

**MEETING of the DOD
TASK FORCE ON THE PREVENTION OF SUICIDE
BY MEMBERS OF THE ARMED FORCES**

15 DECEMBER 2009

**Bethesda Marriott
5151 Pooks Hill Road
Bethesda, Maryland 20814**

1. ATTENDEES

PRINCIPAL MEMBERS & REPRESENTATIVES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
	Ms.	Embrey	Ellen	Performing Duties of the ASD for HA
X	MG	Volpe	Philip	Joint Task Force National Capital Region Medical, Task Force Co-Chair
X	Ms.	Carroll	Bonnie	Tragedy Assistance Program for Survivors, Task Force Co-Chair
	Dr.	Wilensky	Gail	President, Defense Health Board
	CDR	Feeks	Edmond	Executive Secretary, Defense Health Board
X	Col	Bader	Christine	Senior Advisor to the Assistant Secretary of Defense Health Affairs
X	Dr.	Berman	Alan	American Association of Suicidology
X	COL	Bradley	John	Walter Reed Army Medical Center
X	Dr.	Certain	Robert	St. Peter and St. Paul Episcopal Church
X	CMSgt	Gabrelcik	Jeffery	Air Force Review Boards
X	Dr.	Holloway	Marjan	Uniformed Services University of the Health Sciences
X	Dr.	Jobes	David	The Catholic University of America
	Dr.	Kemp	Janet	Veteran's Administration

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	Dr.	Litts	David	Suicide Prevention Resource Center/Education Development Center, Inc.
	Dr.	McKeon	Richard	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
X	Col	McPherson	JoAnne	Executive Secretary, DOD Task Force on Prevention of Suicide by Members of the Armed Forces
X	Mr.	Middleton	Alan	Designated Federal Officer for the Defense Health Board
X	MGySgt	Proietto	Peter	Senior Enlisted Advisor CMC (SD) Navy Annex
X	CDR	Werbel	Aaron	Headquarters, Marine Corps (MRS), Quantico, VA

GUESTS & OTHER ATTENDEES

	TITLE	LAST NAME	FIRST NAME	ORGANIZATION
X	LCDR	Alton	Jeffrey	Navy/Marine Corps Aviation & Safety
X	COL	Belcher	Eric	Army Criminal Investigative Command
X	Mr.	Keleher	Michael	Navy, NCIS
X	Maj	Musselman	Brian	Air Force Accident & Safety Investigations Board
X	Mr.	Parr	Glenn	Air Force Aviation and Admiral Law Branch, Claims and Tort Litigation (JAAC)
X	Mr.	Poorman	Kevin	Criminal Investigations at Headquarters Air Force OSI
X	Mr.	Surian	Guy	Army Criminal Investigative Command
X	LCDR	Tetreault	Sara	United States Navy JAG
X	Mr.	Thompson	Kimball	Navy/Marine Corps Aviation & Safety

2. OPENING REMARKS AND INTRODUCTIONS

MEETING CONVENED at 09:00 AM

MG Volpe welcomed attendees to the meeting of the Task Force on the Prevention of Suicide by Members of the Armed Forces. He explained the role of the Task Force under the Defense Health Board (DHB) and asked Mr. Middleton to officially call the meeting to order.

Mr. Middleton welcomed the Task Force members and the public to the meeting. Mr. Middleton explained that he is the ultimate designated federal officer for the Defense Health Board, a federal advisory committee and a continuing independent scientific advisory body to the Secretary of Defense, and called the meeting to order. (Rapped gavel)

MG Volpe asked the attendees to stand for a moment of silence in honor of military service members. Attendees stood and a moment of silence was observed.

MG Volpe asked the Task Force members to introduce themselves to the audience. Members of the Task Force introduced themselves.

MG Volpe asked Col JoAnne McPherson to take over the meeting and to provide administrative related information.

Col McPherson welcomed everyone to the meeting and provided administrative announcements. She stated that the next meeting of the Task Force will be held on Friday, January 15th at the Hyatt Regency in Washington DC on Capitol Hill, and suggested that attendees visit the DHB website to obtain more information.

3. ARMY CRIMINAL INVESTIGATION COMMAND

Col McPherson introduced the first speakers, COL Eric Belcher and Mr. Guy Surian from the U.S. Army Criminal Investigation Command (CID).

MG Volpe added additional opening remarks and asked Task Force members to focus on learning as much as they can on various investigative techniques related to suicide. MG Volpe also stated that one mission of the Task Force is to determine and make recommendations as it relates to investigating suicides.

