that the death:

(1) was the result of a previously known medical condition and the adequacy of military medical care is not reasonably in issue; or

(2) was the result of enemy action.

***Limited Investigations.*** Where the death of a servicemember occurred at a location within the U.S. and not under military control, while the member was off-duty, and there is no discernable "nexus," or connection, between the circumstances of the death and the naval service, the command need only obtain a copy of the investigation conducted by civilian authorities and retain it as an internal report. JAGMAN 0226(c). The command shall document, in writing, the reasons for making the determination to conduct a limited investigation, attaching the enumerated reasons to the internal report.

***Command Investigations (CI).*** A CI (or in some cases, a litigation-report investigation) will be conducted if the PI shows:

1. The case involves civilian or other non-naval personnel found dead aboard an activity under military control where the death was apparently caused by suicide or other unusual circumstances:

2. the circumstances surrounding the death places the adequacy of military medical care reasonably at issue;
3. there exists a probable "nexus," or connection, between the naval service and the circumstances of the death of a servicemember; or
4. it is unclear if enemy action caused the death, such as in possible "friendly-fire" incidents.

***Line of Duty Determinations:*** A Line of Duty/Misconduct opinion shall be made in all death cases retroactive to 10 September 2001 and regardless of nexus to naval service, pursuant to the National Defense Authorization Act of Fiscal Year 2002 and NAVADMIN 065/03. (**THIS INCLUDES SUICIDES**). LOD determinations effect annuity calculations under the Uniformed Services Survivor Benefits Program. JAGMAN 0229(d).

SBP annuities are calculated as a percentage of the SBP base amount (normally either 35% or 55% of the base amount). When a servicemember's death is determined to be in the LOD, regardless of retirement eligibility, the SBP base is equal to retired pay as if the service member retired with 100% disability (this equals 75% of the member's base pay or high-36 pay. JAGMAN 0229(b). However, if the servicemember is determined to be not in the LOD, then the SBP eligibility and annuity calculations fall under the rules existing before the NDAA of FY 2002; that is, if the servicemember was ineligible for retirement at the time of death, SBP is inapplicable. If the servicemember was eligible for retirement at the time of death, then the SBP annuity would be paid to a qualified survivor, however, it will not be computed on the basis of a nominal total disability retirement. JAGMAN 0229(c).

All active duty death cases must be subject to at least a PI in accordance with JAGMAN 0203. The command conducting the PI will determine if the PI is sufficient to make a LOD determination or if a CI is required. If the command completing the investigation is not a GCMCA with an assigned staff judge advocate (SJA), the command will forward the PI/CI to the first GCMCA in the chain-of-command with an assigned SJA. The GCMCA with an assigned SJA will make the formal LOD determination, subject to a limited review by Commander, Navy Personnel Command if the determination is adverse. JAGMAN 0229(d).

Before making an adverse LOD determination in a death investigation, the GCMCA or his or her SJA shall afford a known potential SBP beneficiary the opportunity to review the report of investigation and provide relevant information to the GCMCA. The known potential SBP beneficiary will normally have 30 calendar days from receipt of the report of investigation to submit information to the GCMCA. JAGMAN 0229(d).

***Independent Reviews.*** Prior to endorsement of an investigation that calls into question the deceased's conduct, the CA may wish the report to be reviewed to ensure thoroughness, accuracy of the findings, and fairness to the deceased member. The individual selected to conduct this review shall have no previous connection to the investigative process and must be outside the CA's immediate chain of command. To the extent possible, the reviewer should possess training,

experience, and background sufficient to allow critical analysis of the factual circumstances. The reviewer is not to act as the deceased's representative, but rather provide critical analysis from the perspective of the deceased, tempered by the reviewer's own experience, training, and education. If the reviewer believes comments are warranted, such comments shall be completed and provided to the CA within ten working days of the report's delivery to the reviewer. The CA is to consider any comments submitted by the reviewer and take any action deemed appropriate. The comments shall be appended to the investigative report. JAGMAN 0231.

***Special routing of death cases.*** An advance copy of all death investigations, with the exception of only a PI or limited investigation, shall be provided to the cognizant Echelon II Commander after the first endorsement. The original report shall note the forwarding of the advance copy, and each subsequent endorser shall provide an advance copy of their endorsement to the Echelon II Commander. JAGMAN 0232.

**COMMAND ENDORSEMENTS****COMMAND INVESTIGATIONS**

***Review and forwarding.*** Upon completing the investigative report, the IO submits the report to the CA, who reviews it and takes one of the following actions:

1. Returns the report to the IO for further inquiry or corrective action, noting any incomplete, ambiguous, or erroneous action of the IO; or
2. determines that the investigation is of no interest to anyone outside the command and chooses to file the investigation, without further forwarding, as an internal report; or
3. transmits the report by endorsement to the next appropriate superior officer, typically to the GCMCA over the CA. The CA's endorsement will set forth appropriate comments, recording approval or disapproval in whole or in part, of the investigation's proceedings, findings, opinions, and recommendations. In line of duty/misconduct investigations, the CA is required to specifically approve or disapprove the line of duty/misconduct opinion.

If the CA corrects, adds, or disapproves findings of fact, opinions, or recommendations, the following language would be used in the endorsement as appropriate;

- \* The findings of fact are hereby modified as follows: (modification)
- \* The following additional findings of fact are added: (numbers start after the last findings of fact in the basic investigation).
- \* Opinion \_\_\_ in the basic correspondence is not substantiated by the findings of fact because \_\_\_\_\_ and is therefore disapproved (modified to read as follows: \_\_\_\_\_).
- \* The following additional opinions are added: (numbers start after the last opinions in the basic investigation).
- \* Recommendation \_\_ is not appropriate for action at this command; however, a copy of this investigation is being furnished to \_\_\_\_\_ for such action as deemed appropriate.
- \* Additional recommendations: (numbers start after the last recommendation in the basic investigation).
- \* The action recommended in recommendation \_\_\_\_ has been accomplished by \_ (has been forwarded to \_\_\_\_\_ for action; etc.).



The CA's endorsement must specifically indicate what corrective action, if any, is warranted and has been or will be taken. Whenever punitive or non-punitive action is contemplated or taken as the result of the incident under inquiry, such action should be noted in the endorsement. JAGMAN 0209(f)(2). CA's can expect superior commanders to require subsequent reports on how lessons learned have been implemented; if administrative investigations are to be effective tools, "tenacious follow-up action is required."

Punitive letters, or copies of recommended drafts, shall be included as enclosures. Non-punitive letters are *not* to be mentioned in endorsements or included as enclosures. JAGMAN 0209(f)(2)(d).

***Routing the CI.*** Upon completion of the endorsement, the CA forwards the original investigative report through the chain-of-command to the GCMCA over the CA. ***CI's are not routinely forwarded to JAG*** (copies may be sent to OJAG, Code 15, if the investigation is a matter of potential interest to the JAG). The subject matter and facts found will dictate the exact routing of the report; for example, area coordinators may be included as via addresses if the investigation relates to an issue affecting their area coordination responsibilities.

One complete copy of the investigation should be forwarded with the original for each intermediate reviewing authority (additional copies are required in death cases). JAGMAN 0209(f)(3). Advance copies of the report of investigation shall be forwarded by the CA in the following cases:

(1) For CI's involving injuries and deaths of naval personnel, or material damage to a ship, submarine, or Government property (excluding aircraft), advance copies are sent to Commander, Naval Safety Center. In aircraft mishap cases, copies of investigations are sent to the Naval Safety Center only upon request. JAGMAN 0209(f)(3)(c).

(2) When the adequacy of medical care is reasonably in issue and which involve significant potential claims, permanent disability, or death, advance copies of the CI are sent to the Naval Inspector General, Chief, Bureau of Medicine and Surgery (two copies). JAGMAN 0210(f)(2)(a).

***Retention of CI's.*** The CA must maintain a copy of all CI's for a minimum of two years after which it should be forwarded to a federal records storage facility for storage.

***Release of CI's.*** The GCMCA to whom the CI is ultimately forwarded is the authority who decides whether release under the Freedom of Information Act or Privacy Act will be made.

## LITIGATION-REPORT INVESTIGATIONS

**Review and forwarding.** Upon receiving the litigation-report investigation, the CA reviews the documents and takes one of the following actions:

1. Return the investigation to the supervisory judge advocate for further inquiry; or
2. endorse and forward the report. JAGMAN 0210(f)(1).

Unlike the endorsement of a CI, the CA may only make limited comments in endorsing litigation-report investigations. The CA may comment on those aspects of the report which bear on the administration or management of the command, including any corrective action taken. The CA shall **not** normally approve or disapprove of the findings of fact. JAGMAN 0210(f)(1)(a). The CA's endorsement must be marked "FOR OFFICIAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT."

**Routing the investigation.** Upon completion of the endorsement, the CA forwards the original investigative report to the Judge Advocate General (Code 15), via the Staff Judge Advocate of the GCMCA in the chain of command. JAGMAN 0210(f)(2). One complete copy of the investigation should be forwarded with the original for the GCMCA. JAGMAN 0209(f)(3). Copies of the report are to be provided to superiors in the chain of command and to other commands which have a direct need to know. Dissemination of the report **shall not** otherwise be made without first consulting a judge advocate. JAGMAN 0210(f)(2).

**Retention of litigation-report investigations.** The original CA is required to retain a copy of the litigation-report investigation, kept in a file marked "FOR OFFICIAL USE ONLY: LITIGATION/ATTORNEY WORK PRODUCT" and safeguard against improper disclosure. JAGMAN 0210(f). The JAGMAN does not prescribe a time period for retention; therefore, before destroying, consultation with a judge advocate or OJAG (Code 15) is advised.

**Release of litigation-report investigations.** For all litigation-report investigations, the Judge Advocate General retains release authority. Convening and reviewing authorities are **not authorized** to release litigation report investigations or their contents. JAGMAN 0210(f)(2), (h).

**ARTICLE 31 RIGHTS**

Name: \_\_\_\_\_ Rank/Rate: \_\_\_\_\_ Activity:

\_\_\_\_\_ Unit:

Telephone number:

I have been advised that I may be suspected of the offense(s) of: \_\_\_\_\_ and that:

- I have the right to remain silent.
- Any statements I do make may be used as evidence against me in trial by court-martial.
- I have the right to consult with lawyer counsel prior to any questioning. This lawyer counsel may be a civilian lawyer retained by me at my own expense, a military lawyer appointed to act as my counsel without cost to me, or both.
- I have the right to have such retained civilian lawyer and/or appointed military lawyer present during this interview.
- I have the right to terminate this interview at any time.

**WAIVER OF RIGHTS**

- I further certify and acknowledge that I have read the above statement of my rights and fully understand them, and that:
  - I expressly desire to waive my right to remain silent.
  - I expressly desire to make a statement.
  - I expressly do not desire to consult with either a civilian lawyer retained by me or a military lawyer appointed as my counsel without cost to me prior to questioning.
  - I expressly do not desire to have such a lawyer present with me during this interview.
  - This acknowledgment and waiver of rights is made freely and voluntarily by me, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.

\_\_\_\_\_  
(Witness signature/date)

\_\_\_\_\_  
(Member signature/date)

Understanding my rights under U.C.M.J. Article 31, I wish to make the following statement:

\_\_\_\_\_

**WARNING ADVISEMENT ABOUT STATEMENTS  
REGARDING ORIGIN OF DISEASE OR INJURY**

**COMPLIANCE WITH SECTION 0212 OF THE JAGMAN**

I, \_\_\_\_\_ have been advised that:

- questions have arisen concerning whether or not my injury/disease, sustained or discovered on \_\_\_\_\_ 20\_\_, was incurred in the line of duty or as a result of my own misconduct;

- in the event such injury/disease is determined to have been incurred not in the line of duty or as a result of my own misconduct, I will be required to serve for an additional period beyond my present enlistment to make up for the duty time lost;

- lost duty time will not count as creditable service for pay entitlement purposes;

- I may be required to forfeit some pay (where absence from duty in excess of one day immediately follows intemperate use of liquor or habit-forming drugs);

- if I am permanently disabled and that disability is determined to have been the result of misconduct or was incurred not in the line of duty, I may be barred from receiving disability pay or allowances, as well as veteran's benefits;

- I may **not** be required to give a statement relating to the origin, incidence, or aggravation of any disease/injury that I may have.

I do/do not desire to submit a statement.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Witness Signature

Witness Name/Rate/Grade/Unit/Telephone Number

---

**PRIVACY ACT STATEMENT**  
*(Sections requiring modification by IO in bolded italics)*

Name: \_\_\_\_\_ Rank/Rate:  
Activity: \_\_\_\_\_ Unit:  
Telephone number:

Today, \_\_\_\_\_, 20\_\_, I acknowledge that I have received the following advisement under the guidelines of the Privacy Act.

This statement is provided in compliance with the provisions of the Privacy Act of 1974 (Public Law 93-579) which requires that Federal agencies must inform individuals who are requested to furnish personal information about themselves as to certain facts regarding the information requested below.

1. **AUTHORITY:** 44 U.S.C. § 3101; 5 U.S.C. § 301. Specify, if possible, other statutory authority listed below that is peculiarly applicable to the matter under investigation.

Authorities applicable to various investigations:

- a. Requirement that enlisted members make up time lost due to misconduct or abuse of drugs or alcohol. 10 U.S.C. § 972.
- b. Retirement or separation for physical disability. 10 U.S.C. §§ 1201-1221.
- c. Manual for Courts-Martial.
- d. Uniform Code of Military Justice. 10 U.S.C. §§ 815, 832, 869, 873, 935, 936, and 938-940.
- e. Military Claims Act. 10 U.S.C. § 2733.
- f. Foreign Claims Act. 10 U.S.C. §§ 2734, 2734a, 2734b.
- g. Emergency payment of claims. 10 U.S.C. § 2736.
- h. Non-Scope claims. 10 U.S.C. § 2737.
- i. Duties of Secretary of the Navy. 10 U.S.C. § 5013.
- j. Duties of the Office Chief of Naval Operations. 10 U.S.C. §§ 5031-5033, 5035-5036.
- k. Duties of the Bureaus and Offices of the Department of the Navy and duties of the Judge Advocate General. 10 U.S.C. §§ 5021-5024, 5131-5133, 5135, 5137-38, 5141-5142a, 5148-5150.

- l. Duties of the Commandant of the Marine Corps. 10 U.S.C. § 5043.
- m. Reservists' disability and death benefits. 10 U.S.C. § 1074.
- n. Requirement of exemplary conduct. 10 U.S.C. § 5947.
- o. Promotion of accident and occupational safety by Secretary of the Navy. 10 U.S.C. § 7205.
- p. Admiralty claims. 10 U.S.C. § 7622-7623.
- q. Federal Tort Claims Act. 28 U.S.C. §§ 1346, 2671-2680.
- r. Financial liability of accountable officers. 31 U.S.C. §§ 3521, 3527, 3531.
- s. Military Personnel and Civilian Employees' Claims Act of 1964. 31 U.S.C. §§ 240-243.
- t. Federal Claim Collection Acts. 31 U.S.C. §§ 3521, 3526, 3529, 3701-3702, 3717-3718.
- u. Forfeiture of pay for time lost due to incapacitation caused by alcohol or drug use. 37 U.S.C. § 802.
- v. Eligibility for certain veterans' benefits. 38 U.S.C. § 105.
- w. Postal claims. 39 U.S.C. §§ 406, 2601.
- x. Medical Care Recovery Act. 42 U.S.C. §§ 2651-2653.
- y. Public Vessels Act. 46 U.S.C. §§ 781-790.
- z. Suits in Admiralty Act. 46 U.S.C. §§ 741-752.
- aa. Admiralty Extension Act. 46 U.S.C. § 740.
- bb. Transportation Safety Act. 49 U.S.C. § 1901.

2. **PRINCIPAL PURPOSE(S)**: The information which will be solicited is intended principally for the following purpose(s):

***[IO, specify each purpose listed below for which the record of the particular investigation could reasonably be used:]***

a. Determinations on the status of personnel regarding entitlements to pay during disability, disability benefits, severance pay, retirement pay, increases of pay for longevity, survivor's benefits, involuntary extensions of enlistments, dates of expiration of active obligated service, and accrual of annual leave.

- b. Determinations on disciplinary or punitive action.
- c. Determinations on liability of personnel for losses of, or damage to, public funds or property.
- d. Evaluation of petitions, grievances, and complaints.
- e. Adjudication, pursuit, or defense of claims for or against the Government or among private parties.
- f. Other determinations, as required, in the course of naval administration.
- g. Public information releases.
- h. Evaluation of procedures, operations, material, and designs by the Navy and contractors, with a view to improving the efficiency and safety of the Department of the Navy.

3. **ROUTINE USES:** In addition to being used within the Departments of the Navy and Defense for the purpose(s) indicated above, records of investigations are routinely furnished, as appropriate, to the Department of Veterans Affairs for use in determinations concerning entitlement to veterans' and survivors' benefits; to Servicemembers' Group Life Insurance administrators for determinations concerning payment of life insurance proceeds; to the U.S. General Accounting Office for purposes of determinations concerning relief of accountable personnel from liability for losses of public funds and related fiscal matters; and to the Department of Justice for use in litigation involving the Government. Additionally, such investigations are sometimes furnished to agencies of the Department of Justice and to State or local law enforcement and court authorities for use in connection with civilian criminal and civil court proceedings. The records of investigations are provided to agents and authorized representatives of persons involved in the incident, for use in legal or administrative matters. The records are provided to contractors for use in connection with settlement, adjudication, or defense of claims by or against the Government, and for use in design and evaluation of products, services, and systems. The records are also furnished to agencies of the Federal, State, or local law enforcement authorities, court authorities, administrative authorities, and regulatory authorities, for use in connection with civilian and military criminal, civil, administrative, and regulatory proceedings and actions.

4. **MANDATORY/VOLUNTARY DISCLOSURE - CONSEQUENCES OF REFUSING TO DISCLOSE:**

a. Where disclosure is voluntary, as usually is the case, use one of the following statements, or a combination of the following statements, as applicable:

(1) Where an individual is a subject of an investigation for purpose 2a or 2b, above: "Disclosure is voluntary. You are advised that you are initially presumed to be entitled to have the (IO select) [*personnel determinations*] [*disciplinary determinations*] in paragraph 2, above,

resolved in your favor, but the final determination will be based on all the evidence in the investigative record. If you do not provide the requested information, you will be entitled to a favorable determination if the record does not contain sufficient evidence to overcome the presumption in your favor. If the completed record does contain sufficient evidence to overcome the presumption in your favor, however, your election not to provide the requested information possibly could prevent the investigation from obtaining evidence, which may be needed to support a favorable determination.”

(2) Where an individual is a subject of an investigation for purpose 2c, above: “Disclosure is voluntary, and if you do not provide the requested information, any determination as to whether you should be held liable for repayment of the Government's loss would be based on the other evidence in the investigative record.”

(3) Where the individual is a claimant or potential claimant in an investigation for purpose 2e, above: “Disclosure is voluntary, but refusal to disclose the requested information could prevent the investigation from obtaining sufficient information to substantiate any claim which you have made or may make against the Government as a result of the incident under investigation.”

(4) Where the individual was treated at Government expense for injuries caused by third parties in connection with a matter being investigated for purpose 2e, above: “Disclosure is voluntary, but refusal to disclose the requested information could result in a requirement for you to assign to the Government your medical care claims against third parties in connection with the incident, or authorize withholding of the records of your treatment in a Naval medical facilities.”

(5) In any other case: “Disclosure is voluntary, and if you do not provide the requested information, any determinations or evaluations made as a result of the investigation will be made on the basis of the evidence that is contained in the investigative record.”

***b. IO, in the unusual situation where a specific statute, regulation, or lawful order of competent authority requires an individual to disclose particular information for the Government's benefit in furtherance of a Government interest, policy, or objective, the following statement should be used: “Disclosure of (specify the particular relevant information required) is mandatory under (cite the statute, regulation, or order), and refusal to disclose that information will subject you to possible disciplinary or criminal proceedings. Disclosure of any other information requested is voluntary, (and there will be no adverse effects if you elect not to disclose it) (but election not to disclose the information could ... .”***

---

(Signature and date)



**BASIC CHECKLISTS FOR SPECIFIC TYPES OF INCIDENTS**

The following pages contain basic checklists for specific types of incidents. They are not all inclusive, but rather a starting point for CAs and IOs. Adding to or adjusting the checklists to address the specific incident is encouraged. Use these in combination with the checklist for the specific type of investigation you are conducting.

AIRCRAFT ACCIDENTS .....	2
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**AIRCRAFT ACCIDENTS**  
(JAGMAN A-2-n)

**NOTE: PARTICIPATION OF THE NATIONAL TRANSPORTATION SAFETY BOARD (NTSB) OR THE FEDERAL AVIATION AGENCY (FAA) IS COVERED BY OPNAVINST 3750.15 (SERIES). REMEMBER, THE JAGMAN IO MUST MAINTAIN AND PROTECT THE PRIVILEGED NATURE OF THE AIRCRAFT MISHAP INVESTIGATION (AMI) OR AN AVIATION MISHAP BOARD (AMB) AND SHALL NOT RELY UPON THE AMI OR AMB NOR OBTAIN ANY MODIFIED EVIDENCE FROM THE AMI OR AMB NOR DISCUSS THE FINDINGS OR PROGRESS OF THE AMI OR AMB INVESTIGATION. SEE JAGMAN A-2-n. CONSULT A JUDGE ADVOCATE IF YOU HAVE QUESTIONS.**

\_\_\_\_\_ If a possibility exists that witnesses will testify before the AMI and the JAGMAN investigation, the JAGMAN IO shall explain to such witnesses the reasons for the apparent duplication of effort. This is particularly important with non-military witnesses. The explanation shall cover:

\_\_\_\_\_ The different objectives of the two investigations;

\_\_\_\_\_ The reasons why procedures vary;

\_\_\_\_\_ The need to preserve the privileged nature of the aircraft accident safety investigation; and

\_\_\_\_\_ The fact that since neither command nor administrative action may alter the privileged character of statements provided to the aircraft accident safety investigation, such statements will not be available to the JAGMAN investigation from any official source.

\_\_\_\_\_ Identity of the pilot(s), co-pilot(s), naval flight officer(s) (NFO), air crew and any passengers.

\_\_\_\_\_ Background, history, training, experience of the pilot(s), co-pilot(s), naval flight officer(s), and air crew(s).

\_\_\_\_\_ Their degree of familiarity with the type of aircraft involved.

\_\_\_\_\_ The military or civilian status of all personnel on board, e.g., Regular, Reserve, or retired; active duty, inactive duty, inactive duty training; TAD, TDY, leave, liberty.

\_\_\_\_\_ Type, model, and bureau number of the aircraft involved.

\_\_\_\_\_ Identification of the squadron, detachment, or unit authorizing the flight and the official who authorized the flight.

- \_\_\_\_\_ If a privately-owned or rented aircraft was involved, identify the owner, authorization for the flight, existence of private insurance, and extent of damage.
- \_\_\_\_\_ The identity of all individuals who were killed, injured, or who suffered property damage as a result of the mishap, including:
  - \_\_\_\_\_ Name, age, address (home and work), telephone number, occupation, injured and/or deceased; and
  - \_\_\_\_\_ A complete description of how injuries occurred (refer to JAGMAN, Chapter II, Part F, for special considerations in death cases).
- \_\_\_\_\_ Sociological, psychological, and human factors related to the accident, including:
  - \_\_\_\_\_ Potential stress factors, fatigue, use of medication, or intoxication.
- \_\_\_\_\_ Type, duration, and purpose of the flight, briefing of the pilot, and other pertinent information regarding the particular flight, including:
  - \_\_\_\_\_ The use of night vision goggles; or
  - \_\_\_\_\_ Other mission-specific factors relevant to aircraft or air crew equipment or performance.
  - \_\_\_\_\_ Review SPINS or other theater specific guidance/direction
- \_\_\_\_\_ Review applicable NATOPS sections
- \_\_\_\_\_ Weather conditions throughout the flight.
- \_\_\_\_\_ Preflight history of the aircraft.
- \_\_\_\_\_ Compliance or noncompliance with pertinent technical directives, including:
  - \_\_\_\_\_ Flight hours since the last overhaul;
  - \_\_\_\_\_ Discrepancies noted on recent "Yellow Sheets"; VIDS/MAF Forms; OPNAVINST 4790.2 [Series]; and
  - \_\_\_\_\_ Flight hours since the last intermediate check.
- \_\_\_\_\_ Description of flight path and maneuvers of the aircraft during the flight, including manner of descent and impact.
- \_\_\_\_\_ Positions of external control surfaces (landing gear, canopy, etc.) during flight.

\_\_\_\_\_ Presence, condition, and use of safety, communication, escape, and survival equipment.

\_\_\_\_\_ Post-accident examination of the aircraft.

\_\_\_\_\_ Detailed description of all damage to the aircraft, including:

\_\_\_\_\_ Wreckage diagrams, disassembly and inspection reports, wreckage photographs, and data on engine, fuselage, and control surfaces.

\_\_\_\_\_ Examination of the scene of the accident, to include:

\_\_\_\_\_ It's precise location;

\_\_\_\_\_ A description of the terrain; and

\_\_\_\_\_ A complete listing and cost of damage or destroyed Government and non-Government property.

\_\_\_\_\_ Description of rescue operation employed, effectiveness, and any difficulties encountered.

\_\_\_\_\_ All instructions in effect at the time of the accident concerning procedures relating to this particular flight, including applicable local and regional flight rules governing the flight and copies of air charts in effect and in use.

\_\_\_\_\_ Performance data on aircraft in question under prevailing wind, weather, and temperature conditions.

\_\_\_\_\_ In the case of deaths resulting from the accident, the precise medical cause thereof, (substantiated by medical records).

\_\_\_\_\_ Cause, nature, and extent of any injuries, including line of duty/misconduct determinations, if required.

\_\_\_\_\_ Involvement of other aircraft, if any.

\_\_\_\_\_ The roles of supervisory, support, and controlling personnel.

\_\_\_\_\_ When the evidence concerning the accident is sufficient to do so, an opinion or opinions as to the cause or the causes of the accident.

\_\_\_\_\_ When the evidence is not sufficient to form an opinion or opinions as to the cause or causes of the accident, a description of those factors, if any, which in the opinion of the investigator(s) substantially contributed to the accident.

**MOTOR VEHICLE ACCIDENT CHECKLIST**  
(JAGMAN A-2-u)

- \_\_\_\_\_ Vehicle(s) identified, including vehicle identification number (VIN), license plate number, make, model, year, and color.
- \_\_\_\_\_ Identify the driver(s) and owner(s), to include the name, age, addresses (home and work), and telephone numbers.
- \_\_\_\_\_ For military members indicate their military status at the time of the accident (e.g., active duty, TAD, leave, liberty, etc.), their grade/rank, and the name, address, location and Unit Identification Code (UIC) of their unit.
- \_\_\_\_\_ If an individual died or is incapacitated as a result of the accident, provide similar identifying information for the next-of-kin or legal representative.
- \_\_\_\_\_ If a Government vehicle was involved, identify the unit to which the vehicle was assigned, and the individual at the unit who authorized use of the vehicle, and its authorized purpose.
- \_\_\_\_\_ Private vehicle involved: name, address, policy numbers, and telephone numbers of the insurer of the vehicle, including the amount and type of insurance carried.
- \_\_\_\_\_ Time of the accident.
  - \_\_\_\_\_ Light and weather conditions.
  - \_\_\_\_\_ Effect on driving conditions.
- \_\_\_\_\_ Location of accident (e.g., highway number, direction of travel, milepost number, street name, intersection).
  - \_\_\_\_\_ Road and terrain factors, road characteristics.
  - \_\_\_\_\_ Any obstructions to the driver's vision.
- \_\_\_\_\_ Speed of the vehicles involved as evidenced by testimony of witnesses, skid marks, condition of road, and the damage to the vehicles.
- \_\_\_\_\_ Actions of other vehicles involved in the accident, including any part played by them in creating the conditions that resulted in the accident.
- \_\_\_\_\_ Traffic conditions at the scene and their effect on the accident.
- \_\_\_\_\_ Traffic laws and regulations in force pertinent to the accident, including traffic safety devices, signs, and markings (e.g., school zone, no passing zone, railroad crossing, reduced speed limit).