COL Belcher & Mr. Surian presented, “**United Stated Army Criminal Investigation Command**”. (Briefing attached)

SUMMARY OF PRESENTATION:

The background and philosophy of CID Command was presented by COL Belcher.

A. CID Command

COL Belcher stated there are 2,000 personnel consisting of civilians, agents, and lab personnel, who support the command's worldwide mission. 200 CID personnel are currently deployed in theater. The CID investigates 10,000 felony cases a year and 140 suicide cases were investigated last year. COL Belcher also informed the audience that he would present on the CID philosophy and Mr. Surian would present on the investigative procedures. He further indicated that the data on suicide rates found in his presentation may be different from statistics seen before because the statistics he is presenting reflect all the deaths in the Army, and some are still pending cause of death determination. Additionally, all deaths are reported but all are not investigated by CID.

B. CID Philosophy

COL Belcher stated that every death is treated as a potential homicide and the command assigns the most qualified agent available to investigate a crime scene. A task force is formed if necessary and heightened sensitivity is required when working with the victims, witnesses, and families. He mentioned that as the investigation progresses, CID keeps the Commander and Next Of Kin (NOK) informed. However, if the NOK is a potential suspect, they do the best they can to handle the situation and are currently working on ways to improve this aspect of dealing with potential suicide investigations.

COL Belcher explained that the command sends all investigation reports to the Armed Forces Medical Examiner (AFME) who completes the autopsies and evidence is evaluated before a determination of death is made. He added that during investigations, the command uses state-of-the-art polygraph testing, a Forensic Science laboratory and Subject Matter Expertise. Mr. Surian mentioned that CID command has 11 polygraphists for 10,000 cases. He explained that there are 10 investigative battalions and each has a Forensic Science Officer (FSO), who is specially trained in a 4-year program; however these personnel are difficult to retain in the Army due to higher salaries in the civilian sector.

COL Belcher spoke of the state-of-the-art lab located in Ft. Gillem in Atlanta, GA. He extended an open invitation to all Task Force members to visit and tour the facility. He mentioned that an issue the lab deals with is the high number of samples they process which creates increased workload. He added that the lab size is expanding and that this should help with processing times. COL Belcher then introduced Mr. Surian who, in turn, presented the CID Death Investigation Process.

C. CID Death Investigation Procedure

Mr. Surian explained that a "duty agent" is assigned 24 hours a day, 7 days a week at every CID office. The duty agent is notified of all deaths and, in turn, notifies the agent in charge that a death investigation is necessary. He added that the Special Agent-in-Charge (SAC) determines the number of agents and capabilities required to complete each death investigation. He further explained that upon arrival at a crime scene, the agent interviews first responders, confirms the deceased has been pronounced dead, assesses scene safety and assures scene integrity. Mr. Surian commented that each crime scene is unique generating a requirement for sketches, photographs and videos.

Documentation at the crime scene is accomplished in great detail. Evidence is collected, entered into the evidence depository and shipped to the lab at Ft. Gillem, GA to be processed. Mr. Surian explained that after a scene has been cleared, a senior agent conducts a walk-through to make sure nothing was overlooked. In the event of an oversight, the investigation process starts anew.

Areas beyond the crime scene are evaluated and interviews are conducted with additional people selected from a list generated from initial interviews. Agents are briefed on their responsibilities to ensure everyone is aware of their role. Mr. Surian further explained that agents participating in an autopsy collect physical evidence discovered during the process. Collected evidence is then sent to the Ft. Gillem lab for examination. He also mentioned that agents arrange psychological autopsies through the AFME if they are deemed necessary.

Mr. Surian elaborated on the forensic analysis involved in investigating a crime. He mentioned that DNA, notes, firearms, projectiles, fingerprints, handwriting samples, electronic media and devices are all evaluated at the lab in Ft. Gillem, GA. He stated the FSO and the headquarters FSO perform independent reviews before each case is closed. Mr. Surian continued his presentation by providing an overview of FY 08 Army Suicide Statistics.

D. FY 08 Army Suicide Statistics

Mr. Surian explained the majority of the suicide cases involve young Caucasian males who are of lower rank and are regular Active Duty Army. He added that most had failed relationships and used a personally owned pistol or handgun to inflict self injury at their primary residence. He added that the most affected Army Military Occupational Specialty (MOS) is 11 Bravo or the Infantry. Finally, Mr. Surian explained that suicide notes are not found at many of the scenes. However, they do find some information on electronic media which the deceased mostly likely has accessed for purposes of conducting research on suicide as a topic.