- \_\_\_\_\_ Any regulations to use safety devices installed in the vehicles (e.g., seat belts, child carriers).
- \_\_\_\_\_ Copies of statutes, ordinances, or regulations should be made an enclosure.
- \_\_\_\_\_ Mechanical condition of the vehicles involved.
- \_\_\_\_\_ If a mechanical defect or condition (e.g., faulty or worn brakes/tires), is determined to have contributed to the accident, include the relevant maintenance history of the vehicle.
- \_\_\_\_\_ Physical condition of the driver(s), including intoxication, fatigue, use of medications or drugs, or other medical conditions, number of hours of sleep prior to the accident, number of hours worked.
- \_\_\_\_\_ The amount of alcohol consumed, results of any blood alcohol or other test for intoxication.
- \_\_\_\_\_ Any medications or drugs taken prior to the accident.
- \_\_\_\_\_ Any unusual stress or abnormal condition that might have affected the driver's alertness.
- \_\_\_\_\_ The opinion section should address any reasonable inferences that may be drawn from these facts relevant to the cause of the accident.
- \_\_\_\_\_ Driving experience of the driver(s) both generally and in the type of vehicles being driven, to include the state which licensed the driver.
- \_\_\_\_\_ Any previous loss of driving privileges and driving-related convictions.
- \_\_\_\_\_ Safety devices installed and whether they were being used at the time of the accident.
- \_\_\_\_\_ Conduct of passenger(s). Opinions may include reasonable inferences on the effect of any passenger's conduct on the driver(s).
- \_\_\_\_\_ Facts and opinions relevant to knowledge by any passenger of any impairment of the driver at the time the passenger entered or had a reasonable opportunity to leave the vehicle.
- \_\_\_\_\_ Damage to vehicle fully described (including photos, if available) and repair costs.
- \_\_\_\_\_ Damage to other property (including photos, if available) and repair costs.
- \_\_\_\_\_ Nature and extent of personal injuries and medical cost, documented by relevant medical records, bills, and receipts.

- \_\_\_\_\_ If death resulted, indicate cause of death to include a copy of the death certificate and any autopsy reports as enclosures.
  
- \_\_\_\_\_ Name, age, address, and telephone number of any witnesses to the accident.
  - \_\_\_\_\_ A description of their (witnesses) location in relation to the accident scene, their ability to observe from that location, and what they saw.
  
- \_\_\_\_\_ Name, address, and telephone number of any law enforcement official who investigated the accident.
  - \_\_\_\_\_ Copy of any law enforcement or police report made concerning the accident should be included as an enclosure and the custodian of the original report should be indicated.
  
- \_\_\_\_\_ Any civilian or military criminal charges brought as a result of the accident and the ultimate resolution of those charges.
  
- \_\_\_\_\_ An opinion regarding the probable cause of the accident. If the evidence is insufficient to establish probable cause, those factors which in the opinion of the investigating officer contributed to the accident should be listed.
  
- \_\_\_\_\_ An opinion regarding the contributory or comparative negligence of any party, if any.
  
- \_\_\_\_\_ If not included in the facts relevant to military or criminal charges filed, an opinion concerning any laws, articles of the UCMJ, or regulations violated.
  
- \_\_\_\_\_ Whether or not the vehicles are economically repairable, and if not, their salvage value.
  
- \_\_\_\_\_ Whether or not the driver (in case of Government vehicle) was acting within the scope of employment pursuant to state law, and whether injuries sustained by military members were incurred in the line of duty or as result of misconduct.
  
- \_\_\_\_\_ Whether or not disciplinary action should be taken and a specific recommendation on forum.
  
- \_\_\_\_\_ If Government property has been damaged, a recommendation as to the disposition of the property.
  
- \_\_\_\_\_ Should the Government initiate a claim?
  
- \_\_\_\_\_ Pertinent recommendations on matters of safety procedures.

**NOTE: Motor vehicle accidents involving Government vehicles almost always involve the potential for claims for or against the Government. In such cases, refer to the "Claims" Checklist in this handbook and include all the facts and opinions required.**

**EXPLOSIONS CHECKLIST**  
(JAGMAN A-2-t)

- \_\_\_ Date, time, and location of the explosion by compartment name and number.
- \_\_\_ Type of explosion.
- \_\_\_ Kind and quantity of the materials, gases, etc., that were involved.
- \_\_\_ Measurable time intervals, if any, between explosions.
- \_\_\_ Existence of barricades and protective gear and the effect of the explosion on them.
- \_\_\_ Existence of any natural obstructions such as a hill, forest, or other object intervening between the site of the explosion and the areas affected.
- \_\_\_ Description of any loss or damaged to Government and private property.
- \_\_\_ Estimated dollar amount needed to replace or repair the loss or damage to property.
- \_\_\_ Range and extent of damage as indicated by maps or photographs showing:
  - \_\_\_ Radius of complete destruction;
  - \_\_\_ Radius of structural damage beyond economical;
  - \_\_\_ Radius of repairable structural damage;
  - \_\_\_ Radius of general glass breakage;
  - \_\_\_ Distances that significant missiles were projected, including kind and weight;
  - \_\_\_ Distance between locations, if explosions occurred at more than one location; and
  - \_\_\_ Distance between ships and other vessels or structures affected and distances to nearby ships or structures not affected.
- \_\_\_ Approximate shape and dimensions of crater, if any, including depth and kind.
- \_\_\_ Weather and atmospheric conditions and their effect on shock waves.
- \_\_\_ Personnel involved and the extent of the involvement.
- \_\_\_ Personnel qualifications in terms of the PQS system or other required safety qualifications.



- \_\_\_\_\_ The level of training of the personnel involved and whether the level of training met required standards.
- \_\_\_\_\_ Identity of personnel injured or killed (with full descriptions of injuries supported by medical records and autopsy reports).
- \_\_\_\_\_ Description of the safety precautions or operating procedures that were in effect at the time of the explosion and whether they were observed or violated.
- \_\_\_\_\_ Opinions on the probable cause(s) of the explosion.
- \_\_\_\_\_ An environmental assessment of the damage caused by the explosion may be necessary, particularly if there is evidence of chemical contamination of the surrounding area. Consult the cognizant trial service office or staff judge advocate.

**SHIP STRANDING CHECKLIST**  
(JAGMAN A-2-p)

**NOTE: THE STRANDING OF A NAVY SHIP COULD CONSTITUTE A MAJOR INCIDENT. A COURT OF INQUIRY WILL NORMALLY BE CONVENED UNLESS A PRELIMINARY INQUIRY INDICATES THAT A COMMAND INVESTIGATION WILL BE SUFFICIENT. THESE INCIDENTS MAY ALSO INVOLVE ASPECTS OF ADMIRALTY LAW AND THEREFORE SHOULD BE CONDUCTED IN COOPERATION WITH OJAG CODE 11 AND THE COGNIZANT JUDGE ADVOCATE.**

- \_\_\_ Tactical situation.
- \_\_\_ Pertinent logs, charts, orders, regulations.
- \_\_\_ Condition of the sea and weather.
  - \_\_\_ Light conditions, visibility.
  - \_\_\_ Rate and direction of the tidal stream.
  - \_\_\_ Time of tide.
  - \_\_\_ Any other factors involving natural elements.
- \_\_\_ Navigational factors.
  - \_\_\_ Sailing directions/coast pilot.
  - \_\_\_ Fleet guide.
  - \_\_\_ Track laid out/DR plot indicated/fixes plotted/track projected.
  - \_\_\_ Notices to mariners.
  - \_\_\_ Compass errors/application.
  - \_\_\_ Depth of water and type of bottom.
  - \_\_\_ Navigation reference points coordinated (radar/visual, points logged/plotting teams coordinated).

- \_\_\_ Material factors.
  - \_\_\_ Radar, fathometer, compasses, ship's depth indicators, ship's speed log.
  - \_\_\_ Alidades, bearing circles, peroruses, periscopes, bearing repeaters.
  - \_\_\_ Ship's draft/submerged keel depth
  - \_\_\_ Ship's anchor.
  - \_\_\_ Ship's control system.
- \_\_\_ Navigation fix errors and navigation reset errors.
- \_\_\_ Ship's course and speed.
- \_\_\_ Mechanical or electronic deficiency or failure of the ship.
- \_\_\_ Ascertain the cause and responsibility for the stranding and resulting damage.
  - \_\_\_ Was the proper chart provided by the Department of the Navy used?
  - \_\_\_ Was the position of the ship at the last favorable opportunity to avoid the casualty accurately determined?
  - \_\_\_ If not, when was it last accurately ascertained?
- \_\_\_ Steps take during the time land was in sight to correct the ship's course and speed.
- \_\_\_ Personnel factors (posted/qualified): **CDO, OOD**, diving officer, navigator, piloting officer, fathometer operator, lookouts, helmsman, planes man, bearing takers, CIC team, leadsman, line handlers, local pilot.
  - \_\_\_ Location of conning officer.
  - \_\_\_ Personnel qualified in accordance with PQS requirements for the systems operation and maintenance.
- \_\_\_ Communications factors: Radio, telephone, IC systems, oral (audibility/understanding).
- \_\_\_ Assistance factors:
  - \_\_\_ pilot - experience/language barrier; and

- tugs, line handlers.
- Organizational factors.
  - Ship organization directives.
  - Watch organization directives.
  - Training and qualification
- Action taken after grounding: Ship secured to prevent further damage (anchors kedged out, ballast shifted, cargo shifted).
  - Draft reading/soundings taken.
  - Damaged surveyed.
  - Excess machinery secured.

**COLLISION CHECKLIST**  
(JAGMAN A-2-q)

**NOTE: ALL VESSEL COLLISIONS AND ALLISIONS, A VESSEL AND FIXED OBJECT, ARE ADMINARLTY INCIDENTS. CONSULT JAGMAN CHAPTER XII AND OJAG (CODE 11) FOR REQUIRED INVESTIGATIONS AND GUIDANCE.**

- \_\_\_ Tactical situation existing at the time of the collision.
- \_\_\_ Personnel manning and qualifications:
  - \_\_\_ CDO, OOD, diving officer, helmsman, lookouts;
  - \_\_\_ CIC team (sonar team, fire control tracking party and navigation team); and
  - \_\_\_ phone talkers.
- \_\_\_ Location of conning officer.
- \_\_\_ Location of commanding officer.
- \_\_\_ Material factors:
  - \_\_\_ Radar, sonar, navigational lights, periscopes, compasses, ship control systems;
  - \_\_\_ ballast, blow and vent systems; and
  - \_\_\_ UNREP special equipment.
- \_\_\_ Communication factors.
  - \_\_\_ Radio, telephone, oral, signal systems.
  - \_\_\_ Interferences (e.g., background noise level).
- \_\_\_ Rules-of-the-road factors.
  - \_\_\_ Operating area factors.
  - \_\_\_ Adherence to op area boundaries.
  - \_\_\_ Existence of safety lanes.
  - \_\_\_ Depth constraints (depth separation, depth changes, out-of-layer operations).

\_\_\_\_\_ Weather, visibility, and other environmental factors.

\_\_\_\_\_ Assistance factors:

\_\_\_\_\_ pilot - experience/language barrier; and

\_\_\_\_\_ tugs, line handlers.

\_\_\_\_\_ Aides to navigation.

\_\_\_\_\_ Use and accuracy of charges;

\_\_\_\_\_ sailing directions/coast pilot;

\_\_\_\_\_ fleet guide;

\_\_\_\_\_ tide and current conditions as calculated and as experienced;

\_\_\_\_\_ maintenance of required navigational standards;

\_\_\_\_\_ notices to mariners;

\_\_\_\_\_ radar and visual points designated and logged; and

\_\_\_\_\_ navigation team properly briefed.

**ACCIDENTAL OR INTENTIONAL FLOODING OF A SHIP CHECKLIST**  
(JAGMAN A-2-r)

- \_\_\_ Is flooding "significant" enough to document?
- \_\_\_ Location of flooding (compartment noun name and number).
- \_\_\_ Date and time of flooding.
- \_\_\_ Type of flooding (e.g., fresh or salt water, oil, JP-5, etc.).
- \_\_\_ Source of flooding (internal or external).
  - \_\_\_ Pipe rupture or valve failure.
  - \_\_\_ Tank rupture/hull rupture/shaft seal failure.
  - \_\_\_ Open to sea through designed hull penetration.
  - \_\_\_ Other.
- \_\_\_ Flooding detection method.
  - \_\_\_ Time duty emergency party called away, general quarters sounded.
  - \_\_\_ Response time.
- \_\_\_ Dewatering equipment used (effective, available, operative).
- \_\_\_ Time flooding was stopped or brought under control.
- \_\_\_ Time required to dewater.
- \_\_\_ Time space was last inspected prior to flooding.
- \_\_\_ Compartments flooded and rate of flooding.
- \_\_\_ Amount of flooding (effect on list, trim or depth control).
  - \_\_\_ Draft forward and aft and list of ship before and after damage.
  - \_\_\_ General distribution and amount of variable weights before damage.

- \_\_\_\_\_ Extent of damage (list all items).
- \_\_\_\_\_ Include photographs or documents to document range and extent.
- \_\_\_\_\_ Summary of steps taken to control damage and to correct list, trim or depth.
- \_\_\_\_\_ Injured incurred by personnel.
- \_\_\_\_\_ Ship's location at time of flooding.
- \_\_\_\_\_ Ship's condition of readiness.
- \_\_\_\_\_ Effect of flooding on ship's ability to carry out mission.
- \_\_\_\_\_ Estimated dollar amount of damage or repairs required.
- \_\_\_\_\_ Opinion on the probable cause of the flooding, including the cause of progressive flooding of other compartments.
- \_\_\_\_\_ Opinion on whether the occurrence of a similar type of flooding is possible on a similar ship.



**FIRES CHECKLIST**  
(JAGMAN A-2-s)

**NOTE: IF THE INVESTIGATED MISHAP IS A FIRE OF UNKNOWN ORIGIN AFFECTING DON PERSONNEL OR PROPERTY UNDER NAVY/MARINE CORPS CONTROL, ANY INVESTIGATION SHALL BE COORDINATED WITH NCIS.**

\_\_\_ Is fire "significant" enough to document?

\_\_\_ Date, time and location of fire, (compartment noun name and number).

\_\_\_ Class of fire (A, B, C, D).

\_\_\_ Time fire detected.

\_\_\_ Means of detection.

\_\_\_ Time fire started.

\_\_\_ Time fire reported.

\_\_\_ Time fire alarm sounded.

\_\_\_ Time fire located.

\_\_\_ Time started fighting fire.

\_\_\_ Time general quarters sounded or fire party called away.

\_\_\_ Time assistance was requested.

\_\_\_ Time assistance arrived.

\_\_\_ Time boundaries set.

\_\_\_ Time fire extinguished.

\_\_\_ Time reflash watch set.

\_\_\_ Fire did/did not reflash.

\_\_\_ Extinguishing agents used (indicate effectiveness).

\_\_\_ Fire main water (submarines: trim/drain system water).

\_\_\_ Light water, foam (portable/installed), CO2 (portable/installed), PKP, Steam

smothering, flooding, other.

\_\_\_ Extinguishing equipment (indicate availability and operability).

\_\_\_ Pumps (portable/installed) size and quantity.

\_\_\_ Nozzles/applicators (LC and HC).

\_\_\_ Foam maker, vehicles, educators, type and size of hoses, other.

\_\_\_ Firefighting organization used.

\_\_\_ Nucleus fire party.

\_\_\_ Repair party (condition I or II watches).

\_\_\_ In-port fire party.

\_\_\_ Outside assistance (explain).

\_\_\_ Fire party/repair locker personnel assigned per appropriate publications, ships organization and regulations manual, battle bill, etc.

\_\_\_ Number of personnel responding and their level of fire-fighting and damage control training.

\_\_\_ Personnel duties and responsibilities. Assigned in writing?

\_\_\_ Fire/repair locker organization charts properly maintained?

\_\_\_ Damage control system diagrams up to date and available for use?

\_\_\_ System of communications. Communications effectively established between control stations?

\_\_\_ Protective equipment used (indicate details and assessments of availability, operability, and effectiveness).

\_\_\_ OBAs, EAB masks, fire suits, boots, gloves, helmets, other.

\_\_\_ Alarm system.

\_\_\_ CO2 flooding, high temperature, other.

- \_\_\_ How it spread.
  - \_\_\_ Through hot deck/bulkhead.
  - \_\_\_ Through hole in deck/bulkhead.
  - \_\_\_ By explosion (type).
  - \_\_\_ Through vent ducts.
  - \_\_\_ By liquid flow.
  - \_\_\_ By wind.
- \_\_\_ Electric power in area.
- \_\_\_ Jettison bill (current, used).
- \_\_\_ If ship underway, course changes (snorkeling, surfaced).
- \_\_\_ Automatic vent closures.
- \_\_\_ Magazines flooded.
- \_\_\_ Operational problems.
  - \_\_\_ OBAs/canisters effective, sufficient number.
  - \_\_\_ EABs effective.
  - \_\_\_ Sufficient water and pressure.
  - \_\_\_ Flooding problems.
  - \_\_\_ Drainage problems (installed/portable).
  - \_\_\_ Lighting (explain).
  - \_\_\_ Adequate equipment readily available.
  - \_\_\_ Adequate intra-ship communications.
  - \_\_\_ Other (explain).

- \_\_\_ Material discrepancies of any equipment used.
- \_\_\_ Determine all heat/ignition sources possible then eliminate those that are improbable.
- \_\_\_ Operating personnel qualified in accordance with PQS requirements for the systems operation and maintenance.
- \_\_\_ Identity of personnel that were injured or killed (with full description of injuries, medical records, autopsy reports).
- \_\_\_ Description of physical effects of the fire.
  - \_\_\_ Include photographs or diagrams to document range and extent of damage.
- \_\_\_ Date of last inspection of involved spaces with any noted discrepancies.
- \_\_\_ Ship's location at time of fire.
- \_\_\_ Ship's condition of readiness.
- \_\_\_ Effect on ship's ability to carry out its mission.
- \_\_\_ Estimated dollar amount of damage or repairs required.
- \_\_\_ Overall assessment of effectiveness of fire/repair locker organization and leadership.
- \_\_\_ Opinion on the cause of fire and the factors that contributed to the spread of the fire.
- \_\_\_ Opinion on whether the occurrence of a similar type of fire is possible on a similar ship.

**LOSS OR EXCESS OF GOVERNMENT FUNDS OR PROPERTY CHECKLIST**  
(JAGMAN A-2-v)

**NOTE ON LOSS OF FUNDS: CHAPTER 6, DEPARTMENT OF DEFENSE FINANCIAL MANAGEMENT REGULATION (DOD 7000.14-R), VOLUME 5, "DISBURSING POLICY AND PROCEDURES," PROVIDES SPECIFIC PROCEDURES, FINDINGS AND RECOMMENDATIONS FOR INVESTIGATION OF MAJOR LOSSES OF FUNDS DUE TO PHYSICAL LOSS, OR ILLEGAL, INCORRECT, OR IMPROPER PAYMENT. COMMAND INVESTIGATIONS APPOINTED UNDER THE JAGMAN ARE USED IN THE CASE OF MAJOR LOSSES OF FUNDS, DEFINED AS THOSE LOSSES OF \$750.00 OR MORE OR ANY PHYSICAL LOSS WHERE THERE IS EVIDENCE OF FRAUD WITHIN THE ACCOUNTING FUNCTION, REGARDLESS OF THE DOLLAR AMOUNT.**

**NOTE ON LOSS OF PROPERTY: FOR LOSSES OF GOVERNMENT PROPERTY, THE COMMAND MAY USE A SURVEY PROCEDURE UNDER APPLICABLE NAVY OR MARINE CORPS REGULATIONS IN LIEU OF A JAGMAN INVESTIGATION. THE FINANCIAL LIABILITY INVESTIGATION OF PROPERTY LOSS (DD FORM 200) MEETS THE INVESTIGATIVE REQUIREMENTS IN MOST SITUATIONS.**

- \_\_\_ Any accountable individual must receive the special notice in JAGMAN A-2-v(e).
- \_\_\_ What items were lost or found in excess and the exact dollar value of the loss or excess, e.g., property, vouchers, cash, and so forth.
- \_\_\_ The nature of the loss or excess (inventory gain or loss, cash shortage, or overage, etc.).
- \_\_\_ In cases of loss of funds, whether the loss was
  - \_\_\_ loss of proceeds of sale of Government property; or
  - \_\_\_ physical loss of funds (e.g, embezzlement or fraudulent acts of subordinate finance personnel); or
  - \_\_\_ result of illegal or improper payment (e.g., payments on forged checks or vouchers).
- \_\_\_ How the loss or excess is being carried in the command's accounts.
- \_\_\_ Identity and position of the accountable officer.
  - \_\_\_ Identity and position of any other person who had custody of the funds or property.
  - \_\_\_ The general reputation of the accountable individuals for honesty and care in the handling and safeguarding of funds or property entrusted to them.

- \_\_\_\_\_ The experience and training of the accountable individual in the handling of funds or property.
- \_\_\_\_\_ The workload, including collateral duties, of the accountable individual at the time of the irregularity.
- \_\_\_\_\_ A description, with diagrams where appropriate, of the physical working conditions of the accountable individual who incurred the loss or excess.
  - \_\_\_\_\_ Physical security arrangements and devices.
  - \_\_\_\_\_ Security containers and persons with access to them and whether they were being used properly at the time of the irregularity.
- \_\_\_\_\_ Internal control procedures in effect in the division, department, or office where the irregularity occurred, and a statement whether they were being applied properly at the time of the irregularity.
  - \_\_\_\_\_ Information on recent inspections, assist visits, management control reviews, or other evaluations of procedures.
- \_\_\_\_\_ Identification of the regulations pertinent to the handling of the property or funds involved and were such regulations followed?
- \_\_\_\_\_ A description of remedial measures taken to prevent recurrence of the irregularity.
- \_\_\_\_\_ Opinion as to cause of irregularity, or if cause cannot be determined, most likely cause.
- \_\_\_\_\_ An opinion whether the loss or excess was proximately caused by the fault or negligence of any accountable individual or by an act of a non-accountable individual that can be the basis for financial liability under Section 0607, Chapter 6, DOD 7000.14-R .

**CLAIMS FOR OR AGAINST THE GOVERNMENT CHECKLIST**  
(JAGMAN A-2-m)

**NOTE: CA'S SHOULD CONSULT WITH A JUDGE ADVOCATE REGARDING THE TYPE OF INVESTIGATION TO CONVEENE IN ANY CASE IN WHICH THERE IS POSSIBILITY OF A CLAIM FOR OR AGAINST THE GOVERNMENT.**

\_\_\_\_\_ The identity of individuals involved, including name, rank/grade, unit, age, address (home and work), telephone number, occupation.

\_\_\_\_\_ How they were involved?

\_\_\_\_\_ Killed as a result of the incident (identifying information for the next-of-kin or legal representative must be provided).

\_\_\_\_\_ Injured party.

\_\_\_\_\_ Owner of property damaged.

\_\_\_\_\_ Military member whose acts or omissions are alleged to have caused the harm.

\_\_\_\_\_ Witness.

\_\_\_\_\_ Information on how those involved may be located.

\_\_\_\_\_ Permanent address that will be accurate for at least 5 years after the accident.

\_\_\_\_\_ Indicate each individual's status.

\_\_\_\_\_ Military: Regular or Reserve, on active duty, TAD, leave, liberty, etc., at the time of the incident.

\_\_\_\_\_ Civilians: Federal employee, personal services contractor employed by an independent contractor, etc.

\_\_\_\_\_ If maintenance or training is involved, identify the individual responsible for the maintenance or training issue.

\_\_\_\_\_ Date, time, and place of incident, including a full description of location, terrain, weather, light conditions, obstructions, and photographs of the site.

\_\_\_\_\_ Nature of the claim (e.g., wrongful death, personal injuries, property damage).

- \_\_\_\_\_ A factual description of how the individual(s) was injured,
  - \_\_\_\_\_ What equipment was being used.
  - \_\_\_\_\_ Who was operating the equipment.
  - \_\_\_\_\_ Who was supervising (or should have been supervising).
  - \_\_\_\_\_ Whether equipment failed or was operated incorrectly.
  - \_\_\_\_\_ If equipment failure, the maintenance history of the equipment.
- \_\_\_\_\_ If the injury occurred on Government property.
  - \_\_\_\_\_ The condition of the property.
  - \_\_\_\_\_ Who is responsible for the property's upkeep.
  - \_\_\_\_\_ Authority for the injured party to be present on Government property.
- \_\_\_\_\_ The nature and extent of personal injuries.
  - \_\_\_\_\_ Amount of medical, dental, and hospital expenses incurred, supported by itemized bills or receipts for payment.
- \_\_\_\_\_ Nature and extent of treatment.
  - \_\_\_\_\_ Number of days hospitalized.
  - \_\_\_\_\_ Name and address of all treating hospitals and medical facilities.
  - \_\_\_\_\_ Name(s) and addresses of all treating physicians or other care givers.
  - \_\_\_\_\_ Extent and nature of all follow-on or outpatient care.
  - \_\_\_\_\_ Prognosis.
  - \_\_\_\_\_ Degree of disability, if any (total, partial permanent, partial nonpermanent).
  - \_\_\_\_\_ Necessity for future treatment and estimated costs.



\_\_\_ Salary/earnings lost due to time lost from employment

\_\_\_ Actual number of work days lost.

\_\_\_ Estimated compensation for that period based on hourly wage or salary.

\_\_\_ Full time, part-time, or self-employed.

\_\_\_ Diminished earning capacity.

\_\_\_ If an individual died as a result of the incident under investigation and the estate or survivors may file a claim against the Government, consult with a judge advocate regarding the wrongful death or survival statute applicable in the jurisdiction where the harm occurred.

\_\_\_ If an individual died.

\_\_\_ Time of death relative to the injury.

\_\_\_ Intervening treatment and state of consciousness.

\_\_\_ Cause of death as established by autopsy.

\_\_\_ Pre-existing medical conditions.

\_\_\_ Age.

\_\_\_ Occupation.

\_\_\_ Burial expenses.

\_\_\_ Heirs.

\_\_\_ Amount of property damage.

\_\_\_ Include photographs before and after, if possible.

\_\_\_ Estimates or bills of repair and receipts.

\_\_\_ Whether any pre-existing damage existed.

\_\_\_ Original purchase price.

\_\_\_ Date of purchase.