SUMMARY OF QUESTIONS AND DISCUSSION:

COL Bradley thanked the speakers for their presentation and introduced himself. COL Bradley asked, with respect to suicide notes, whether the command considers communication with family members, friends, or postings on social networking sites evidence of suicide intent. Mr. Surian replied that the command would consider that a suicide note if the note to the family member or friend states they were going to commit suicide.

MG Volpe asked for clarification of the information regarding components--are these the only components investigated by the CID command? Mr. Surian replied that yes, the components listed are the only ones investigated by CID. MG Volpe also asked if the suicides listed are only located on-post. Mr. Surian stated that some suicides listed are off-post and that the suicides listed are the only ones that the CID command is notified of to investigate. Mr. Surian added that the difference between the numbers on his slide (15) and Army G-1, Casualty Affairs, and Mr. Morales's crew, would be that the CID command is not notified of all off-post death investigations and if they are not notified, they do not conduct an investigation.

MG Volpe asked if the National Guard and Reserve listings applies to suicides while personnel are active vs. inactive. Mr. Surian stated yes, the numbers reflect Guard and Reserve suicides while on active status.

Ms. Carroll introduced herself and asked Mr. Surian to speak to the Family Advocacy Program mentioned in his briefing slides. Mr. Surian stated that the CID command checks with Family Advocacy to see if the family was referred to them for any reason to include issues that could have been a cause of, or were stressors contributing to the suicide event.

Ms. Carroll asked if they could provide information about the Family Advocate on post with CID during the investigation period. Mr. Surian stated that the CID command does not have a Family Advocate assigned to it but they normally work with the installation's Family Advocate Program staff. Ms. Carroll replied other services have a Family Advocate. Mr. Surian stated the investigative service does not.

MG Volpe commented that the suicides listed on slides 25 and 26 for suicides that occur on- and off-post are fairly even. MG Volpe asked if the suicides that occurred off-post listed is reported to CID command. Mr. Surian stated yes, that is correct. MG Volpe asked if there could be more off-post that are not listed. Mr. Surian stated that there would be more reported off-post than what is listed.

MG Volpe commented that on slide 26 the location appears to be the primary residence and asked if that includes the barracks. Mr. Surian stated yes it includes barracks, apartments, quarters and if in-theater, it would include a Containerized Housing Unit (CHU).

MG Volpe asked Mr. Surian to explain information on slide 28. Specifically, he wanted the board members to know what each Military Occupational Specialty code stood for. Mr. Surian stated 92 Yankee is supply clerk, 42 Alpha is admin/clerk. MG Volpe added that 68 Whiskey is a medic. Mr. Surian stated 31 Bravo is military policeman and he wasn't sure what 21 Bravo and 19 Delta are. A speaker in attendance stated 19 Delta is a scout.

MG Volpe asked if the numbers were just raw numbers. Mr. Surian stated yes the numbers are raw data.

MG Volpe asked what is considered foreknowledge. Mr. Surian stated foreknowledge means that the person said they would actually attempt suicide.

MG Volpe asked if all active duty members who commit suicide regardless of location should be handled as a joint investigation. COL Belcher stated the CID command is currently working to conduct joint investigations. MG Volpe asked if there is a legal requirement for a joint investigation. COL Belcher stated that there is no legal requirement. MG Volpe replied the Task Force has the ability to make legislative recommendations.

Dr. Holloway asked if the info on slide 27 indicates that a third of the individuals that died by suicide did not have a history of deployment. Mr. Surian stated although the statistics report only 1/3 have a history of deployment, almost all in the Army have deployed at sometime during the last eight years, and that only a very small number of Army personnel have never deployed. Dr. Holloway asked if the reason the statistics appear this way is because they don't have information on the deployment histories of the individuals. Mr. Surian responded that this is correct. Dr. Holloway asked why this information is difficult to obtain. CDR Werbel added that the Army had previously briefed the Task Force revealing that about one third of the members committing suicide had never deployed, about one-third occurred during deployment, and about one-third had a history of previous deployments.

Dr. Berman asked COL Belcher and Mr. Surian if they could speculate regarding foreknowledge—whether they thought family members willingly indicated that they had foreknowledge of the suicide. Mr. Surian responded that it is difficult to speculate this issue, but that families might be hesitant to express foreknowledge.