- Salvage value of property.
- Government property damaged.
  - Estimates or bills of repair and receipts.
  - Original purchase price.
  - Date of purchase.
  - Salvage value of property.
  - If no damage, so state.
- Whether the claimant has insurance for this type of damage or injury.
  - Insurance company.
  - Policy number.
  - Policy provisions relevant to this claim or incident.
  - Extent of coverage and limits on liability.
  - Whether a claim has been or will be made against the insurance carrier, the status of any such claim.
- Names and addresses of other owners, if claimant is not the sole owner of the property.
- Existence of any police or other investigative report, name and addresses of investigating officer and unit, custodian of original investigation (provide a copy of any police report as an enclosure).
- Whether civilian or military criminal charges were filed.
  - Jurisdiction in which they were filed.
  - Status or final disposition of those charges.
- Existence of any law, regulation, or order relevant to the incident and whether it was violated.
  - If a stray animal was involved, whether the jurisdiction has an "open range" law (attach a copy as an enclosure).

- \_\_\_\_\_ An opinion whether any military personnel involved were acting in the scope of their employment at the time of the incident.
  
- \_\_\_\_\_ An opinion regarding the cause(s) of the incident. If the facts are insufficient to form an opinion regarding cause(s), indicate factors which significantly contributed to the incident.
  
- \_\_\_\_\_ An opinion regarding fault or negligence.
  
- \_\_\_\_\_ An opinion whether a claim is likely to be filed, the amount likely to be claimed, and names and addresses of any potential claimants and their legal representatives.
  
- \_\_\_\_\_ An opinion whether a claim should be filed by the Government for personal injuries to its employees or property damage.
  
- \_\_\_\_\_ Sonic boom/jet noise/artillery noise:
  - \_\_\_\_\_ Detailed description of the alleged damage;
  
  - \_\_\_\_\_ Photographs of the allegedly damaged building or structure involved, including significant details of construction, size of rooms, age, and general state of repair;
  
  - \_\_\_\_\_ Detailed examination and description of any alleged plaster damage;
  
  - \_\_\_\_\_ Existence or absence of glass damage in the allegedly damaged building or structure and whether any other glass damage resulting from the incident was reported and verified;
  
  - \_\_\_\_\_ Whether windows and doors were open or shut at the time of the boom;
  
  - \_\_\_\_\_ Whether any loose objects, such as dishes, glassware, or trinkets inside the building or structure were moved as the result of the boom;
  
  - \_\_\_\_\_ Existence or absence of similar damage to other buildings in the immediate neighborhood;
  
  - \_\_\_\_\_ Type of surrounding community development, type of construction, and density of buildings or structures in the immediate area, and so forth;
  
  - \_\_\_\_\_ Occurrence or absence of seismic disturbances registered in the locality at the time involved;
  
  - \_\_\_\_\_ Other potential sources of damage, such as heavy truck or rail traffic, explosions or earthquakes, and their distance and direction in relation to claimant's building or structure;

- \_\_\_\_\_ Any unusual weather or climatic conditions that may have affected the building or structure:
  
- \_\_\_\_\_ Complete physical description of the aircraft alleged to have caused the damage, including markings, whether jet or propeller driven, and any other distinctive characteristics;
  
- \_\_\_\_\_ Full description of the approximate altitude, maneuvers, speed, direction of flight, time of day, date, formation, and number of aircraft;
  
- \_\_\_\_\_ Any complaints of noise or sonic booms received by any duty office which coincides with the alleged damage; and
  
- \_\_\_\_\_ Authorization, description of flight, aircraft involved, applicable charts, and air controller transcripts or audiotapes of aircraft in the vicinity of the alleged damage.

**HEALTH CARE INCIDENTS CHECKLIST**  
(JAGMAN A-2-x)

**NOTE: INVESTIGATIONS UNDER JAGMAN A-2-x ARE SEPARATE FROM ANY QUALITY ASSURANCE INVESTIGATION CONDUCTED BY THE STAFF OF A MILITARY TREATMENT FACILITY SOLELY FOR QUALITY ASSURANCE PURPOSES.**

- \_\_\_ Comprehensive chronology and description of all relevant facts.
- \_\_\_ Identification of all involved health care providers, including:
  - \_\_\_ Credentials (education, training, and experience).
  - \_\_\_ Status (trainee or staff; Government employee or contractor).
  - \_\_\_ Role (attending, consulting, supervision).
- \_\_\_ Full identification of the staff physician responsible for the patient's care at the time of the incident.
- \_\_\_ If maintenance of equipment or training of personnel is involved, identify the individual(s) responsible for the maintenance or training at issue.
- \_\_\_ Patient information.
  - \_\_\_ Name, date of birth, age, sex, address, phone number, marital status, dependents, occupation.
  - \_\_\_ Medical history.
  - \_\_\_ Condition immediately prior to incident.
  - \_\_\_ Current condition.
- \_\_\_ Nature and extent of injuries alleged to have occurred.
  - \_\_\_ Additional treatment required.
  - \_\_\_ Prognosis.
  - \_\_\_ Degree of disability.

- \_\_\_\_\_ Loss of chance of recovery.
- \_\_\_\_\_ Names and addresses of subsequent treating physicians or health care providers.
- \_\_\_\_\_ A copy of the claim and any other documents or correspondence which shed light on the claimant's or potential claimant's contentions concerning the matter.
- \_\_\_\_\_ Secure all of the medical records, inpatient, outpatient, and special studies (x-rays, tissue slides, EKG tapes, fetal monitoring strips, etc.).
  - \_\_\_\_\_ Indicate the date and person who secured those items and the current location and custodian of each.
- \_\_\_\_\_ Complete copy of the medical record. Entries must be reviewed to ensure handwriting is legible and, if illegible, typed transcripts should be attached to the investigation.
- \_\_\_\_\_ All special studies must be retrospectively reviewed to assess whether the original interpretations were accurate.
  - \_\_\_\_\_ Retrospective reviews must be structured as "blind" reviews, e.g., the reviewer should not be aware of the previous interpretation.
  - \_\_\_\_\_ A summary containing the name and credentials of the person conducting the retrospective review and that person's findings must be included with the investigation. The summary should not be signed by the reviewer.
- \_\_\_\_\_ Copies of all relevant documents.
  - \_\_\_\_\_ MTF staff bylaws.
  - \_\_\_\_\_ MTF policies, procedures, and protocols (clinical/surgical, nursing, and ancillary services such as the laboratory or pharmacy, and health care administrative policies) in effect at the time of the incident.
  - \_\_\_\_\_ All relevant logbook entries pertaining to the patient maintained by labs/clinics/offices (e.g., emergency room logs reflecting arrival/departure times, ambulance log book/trip sheets/rescue service reports, and centralized appointment registers/printouts or pharmacy history printouts.
  - \_\_\_\_\_ All patient information pamphlets, brochures, or sheets which were provided to the patient.
  - \_\_\_\_\_ In cases involving contract providers, a copy of the contract.

- \_\_\_\_\_ In cases involving possible equipment/device failure.
  - \_\_\_\_\_ Photographs of equipment/devices taken before the equipment/device is moved, used again, altered, tested, or repaired. Photographs must be annotated to reflect the time, date and identity of the person who took the photograph.
  - \_\_\_\_\_ The date, location, and names of the persons involved in the evaluation of the equipment/device and the findings thereof. Equipment/devices must be removed from service and secured until examined by appropriate technical representatives. Equipment/devices must not be used, altered, tested, or repaired until properly evaluated.
  - \_\_\_\_\_ Copies of maintenance reports and any protocols.
- \_\_\_\_\_ Review of the staffing levels (physician, nursing, corpsman, and ancillary) at the time of the incident.
  - \_\_\_\_\_ "Currency" of members to perform their duties at the time of the incident.
  - \_\_\_\_\_ "Orientation" to perform the duties assigned at the time of the incident.
- \_\_\_\_\_ The standard of care for any practices, procedures, policies, protocols, or systems involved in the incident and the basis which establishes that standard of care (provide a copy of relevant medical literature, text, treatises, articles, policy, practices, or procedures).
  - \_\_\_\_\_ This refers to clinical/surgical procedures, nursing procedures, ancillary services such as the medical laboratory or pharmacy procedures, and health care administrative policies. The source and date of documents relevant to the standard of care must be provided.
- \_\_\_\_\_ Summaries of expert reviews of the care documented by the investigation.
  - \_\_\_\_\_ Identify the reviewer and the reviewer's credentials.
  - \_\_\_\_\_ Evaluation (e.g., expert opinion) describing the duty that was owed the patient (standard of care).
  - \_\_\_\_\_ Manner in which the duty was either met or not met.
  - \_\_\_\_\_ In instances where the duty was not met, an opinion on whether the act or omission resulted in harm to the patient and, if so, a description of the harm, including an explanation of how the harm may affect the patient in the future.

- \_\_\_\_\_ Where there has been a deviation from the standard of care, an opinion regarding the cause(s) or contributing factors for any deviation from the standard, the name(s) of persons responsible for the deviation, and a description of corrective action, if required, in terms of personnel, equipment, or policy.
  
- \_\_\_\_\_ Each provider whose actions are at issue must be provided an opportunity to make a statement for inclusion in the investigation. The IO should summarize the results of the interview using care to be as accurate and complete as possible. Summaries of interviews with providers shall not be signed, instead authenticated by the IO's signature.



**FIREARM ACCIDENT CHECKLIST**  
(JAGMAN A-2-y)

**NOTE: IF AN INCIDENT INVOLVES ACCIDENTAL OR APPARENTLY SELF-INFLICTED GUNSHOT WOUNDS, A CI IS REQUIRED.**

- \_\_\_\_\_ Date, time of day, and names and addresses of witnesses present.
- \_\_\_\_\_ Description of physical location of incident and light and weather conditions.
- \_\_\_\_\_ Description of the firearm.
  - \_\_\_\_\_ Mechanical condition.
  - \_\_\_\_\_ Safety mechanisms.
  - \_\_\_\_\_ Whether the safety mechanisms were used by the firearm handler.
- \_\_\_\_\_ Authorization for possession of the firearm.
  - \_\_\_\_\_ How, when, and where it was obtained.
- \_\_\_\_\_ Description of firearm handler's formal training, experience, and familiarity with the firearm's condition, safety procedures, and proper use.
- \_\_\_\_\_ Discussion of any psychological problems, mental impairment due to drug or alcohol use, and mental responsibility of the firearm handler.

**POLLUTION INCIDENTS CHECKLIST**  
(JAGMAN A-2-z)

**NOTE: REFERENCE SHOULD BE MADE TO OPNAVINST 5090.1C CH-1 FOR ADDITIONAL FACT-FINDING AND REPORTING REQUIREMENTS. ADDITIONALLY, THIS MAY REQUIRE USE OF A LITREP AND/OR BE TREATED AS AN ADMIRALTY INCIDENT. CONSULT A JUDGE ADVOCATE.**

- \_\_\_ Location and circumstances of the spill, including:
  - \_\_\_ Weather and conditions at the site (visibility, darkness, presence/phase of the moon).
  - \_\_\_ How, when, and by whom the spill was detected.
- \_\_\_ Description of the activity occurring when the spill occurred (e.g., shifting fuel, taking on fuel, pumping bilges).
- \_\_\_ Type of material (e.g., fuel, oil, other hazardous material).
- \_\_\_ Estimated quantity of material spilled and the basis for the estimate.
- \_\_\_ Source of the spill, (e.g., tank, drum, or valve).
- \_\_\_ Identity of personnel involved, including:
  - \_\_\_ Name, rank/grade, unit, address (home and work).
  - \_\_\_ Training and experience for task.
  - \_\_\_ Who was (or should have been) providing supervision.
- \_\_\_ Whether required reports were made (e.g., reports required by OPNAVINST 5090.1 series, reports to the National Response Center, reports required by state and local law, reports to the Navy operational chain-of-command).
- \_\_\_ Whether local SOPA and command instructions were complied with.
- \_\_\_ Description of cleanup.
  - \_\_\_ Membership of the quick response team and training.
  - \_\_\_ Response time.
  - \_\_\_ Actions taken.

- \_\_\_\_ Equipment used.
- \_\_\_\_ Effectiveness of equipment and personnel.
- \_\_\_\_ Availability and readiness of equipment and personnel.
- \_\_\_\_ Nature and extent of damages to Government and private property.
- \_\_\_\_ Personal injuries, if any, including name of injured parties and extent of injuries.
- \_\_\_\_ Relevant training documents (e.g., Personnel Qualification Standard (PQS) records), deck/watch logs, and engineering logs which support the facts.
- \_\_\_\_ An opinion regarding the cause of the spill.
  - \_\_\_\_ Faulty equipment, container, fitting, valve.
  - \_\_\_\_ Operator error/safety.
  - \_\_\_\_ Operational procedure error.

**AVIATION MISHAP JAGMAN LESSONS LEARNED:**  
**A Judge Advocate's observations and suggestions**

LCDR SEAN M. SULLIVAN, JAGC, USN

**Summary**

**Phase I: Preparation**

Make lists:

*Make lists of things to do, things needed and ideas*

The Education of the Team:

*Identify experience levels; provide them with electronic copies of the necessary references; routinely contact multiple Judge Advocates for advice, opinions and guidance. This knowledge base is invaluable and critical throughout the investigation; discuss and establish roles in the investigation from the get-go; make clear the role of a Judge Advocate on the team; review the appointment order to assure clarity on tasking.*

Logistical Coordination:

*Travel arrangements are time consuming and difficult; contact your liaisons prior to departure; arrange a location to work out of at the investigation destination.*

Medical Preparedness:

*Receive shots specifically required for the AOR (anthrax, etc).*

Gear:

*Issue specialized gear and uniforms.*

Administrative matters:

*Account for administrative time.*

Investigation Support:

*The following list of items we needed or used to accomplish the investigation:  
Electronic resource thumb drive, etc.*

Family Preps:

*Flexibility of family is important.*

**Phase II: Planning and Strategy**

JAGMAN Investigations Initial Planning/Strategy:

*Review what everyone knows about the incident and share; start with the big picture; the investigation has bigger implications.*

### Evidence

*Locating and collecting evidence is critical; consider significant changes in the status, location, position, etc to the evidence since the mishap*

### Witnesses

*It was with witnesses that my skill-set as a Judge Advocate paid dividends; after drawing up an exhaustive list of who to interview, speculate on what information that particular witness could provide; record all interviews; request an advance voluntary written statement; provide 31(b) rights advisements as a precaution; in the midst of an interview is no the time to try and figure out what to do if the unexpected comes up; at the beginning of each interview, recite what administrative actions were taken with each witness prior to starting the interview, e.g. that a Privacy Act statement was reviewed, signed, and that the witness had no questions and that they agreed to allow us to record the interviews or that a 31(b) advisement was provided and then we would review the waiver of rights and agreement to provide an electronic statement.*

### Style of Questioning:

*Consider style and manner for conducting interviews; let the witness talk through everything first; plan to conduct multiple interviews of each primary witness, and tell the witnesses such.*

### Classification

*Pay careful attention to the likelihood of classified material.*

### Time restraints

*Coordinate schedules early; establish expectations and to stick to it*

### CA Management

*Educate the Convening Authority; the continuous involvement with the JAGMAN team and the CA could create a questionable appearance of command influence in the investigation*

## **Phase III: Investigation in Progress**

### Strategy

*After each witness interview and each new piece of evidence and information, take time to discuss how that piece fits into and impacts theories on the mishap; another critical component is the amount of time spent together as a team; make the best of this difficult task, and have fun along the way. Good humor and jokes were always a good release from the herculean efforts and time we were all investing.*

### Evidence

*Innovate new means to capture what occurred; tap into existing resources and relationships.*

#### Witnesses

*Eyewitness testimony is critical; establish routines and practices to make interviews as efficient as possible and more important, as effective as possible; begin the interview with an open-ended question and take notes throughout; record every witness; be aware of specialized training for interrogation*

#### Take pictures

*TAKE PICTURES.*

#### Simulate/observe the event

*When possible, observe and simulate the event.*

#### Coordination with other investigations:

*Out of necessity and to avoid contamination of our investigation, work out a system of requesting specific information or documents; sign them out and then sign them in when you return them.*

#### Role Management

*Always be conscious of your status as a Judge Advocate; ask what could be considered “stupid questions”.*

### **Phase IV: Blame-storming**

*Conduct a comprehensive review of what you have, what you know, what you think didn't happen, what you think happened and what you could prove.*

#### Follow-up with evidence/witnesses

*Draw up a list of follow-up questions for the witnesses and of documentation that are still needed to support your theory on the mishap.*

#### Format review

*The format is a guide and not the law, if you need to innovate to report what you investigated, then so be it.*

### **Phase V: Drafting**

#### Drafting Strategy

*Timeliness, how much time do you have and do you need to complete the report; lay out schedules and coordinate times that you can all work together and times that you can work independently on the report.*

### Work Distribution

*Rather than assigning sections to be completed independently at the risk of losing cohesiveness and logical flow, assign work by schedules, not by particular sections of the report.*

### Findings of Fact:

*First outline a logical order of subsections of the report; rather than trying to assign the enclosure numbers to support each finding of fact during drafting, instead cite the enclosure by name, which allows for changes in the order of findings of fact in subsequent drafts; establish patterns of citation.*

### Enclosures

*Use a separate working document, which allows change to the order of enclosures easily, without impacting the format or order of the working document; numbering the enclosures was one of the very last things we did; consider how to handle the enclosures, is there potential classification of all or portions of the report; by having the separate enclosures, it gives the flexibility to classify the report or enclosures independent of one another*

### Opinions

*Writing the opinions was logical and easy; we drafted all of our opinions, and then went through each opinion identifying every Finding of Fact that supported the opinion; supporting the opinions was more labor intensive than any of us had anticipated.*

### Recommendations

*The IO's recommendations had the potential to change how the Navy, the community, the WING and the squadron did business.*

### Proof read and re-proof read

*By only having one working copy, we did not have to worry about the gremlins of grammar, style, etc that appear as later revisions merge into one document. However, by reading and re-reading the same 30+ page document over and over, we became desensitized to our mistakes.*

## **Other Observations/ Recommendations:**

### Timeliness

### Inter-investigation knowledge and involvement

### Location, Location, Location...

### Recommendations

## **Background**

In late OCT 2008, an aircraft conducting classified missions at a forward airfield crashed while landing with the squadron CO at the controls. All personnel survived with minor injuries; however the aircraft was destroyed by the crash and ensuing fire resulting in a loss in excess of \$93M. The plane came to rest in close enough proximity to the runway as to shut down field operations until it could be moved. The aircraft was moved 200 feet within hours of the crash and then moved again approximately a week later to begin salvage efforts. Crew members were returned to CONUS and maintainers and command personnel remained on location. Members of an Aviation Mishap Board (AMB) investigation were on scene within a week of the mishap to collect evidence, conduct interviews and to examine the wreckage first-hand to determine the cause of the mishap from a safety perspective. The AMB had first access to all evidence, witnesses and information, as well as the ability to examine the aircraft prior to salvage and recovery efforts. A JAGMAN team was not assembled/appointed until approximately 2 weeks after the incident and was not deployed for another two days after that. A great deal had to be coordinated and accomplished prior to our departure, and upon our return. Prior to departing overseas, we conducted preliminary interviews of the flight station personnel. The JAGMAN team had limited time on the ground in theater to conduct the investigation and then had to return CONUS to continue the investigation. While forward and on the ground we conducted more than a dozen interviews, met with multiple agencies and services and conducted a combat approach similar to the mishap aircraft's. Upon our return we re-interviewed the flight station, the entire air crew, the squadron command leadership, the WING Commodore, the training officer, medical personnel, the maintenance supervisors and personnel, and mission planning personnel. After spending approximately 560+ hours working on the investigation, the JAGMAN was complete on 19 DEC.

## **Phase I: Preparation**

Although I have assisted numerous JAGMAN investigations over the past 3 years, none of them necessitated such a short turn around from appointment to traveling overseas, nor had any of my prior investigations had as much attention in the media due to the location, the aircraft and the pilot at the controls. Some of my "lesson's learned" may seem common sense, e.g. making check lists, but when there is no single guidance or right way on where to begin to get ready to go and continuous information and tasks keep coming in, it does not seem so common. The NJS investigator's handbook was an exceptional tool, but I have worked to fill in some of the more finite detail.

## **Make lists**

First, *make lists of things to do, things needed and ideas* that come up as you prepare to depart and continuously update them. I kept separate lists on what I needed to accomplish, what I needed to travel, what we needed to support the JAGMAN, ongoing tasks from my SJA duties, a packing list, items for discussion with the team, etc, etc. The lists I made were invaluable with coordinating all of the different moving parts to getting the team overseas, and then especially



once overseas when the fatigue of not sleeping more than 3-4hrs a day and the effects of transiting 9 time zones set in. Write it down and check it off.

### **The Education of the Team**

*Identify experience levels* of your team members as soon as possible. Both of the other members of my team had little to no JAGMAN experience. They had reviewed “PIO reports” from squadron investigation officers on drug/UA cases, etc, but they had never taken part in something of this magnitude. The concept of a MISHAP JAGMAN was foreign to them. The good news was that being from the air community, they knew what an Aviation Mishap Board was, and were able to equate a JAGMAN on those terms, with the lack of privilege associated with that investigation and the additional authority to form opinions and recommendations on issues outside of just safety matters.

To aid in educating the team, as soon as possible I *provided them with electronic copies of the necessary references*, culling out only the applicable sections of Chapter II as a primer, and then also providing Chapter II in its entirety for later review; I also provided the applicable sections of the Investigator’s Handbook and copies of the applicable associated checklists. I redacted copies of actual JAGMAN investigations I had assisted with and provided those samples as well. I found that I did not have copies of a significant air mishap investigation, and so I was able to acquire some copies from other Judge Advocates of prior air mishaps; these were invaluable throughout the investigation as an easy guide to point to for the team on “how this is done”. I also found that my JAGMAN training power points were out of date, and thanks to the assistance of multiple Judge Advocates (and recent BLC grads) I was able to put together a collection of PPTs for me to train the team with. *I routinely contacted multiple Judge Advocates for advice, opinions and guidance. This knowledge base was invaluable and critical throughout the investigation.*

Hand-in-hand with educating the team on what a JAGMAN investigation entails, it was important that *we discussed and established our roles and responsibilities on the investigation team from the get-go*. Fortunately, I discussed the composition of the members of the team with the Convening Authority prior to appointment, so we could avoid any potential pitfalls of perception of unfairness, or the issues associated with appointing members from the squadron with the mishap. The CA initially wanted to appoint a technical expert (pilot) from the mishap squadron to assist the team due to the unique nature and environment of the squadron; however, I countered with advising that they appoint someone who had served recently with the squadron, but had no continuing interest in the squadron or who could by chance become part of the investigation. As we saw over the course of our investigation this proved to be a very good decision since all team members had no association with the squadron, as compared to the Aviation Mishap Board which was primarily made up of squadron officers; our results and findings were less scrutinized for possible nepotism.

The single greatest difficulty for me in the discussions of our roles was *making clear the role of a Judge Advocate on the team*. I found the natural assumption to be, “it is a JAG-MAN, and you are a ‘JAG’, therefore it is your investigation”. As with other investigations, I felt the assumption was that I would tell everyone what to do and how to do it, they would accomplish it,

and I would type up the report. This is not a criticism of the other members, but rather an indication of the need for more training and exposure of JAGMANs and the roles of those involved out in the fleet. It was important to remember, however, that I was not appointed as the investigator, but as a legal advisor, and that meant that I was not the one signing the report. Further, expecting me to type up the entire report and just to have the IO sign it was not practicable, because the appointed IO was selected as the investigator and would be the one to testify about the contents of the report, namely their findings, opinions and recommendations based on their experiences, etc. I indicated I was glad to share in the responsibilities with drafting, etc and I would be there every step of the way providing guidance and my opinions, but leaving the evidence and testimony with me, was not how things would get done properly.

Finally, as a team we *reviewed the appointment order to assure clarity on our tasking*. We talked through some ideas on where to find information to support our tasking, and how it related to our investigation. The important initial take-away was that although we had to address all the tasks of the appointing order, if we came across information outside our initial direction and we determined it to be germane to the investigation, we could include it. I stressed that it was always easier to remove irrelevant information later on than to have to go back and try and find relevant information.

### **Logistical Coordination**

*Travel arrangements were time consuming and difficult.* Luckily, I was assigned to a squadron that had extensive experience with getting sailors into and out of the remote locations we had to travel to. The only hindrance was that the command operates on DTS, whereas the RLSO did not. They had to create a DTS account for me and take ownership of my travel, etc. This worked smoothly both going to and returning from location. Of note, bring multiple copies of your orders. On any MAC flight, they will keep your original orders, so give them a copy, not the originals. [Most, if not all commands use DTS now]

*Contact your liaisons prior to departure.* Once travel arrangements were made, we neglected to bring contact numbers for our liaisons along the route, relying on the command's assurances that we would be met and accommodations had been set aside. Once we arrived overseas, there was no one there to meet us. Fortunately, our technical expert had done a detachment tour at one of our interim stops and he still had phone numbers for other commands at that location. We also were able to spot other Americans servicemembers at the airport, and were able to secure transportation and ad hoc accommodations through them. If we did not have the old phone numbers and if there would not have been easily identifiable American servicemembers (blue jeans, tennis shoes, high-and-tight haircuts), we would have had significant difficulties due to lack of language, currency and connectivity. Furthermore, we received inconsistent guidance on entry procedures through each country. I had been told to use my passport for entry and not to stop when processing through customs, even if the metal detectors go off, compared to the other members being told to use Military Identification or to use a copy of your orders and to stop. This inconsistency resulted in me having to pay for a VISA on location using my government credit card. We had no difficulties with customs.

Additionally, *arrange a location to work out of at the investigation destination*. We spent time on arrival on location and in CONUS finding a suitable location for interviews, evidence review, etc. We had to work to get phone and computer access, which were essential. We were fortunate enough to have an officer tasked to assist us on location who had an email account and a local cell phone. We were able to set up appointments and communications through him. Making photo copies proved near impossible.

### **Medical Preparedness**

Prior to my departure, I had to retrieve my medical record and receive *shots specifically required for the AOR* (anthrax, etc). I also had to get prescribed anti-malarial medication prior to departure. This was not something I had given any prior thought to but it required a great deal of time to accomplish.

### **Gear**

In order to travel to the FOB, I had to be issued *specialized gear and uniforms*. I was provided DCUs, boots, a flight suit, jacket, thermal gear, etc. I did not have any gear suitable for the location that I had to travel to. Unfortunately, there was not enough time to get JAG collar devises and name-tapes ordered and attached to my uniforms prior to departure. I was also offered a weapon, but I declined. From my understating there is a great deal of issues associated with having the weapon issued (travel, care, accountability, etc). Since I did not elect to take a weapon (none of the team did) I can't speak to the issues, but I do know that the AMB team elected weapons and indicated that it was VERY difficult and an unnecessary encumbrance.

### **Administrative matters**

*Account for administrative time*. In coordinating our departure, there was a great deal of administrative tasks that had to be done. I had to get orders, verify my security clearance, receive classified briefings, verify I had a passport, conduct ISOPREPS, and demonstrate proficiency with a sidearm.

### **Investigation Support**

In conducting the investigation, I composed the following list of items we needed or used to accomplish the investigation:

*Electronic resource thumb drive* with copies of the following:

JAGMAN

MCM

Sample Docs: witness summary, evidence summary

Privacy Act Statements

31(b)

Investigators Handbook

Sample JAGMANs

Quickman

*A clean thumb drive for data*

-A laptop that allowed thumb drives could have been useful

*Digital Camera*

*Digital Voice Recorder*—we recorded (with permission) all of our interviews.

This proved to be the most effective way to interview, especially cross referenced with notes.

*Hard copies of the following:*

Privacy Act (plus one for later photo copies)

Art 31(b) rights forms

Investigation Checklists—I maintained a master checklist and signed off on each item as we accomplished each task.

Appointment order

*Notebooks-Steno and pocket sized*

*Pens (multi colored)*

*Permanent Markers*

*Dry Erase Markers*

*Highlighters*

*Post-it notes*

*Blank Data CDs*

*Business Cards (with Local contact info)*

*\*A civilian email account*

- Overseas (unlike w/ NMCI) I was able to access my civilian account. I could have/should have sent myself documents, POCs, etc. It is also a good means for the command, family etc to reach you.

## **Family Preps**

Originally, I had 10 days of approved leave to take my family to Florida when I joined the investigation. Nonetheless, the *flexibility of my family was an important aspect to being able to assist in the investigation*. Due the nature of the investigation, the event and the location, there was limited information that I could pass to my family. Nonetheless, it was important to brief them on the significant amount of time that I was going to have to invest in the investigation, my travel arrangements and the unpredictability of communications, which provided more comfort than not.

## **Phase II Planning and Strategy**

Prior to initiating our investigation, we spent a few hours discussing how we wanted to proceed in our investigation, including theories of the mishap, our approach to information, evidence, possible witnesses, time restraints and how we wanted to handle the convening authority.

## **JAGMAN Investigations Initial Planning/Strategy**

Our first step was to *review what we all knew about the incident and share* whatever information that we had. The senior member had access to all of the information put out in sitreps and briefings from the date of the mishap, so he had a much higher level visibility on what possibly occurred. He also had some preliminary pictures that had been forwarded of the aircraft. The other member and I had only reviewed the initial sitrep.

We elected to *start with the big picture*, in other words, to discuss all possible theories of what had occurred, i.e. mechanical failure, pilot error, act of god, hostile fire or a combination of any or all. We explicitly agreed that no single theory, until proven, was what occurred due the danger of trying to look for evidence to prove our theory, vice looking for evidence to prove what happened. To guide our process, we decided to rule out the possible causes and to drill down on what occurred. This strategy would be helpful when we concluded the collection of all of the evidence and testimony.

We also discussed and took into account the fact that the findings of *the investigation had big implications* beyond what they as aviators were used to. We had to temper our investigation with the fact that not only could they address safety concerns with the investigation, but that recommendations as to culpability for misconduct could be made, if necessary.

### **Evidence**

*Locating and collecting evidence was critical*, and would prove to be a dynamic and challenging endeavor due to the scattering of evidence and the location of the mishap. Although we knew we would have difficulty observing the evidence and collecting it, we sat down and made a list of the items that were required to establish what did not occur and conversely what did occur. We then made a best guess as to where the information would likely be, and other possible locations. For example, maintenance records, service records, training jackets, log books, SOPs, threat assessments and manuals. We also came up with items that may/may not exist depending on whether it was being tracked or recorded, e.g. Radar data, communications with the tower, communications within the aircraft, etc.

First, there had been *significant changes in the status, location, position, etc to the evidence since the mishap*. Due to the passage of time between the mishap and the JAGMAN investigation, our investigation was well behind on getting to the evidence and being able to secure it, observe it and record it in the manner and status that it came to rest as a result of the mishap. Second, unfortunately from a collection standpoint, the war must go on and as a result, within hours of the mishap the aircraft had been moved, components were removed within days to put on another aircraft or sent for engineering analysis and the salvage and clean up had begun. Luckily, the AMB had arrived on scene and had taken numerous photographs of the aircraft before the aircraft was moved and salvage efforts were initiated, and they had collected a majority of the hard copies of the documentation that we required. However, although the AMB had collected this information, we had difficulty accessing it, due to custody concerns and the requirement to shield the JAGMAN investigation from any privileged information that AMB had

acquired, e.g. testimony or AMB generated analysis. This interdependence and recognition of the requirement to shield the AMB's information would continue to impact our investigation.

## **Witnesses**

*It was with witnesses that the team conveyed that my skill-set as a Judge Advocate paid dividends.* Initially we took the same approach with our witnesses, as we did with evidence collection. We identified who was required, e.g. the crew, maintenance personnel, etc, who was necessary, e.g. tower personnel, and who was desired, e.g. any and all eye-witnesses. As with the collecting of hard evidence from the mishap, collecting witness statements would also prove difficult due to the passage of time. Not only had witnesses scattered back CONUS and overseas, but there was a natural degradation of recollections and the inevitable subjective interpretations of what had occurred.

I approached the witnesses similar to preparing a case for trial; after *drawing up an exhaustive list of who we wanted to interview, we speculated on what information that particular witness could provide*, be it first hand knowledge of the mishap and/or information on their area of expertise. We also discussed what motivations might possibly lie behind the testimony that the witnesses would provide, knowing that the possible cause of the mishap could lie with pilot error, or mechanical error, etc., as well as how to deal with potential assertions of rights, misleading statements or lack of cooperation. One of the best decisions that we made at this point was to *digitally record all of our interviews* (however, as discussed later, we strayed from this practice). We also decided to *request an advance voluntary written statement* from everyone (except those we thought may need 31(b) rights advisements) we wished to interview, as the starting point to guide our questioning.

With respect to 31(b) rights, as a result of our preliminary sharing of evidence and preliminary theories on the cause of the accident, *we elected to provide 31(b) rights advisements to the flight station crew, as a precaution.* I provided a brief on what 31(b) rights were, and the implications of providing them vs. not providing them. Throughout the entire investigation, I continued to discuss scenarios with the team that may necessitate stopping the interview and providing advisements, and how to accomplish that. My mantra was that *in the midst of an interview was not the time to try and figure out what to do, if the unexpected came up.* I also provided briefs on Privacy Act requirements and the manner in which we as a team could effectuate Privacy Act advisements, when necessary. Additionally, we agreed that *at the beginning of each interview, I would recite what administrative actions we had taken with each witness prior to starting the interview, e.g. that a Privacy Act statement was reviewed, signed, and that the witness had no questions and that they agreed to allow us to record the interviews or that a 31(b) advisement was provided and then we would review the waiver of rights and agreement to provide an electronic statement.*

## **Style of Questioning:**

*Consider the style and manner for conducting interviews.* One of the issues I did not foresee my extensive involvement in was with respect to the style and manner that we would interview witnesses. Conducting interviews of witnesses is something that as a Judge Advocate

becomes routine, but for the other team members, it was a new and intimidating concept. Our preliminary discussions on matters like Privacy Act and 31(b) rights, led well into how the team should handle a particular witness, or the possibility of an uncooperative or lying witness and through later practice we developed a manageable style that worked for everyone.

Unlike in a courtroom, what worked best was to *let the witness talk through everything first*, not knowing what they would say. A wide open question of: “start wherever you would like, and tell me what happened” or “what did you see?” made interviews easy, albeit lengthy and set the witness at ease. Taking notes and jotting follow-up questions while they spoke let the witness highlight what they thought was the most useful. It also gave insight into that particular witness’s motivations as we learned through their unguided and unsolicited testimony what they thought was important. We also found that ending with “is there anything else you think we should know?” was effective in bringing information that we had not asked about or considered. The bottom line was to expect the unexpected; we never knew what we would get from some witnesses.

We also *planned to conduct multiple interviews of each primary witness, and told the witnesses such*. We found this strategy to be effective since information was always evolving, as were the theories of what happened. It also gave the witnesses an opportunity to add additional detail or to refine points in their testimony. None of the witnesses expressed any dissatisfaction or inconvenience with having to do so, especially since they were on notice that we would likely have to talk to them again.

### **Classification**

Due to the nature of the mission, the squadron and the location, we had to *pay careful attention to the likelihood of classified material being necessary* and germane to the investigation. We made a strategic decision to attempt to keep the investigation devoid of any classified material or information, knowing that using classified material would impact the manner in which the investigation would have to be handled, secured and reported.

### **Time restraints**

*Coordinate schedules early*. All of the members of our team had a “day job”. The senior member was heavily involved in program management for multiple developing platforms, and as a result he had a very busy and involved schedule in another state. Additionally, the technical advisor pilot was a department head, as the Maintenance Officer at another local squadron which necessitated huge amounts of time dedicated to his job at all hours. As a Judge Advocate, my time was also monopolized by handling 34 different command clients in two different states. From the outset, we all agreed that we were going to put in every effort necessary to accomplish the investigation as close to our initial deadline as possible, no matter the hours required. As a result we worked very long hours (up to 14+/day), while still trying to balance our day jobs. When we were unable to be together, we planned on teleconferences and continuous email correspondence. *We established our expectation and were able to stick to it due to our schedule planning more than a month in advance.*

## **CA Management**

*Educate the Convening Authority.* Similar to the efforts I had to make with the JAGMAN team, I had to educate and manage the expectations of the CA from the outset on issues such as the time necessary to complete the investigation, my role as a Judge Advocate and our support requirements. I was asked numerous times “how long will this take?” My response was typical of a lawyer, in that “it depends”. Through coordination and continuous updates on our strategy, progress, needs etc, the CA felt satisfied that every effort was being made to accomplish the investigation in both an expeditious and thorough manner. With this information, he was able to provide the same comfort of progress to his superiors. Along similar lines, I was contacted by numerous Judge Advocates from various Fleet and Theater commands that had visibility and interest in the mishap. Providing them with similar regular status reports was adequate to satisfy their desire for information and progress, and also helpful to me for guidance. Ultimately, as each possibility of cause was ruled out, interest from the various commands waned. On a related topic, in my opinion, *the continuous involvement with the JAGMAN team, in particular my advisor role and the CA creates a questionable appearance of command influence in the investigation and therefore my interactions on discipline matters had to be handled carefully.*

## **Phase III: Investigation in Progress**

Once we were in the process of conducting our investigation, the planning and strategizing we conducted prior to initiating the investigation helped guide where and what we needed to do next; however, it became very apparent that flexibility and resourcefulness was just as necessary in collecting the evidence, finding and interviewing witnesses and piecing together what had happened.

## **Strategy**

Although we had laid the framework for our strategy prior to starting the investigation, *after each witness interview and each new piece of evidence and information we would take time to discuss how that piece fits into and impacts our theories on the mishap.* This on-the-fly review kept facts fresh in our heads and enabled us to talk through both consistencies and inconsistencies. Further, this constant review stimulated ideas of new areas to investigate. This was critical to keeping an open universe and uncovering systemic causes that underpinned the actual causes of the mishap. As ideas and associated needs were generated, we all continued to make and update lists. *Another critical component of this success was the amount of time that we spent together as a team.* We traveled, interviewed, observed, ate, and bunked together as much as possible. Spending as much time as we did as a group, with focus on one singular purpose, created a team dynamic that inspired the sharing of thoughts, ideas, needs and theories on the investigation. *We also made the best of this difficult task, and actually had a great deal of fun along the way. Our good humor and jokes were always a good release from the herculean efforts and time we were all investing.*



## Evidence

When we began to identify and collect evidence, it was apparent that we would have *to innovate new means to capture what had occurred*. In the two weeks that had passed since the mishap, the aircraft had been moved, the crash site had been paved over in some parts, components were removed for salvage and some were to be sent away for engineering, like the propellers, engines, wheel mounts and tires. Basically all the critical evidence had been manipulated in some fashion or another. Additionally, since the runway had to continue to be used, some of the tire marks on the runway had been obscured by subsequent landings. As a result, we were forced to attempt to capture the remaining existing information as best as possible, for example the radar returns of the mishap. The tower personnel still had a recording of the mishap approach, but it was no longer in a format that we could download; we could watch it, but not take it with us. We worked around this by recording a video of the approach with my digital camera.

To further recover what had been lost or changed, we immediately set out to identify possible involvement from other services or base organizations. We started with the airfield commander's safety office. This USAF component and starting point was ultimately critical to recovering changed or lost evidence and information, and was also instrumental in bridging service lines amongst the other organizations on base. For example, through them we were able to get into contact with a detachment of combat engineers who had surveys and diagrams of the airfield, and had surveyed the crash site, including the tire marks on the runway immediately following the accident. Additionally, the safety office got us into contact with the base PAO who was on scene at the time of the mishap, and had taken dozens of photographs that we were able to acquire. They provided points of contact all over the base for interviews, coordination of aircraft operations for our examination of the runway, and most important, they provided credibility and the "foot in the door" for our team. One of the most significant was their ability to get us through security and onto the airfield commander's schedule on very short notice. The interview with the General was very insightful and garnered the express cooperation of multiple tenant commands in our investigation. The bottom line, *tap into existing resources and relationships*.

## Witnesses

As a result of the changes in the evidence, *eyewitness testimony was critical*. Locating and identifying witnesses after the fact was nearly impossible; witnesses had transferred, return CONUS, were no longer DOD contractors, or were unknown. While on location, the USAF safety office pointed us in many good directions regarding whom to talk to, but much of the identification of witnesses came from a lot of asking around. We approached every command along the flight line inquiring for witnesses, i.e. for who was on duty or conducting operations on the night of the mishap. Through this approach and through the interviews we conducted, we found more and more witnesses. In fact, during our canvassing we identified a USAF SSgt (not interviewed by the AMB) who was sitting in his duty vehicle adjacent to the exact location on the runway that the aircraft touched down and who had witnessed the mishap with a front row seat.

For all of our witnesses, we *established routines and practices to make interviews as efficient as possible and more important, as effective as possible*. This was our routine: we started with a brief introduction of who we were and what we were doing and why. We then explained the differences between our investigating and other types of investigations, as well as thanked witnesses who had participated in other related investigations. After the pleasantries we asked permission to record the interview, then began recording. I stated the time, location, and who was being interviewed, then briefly went over privacy act rights and/or 31(b) rights were applicable and had the witness agree on the record to being interviewed with recording. I followed up with an advisement that we were attempting to keep the interviews unclassified and asked that if it was necessary to divulge classified information that we would stop the tape and make arrangements to secure that information. *Then we began the interview with an open-ended question and took notes throughout.*

We implemented our pre-planned strategy and recorded almost every witness. *We should have recorded every witness.* There were witnesses that we thought may not give us anything, but that we wanted to interview to close the loop. The three times that we made this mistake, every time there was information provided that we wished we had on tape! Ultimately, this mistake led to re-interviews that would not have been necessary had we recorded them and this resulted in wasted time or a written summary of interview. Before completing the interviews we advised them not to discuss the content or context of the interviews and to be available for recall.

An unanticipated difficulty with interviewing the witnesses, especially the witnesses that were at the controls of the aircraft, was as a result of their *specialized training for interrogation* from SERE school. Lacking the training or exposure on my part, it was difficult to work around their evasiveness, at times. The other members of the JAGMAN team had received the training and quickly picked up on the evasive tactics and were able to work within that context, but I repeatedly felt at a disadvantage and lacking an effective skill-set.

### **Take pictures**

I brought my own digital camera with me to take pictures. ***TAKE PICTURES.***

### **Simulate/observe the event**

One of the more insightful experiences in conducting the investigation was the opportunity to *simulate the event* in an operational P-3 trainer at the mishap location. Our technical advisor was a current P-3 pilot who was able to recreate the approach and mishap based on the data that we recovered from radar returns, tower communications and the testimony of the flight station. With the IO acting as co-pilot and me calling out data waypoints from the flight engineer station, we were able to see and record exactly what the flight station saw and experienced. After piecing the data together, the recreation of the event provided information on how “busy” the cockpit was during the approach, and what was demanded of the flight station in order to attempt to land the aircraft. We also were able to observe operations from the tower at the location of approaching aircraft and to observe a combat approach from the cockpit of similar aircraft.

## **Coordination with other investigations**

One of the most challenging issues throughout the investigation was requirement of coordination with the AMB investigation. As a result of our arrival well after the mishap, and well after the AMB had engaged, most hardcopy data and evidence was in the custody of the AMB. This presented difficulties due to the requirement that the AMB's information remain privileged. However, there was no written guidance shielding our investigation from theirs and as a result, this one-way protection created a desire from the AMB to want to know what we knew as we knew it. Further, anytime we wanted to review copies of logbooks, training jackets, and flight data, pictures, etc, we had to secure it from the AMB with caution, so as not to inadvertently obtain privileged information. *Out of necessity and to avoid contamination of our investigation, we worked out a system of requesting specific information or documents; we would sign them out and then return them.* One anomaly was the discovery of created training records for one of the pilots, post mishap, but memorializing a flight a year earlier. After investigation, it was determined that the record was produced after the mishap at the request of one of the AMB investigators by the training officer. As a precaution, in order to determine the reason for the documents creation, even though the reason was most likely benign, it necessitated calling in the AMB member and questioning her after advising her of her Article 31(b) rights. Needless to say, this impacted our relationship with the AMB.

## **Role Management**

I learned quickly that *I had to always be conscious of my status as a Judge Advocate.* Because we were involved in a "JAGMAN", the natural assumption was that I would give direction, vice recommendations for the team. Additionally, as the investigation wore on, I became aware of the team's desire for "legal" justifications, and that they would, at times, defer to my suggestions as such. I also was asked for "in my legal opinion" a lot. I was always cautious to address those concerns and to make sure that the subject was within my legal lane. Another interesting aspect of my status/role of Judge Advocate was the negative perceptions and preconceptions of who I was and what I was doing by witnesses, etc. As a result I was always sensitive to whom I was talking to and about what. I routinely explained that I was there to assist in the "JAGMAN" investigation and did my best to make people comfortable.

One enormous positive of being a JAG during this investigation was the ability to *ask what could be considered "stupid questions"*. I got into the habit of challenging information and testimony that would be second nature to pilots, e.g. hand positions during flight, flap positions, aircraft capabilities, etc. By asking the team to address rudimentary questions on flight, we uncovered multiple deviations from basic/standard flight operations that helped raise additional issues and concerns for our investigation and ultimately led to the cause of the mishap.

#### **Phase IV: Blame-storming**

Once we were complete with gathering all of our evidence and statements we *conducted a comprehensive review of what we had, what we knew, what we thought didn't happen, what we thought happened and what we could prove, we jokingly termed it "blame-storming"*. Through our process of blame-storming we reviewed and reformed our theory of the mishap. We started with the BIG picture and worked our way down to the minutia that contributed to the mishap. We found it effective to draw it on a large chalk/white board. For example, we started with the mishap and drew major contributory causes in boxes that led to it: Pilot error, Cockpit Resource Management, Training, etc. Then we broke each cause into sub-causes and so on. By graphically illustrating the causes, at a glance we could see if the links made logical sense and were able to follow them from minor detail to major mishap. Additionally, through this we were able to eliminate extraneous reasons, identify areas of overlap and focus on the root of the mishap. We also were able to cite to the evidence that supports each cause on the board and see where we were missing supporting information and determine if we had addressed the directions in our appointing order.

#### **Follow-up with evidence/witnesses**

After eliminating and determining our causes of the mishap and reviewing the evidence that we had in support, *we drew up a list of follow-up questions for the witnesses and of documentation that we still needed to support our theory on the mishap*. Once we acquired the additional information, we annotated on our graphic.

#### **Format review**

Concurrently with analyzing our theories and evidence, I began to conduct reviews with the team on the proper format for a JAGMAN. I again referenced the materials I provided the team early on and went through each section. Having completed the investigation the team had a much better sense of how it all fit together at this point. Nonetheless, I had to stress that as we review and prepare to write the report that we must adhere to the concept that Findings of Fact are supported by specific evidence, which will be listed as an enclosure in the order they are referenced. Each opinion must then be supported by specific findings of fact. Our recommendations will come later. As far as the appearance of the report, I advised that the *format is a guide and not the law. If we needed to innovate to report what we investigated, then so be it*. Ultimately, we incorporated charts, statistics and graphs as a more effective way to convey information from which to draw our opinions and recommendations.

#### **Phase V: Drafting**

As with drafting any persuasive paper, it is important to know and understand your reader. Due to the high level of attention that this investigation was receiving from within the Navy, as well as with the media, coupled with the potential that a squadron CO was going to be relieved for crashing one of his own aircraft, we were especially sensitive as to who the highest ranking likely reader would be, as well as how it would be perceived by the media. We investigated and drafted the investigation with the assumption that the Secretary of the Navy and CBS news (who

had a FOIA request filed before we returned from overseas) would be reading our report. This assumption did not impact or drive what we investigated, but was a consideration in the thoroughness and tone of the investigation.

### **Drafting Strategy**

The first issue we addressed was *timeliness*. In other words, *how much time would we have and need to complete the report*. In our case we had a week before the initial deadline. After considering all of our work schedules and the time we could devote to the report, as well as how much information we would need to synthesize into the report, it was obvious that we would need an extension; one extension was granted. *We also laid out our schedules and coordinated times that we could all work together and times that we would work independently on the report.*

### **Work Distribution**

Coupled with scheduling, we also needed to distribute the work load for drafting. *Rather than assigning sections to be completed independently at the risk of losing cohesiveness and logical flow, we assigned work by our schedules, not by particular sections of the report.* For example, the IO initially put together a draft findings of fact, which was then sent to me and then sent to the technical advisor and so on. We all chopped on the findings of fact and kept adding information, and refining the order. Since we opted not to assign particular sections of responsibility, we instead created one working copy that we sent back and forth to work on. We updated the title with each change by date and version, e.g. DEC 16 rev II., DEC 17, and so on. Once the findings of fact were ready for smoothing, we started on opinions in the same manner.

However, for certain aspects of the report, we handled individual tasks. For example, one item that was handled independently in drafting was a working list of enclosures. Rather than having to keep changing the list as we worked, we had a separate document that was our enclosure list. Once we had the report finalized, we numbered the list and then chopped it into the report. Another example was the creation of the illustrative charts to be put into the reports as well as the creation of 72 hour histories for the flight station. After each was completed they were chopped into the working copy.

### **Findings of Fact**

While drafting our findings of fact in support of our theory of causation of the mishap, we decided to *first outline a logical order of subsections of the report*. We decided to break the report into the following subsections: Air crew qualifications and background, pre-flight events, take-off, departure and on-station, approach, wave off communications, attempt to stop, and then egress. Also, *rather than trying to assign the enclosure numbers to support each finding of fact during drafting, we instead cited them by name, which allowed for changes in the order of findings of fact in subsequent drafts*. Similarly, we established *patters of citation*, especially in the background sections of the findings of fact. For example, as each member of the crew was addressed in the findings of fact, we referenced their designation letters, then their flight up-chit (medical clearance), then their log book, then their orders. By using this routine for every

member of the crew, we addressed the same relevant facts with each, and also assured that nothing was overlooked or inadvertently not included in the enclosures.

### **Enclosures**

For our enclosure list *we had a separate working document, which allowed us to change the order easily, without impacting the format or order of the working document. Numbering the enclosures was one of the very last things we did before tendering the investigation.* We also had to give careful consideration on how we were going to present the enclosures. We decided to secure all the enclosures in a separate three-ring binder with plastic sleeves. We also opted for numerous electronic enclosures, such as the witness interviews and relevant pictures and diagrams because there were so many and we also had no means to timely transcribe all of the witness statements. Another factor *considered in our determinations on how to handle the enclosures, was the potential classification of all or portions of the report. By having the separate enclosures, it gave the flexibility to classify the report or enclosures independent of one another.*

### **Opinions**

Once we completed the findings of fact, *writing the rest of the report was logical and easy. We drafted all of our opinions, and then went through each opinion identifying every Finding of Fact that supported the opinion.* To accomplish this labor intensive task (we had 186 Findings of Fact), we printed the report and laid out each page on a large conference table. The technical advisor and I split the Findings of Fact in half and the IO managed the opinions. As the IO read out each opinion, the technical advisor and I called out the paragraph numbers in sequential order of the Findings of Fact from our sections that supported each opinion. The IO then annotated the paragraph number to each opinion. After we completed this process for all 34 opinions, we cross referenced the Findings of Fact cited, and determined which were not referenced in the opinions. If a finding of Fact was not referenced, we then decided if it was relevant and should be referenced or if it was irrelevant and should be deleted. As a result, there were findings that we deleted and this led to re-numbering. *The supporting of the opinions was more labor intensive than any of us had anticipated.*

### **Recommendations**

One aspect of the investigation that I stressed to the team from the outset was that the *IO's recommendations had the potential to change how the Navy, the community, the WING and the squadron did business.* We shaped our recommendations with that in mind, from lowest level to top level. We were certain to be specific and actually make substantive recommendations.

### **Proof read and re-proof read**

Our strategy of one working copy worked well with identifying and addressing issues of grammar, style, logic and flow. *By only having one working copy, we did not have to worry about the gremlins of grammar, style, etc. that appear as later revisions merge into one*

*document. However, by reading and re-reading the same 30+ page document over and over, we became desensitized to our mistakes. We opted to bring in an outside officer to review our work. As a result we found a few minor changes that were needed, and it helped create an overall better document.*

## **Other Observations/ Recommendations**

### **Timeliness**

The single biggest factor in this investigation was timeliness. Although our investigation was thorough and complete, it was significantly impacted by the two weeks that passed from the time of the mishap to the initiation of our investigation. There were a few factors that led to this passage of time:

1. Familiarity with JAGMAN process by CA: It is my perception that due to the rarity of this type of event for this community, the necessity of a JAGMAN investigation was not readily apparent. In fact, I called the CA about the mishap days after it occurred and offered my services for the ensuing JAGMAN. More than a week passed until I was contacted again about initiating a JAGMAN. In that time the CA had already assembled and dispatched an AMB investigation. A JAGMAN investigation was a secondary thought.
2. Familiarity with other types of investigations: Due to the community and the CA's familiarity with AMB investigations, there was no time lost in coordinating and initiating an AMB investigation. As a result the AMB was half way around the world and on the ground in days, vice weeks of the mishap. There is a significant advantage to investigating a mishap as close to the occurrence as possible, to wit: witnesses are still readily handy, recollections are still fresh, evidence is still in situ of what occurred, and resources are still primed to assist. There was a distinct lack of familiarity of the process and necessity of a JAGMAN investigation by the CA, the community and even JAGMAN team members; as a result the investigations that they were familiar with were timely.
3. Appointment/transport of the team: Due to factors 1 and 2, the appointment of the team, and the mustering of resources to support the team were behind the power curve. However, since the AMB had already gone through the very same process of ramping up and coordination overseas, there were benefits to being the second team in coordination and logistical know-how, but it still took 3 days each way to get in and out of the location.

### **Inter-investigation knowledge and involvement:**

Entering this JAGMAN investigation, I had little or no knowledge of the other types of investigations that had to occur for this mishap. Not only was a JAGMAN necessary, but an AMB was required as well as a Field Naval Aviator Evaluation Board (FNAEB) for each of the pilots involved. As a result there was a great deal of rapid education that I had to initiate for

myself and for the team, especially as it related to information and evidence sharing and advising the CA on actions associated with each investigation. Locating the governing resources and then reviewing, digesting and putting the guidance into practice on the fly, created the increased possibility of damaging the credibility, the effectiveness and the reliability of all of the investigations. In fact, I was consulted by not only the CA on the proscribed manner of how the other investigations should proceed and the type of information that could be shared between us, but also by the investigation teams themselves! This observation excludes the investigations that were conducted by the other DOD components and services, as a direct result of my lack of familiarity with what was required of the other involved agencies. More education/exposure to the other types of investigations within the Navy and other services should be addressed and disseminated.

### **Location, Location, Location...**

Being able to travel to the location of the mishap and being able observe the evidence first-hand, as well as operations and other factors at the location of the mishap was invaluable. There was no single piece of evidence or collection of evidence that could replace the insight gained from being on location. Further, the ability to find eye-witnesses from other services, on location, would not occur if we had not traveled forward. Additionally, in meeting with the base commander, he remarked that of all of the mishaps that occur at his various airfields, *more often than not*, investigative teams do not travel to the location to investigate, but merely rely on second-hand information! In his mind, and mine, that is ineffective.