MG Volpe asked if the AFME office only evaluates cases investigated by the CID command and whether that information is reported and used to inform suicide prevention programs of the data. Mr.

Surian stated the AFME report is done before the final CID report. If CID concurs with the AFME report the final report is written. The Command, G1, and Casualty Affairs branch are all kept updated. The family is briefed monthly. NOK can request the report via the Freedom Of Information Act. Information regarding others is left out.

MG Volpe asked which investigations have psychological autopsies. COL Belcher and Mr. Surian stated that AFME determines if a psychological autopsy is indicated on a case by case basis.

Dr. Jobs asked if the speakers knew the number of deployments or exposures to combat taken by infantry data as it relates to post traumatic stress disorder (PTSD). Mr. Surian stated that statistics for deployments came from agents and do not include combat and statistics for mental disorders came from medical records.

Dr. McKeon asked if an undetermined death category exists. Mr. Surian stated there is an undetermined death category and it is seldom used. Mr. Surian also stated there is also a probable cause category and there are 1-2 per year that are considered undetermined.

CDR Werbel asked if agents receive sensitivity training regarding suicide crime scenes. He also asked who makes the final decision on whether a death is homicide or suicide. Mr. Surian stated there is no formal sensitivity training. COL Belcher added that CID agents do get critical incident response training which applies to natural disasters, mass casualties, and death scenes. COL Belcher and Mr. Surian agreed that the AFME has the final determination regarding cause of death and that usually, CID only takes issue with the cause in cases of "Russian Roulette". COL Belcher stated that in the case of "Russian Roulette," CID prefers to make an accidental death determination whereby AFME prefers a determination of suicide since playing "Russian Roulette" is an inherently dangerous act. In the end, the AFME has final legal determination regarding cause of death.

Dr. David Litts asked if there was a reason why the CID command has nine undetermined cases. Mr. Surian stated that while there are nine pending cases within the military for 2008, a large amount of lab work is required making the process time intensive. Murder cases have top priority but in the civilian world determinations, overall, are made more quickly.

MG Volpe and Col McPherson thanked COL Belcher and Mr. Surian for their presentation. Col McPherson announced a break.

4. AIR FORCE OFFICE OF SPECIAL INVESTIGATIONS

Col McPherson introduced Mr. Kevin Poorman. (Biography attached)

Mr. Poorman presented, "**Air Force Office of Special Investigations (OSI)**". (Briefing attached)

SUMMARY OF PRESENTATION:

The mission of the OSI is to identify, exploit, and neutralize criminal, terrorist and intelligence threats to the US Air force, DOD and U.S. Government. The authority and jurisdiction of OSI is derived

from Public Law 99.145, 1985 Defense Authorization Act, and mandates that the Secretary of the Air Force give authority to OSI to conduct independent investigations including those involving suicides.

Five specific manners of death were stated to include, 1) Suicide, 2) Accident, 3) Natural, 4) Homicide and 5) Undetermined. The OSI's primary concern is active duty suspects since non-military members cannot be prosecuted. The OSI is headquartered at Andrew's AFB and staff consists of active duty enlisted, officers and civilian agents located in eight regional operating locations servicing over 200 locations.

All investigators go through an 18 week training program. The first 11 weeks of the program's curriculum is the same as what the Bureau of Alcohol, Tobacco, and Firearms agents and Secret Service agents receive. The last seven weeks cover military law, punitive violations, and interpersonal violent crimes. Forensic Science Consultants are assigned regionally at the MAJCOMs and have Masters Degrees from George Washington University. They do a one year fellowship at AFME and are sent to Chicago for an extend period of time to view autopsies. Forensic Science consultant positions are limited in the military since they are so expensive and their range of knowledge is not necessary for basic investigations.

OSI considers electronic communication an acceptable medium for a suicide note. Mr. Poorman stated OSI investigates about 150 suicide notes a year and that the organization works closely with Suicide Prevention Programs and documents all data in DODSER. The medical examiner and coroner make death determinations. Mr. Poorman stressed the Air Force emphasizes the need for an autopsy on all AD deaths and that due diligence is done in each and every investigation.

The Family Liaison Program was started by Navy Criminal Investigative Service in the mid 1990's due to families feeling left out of the process. The program is required by DoD Directive 5505.10. Within 72 hrs after family notified, a Family Liaison reaches out to the family after they are informed by casualty services that the death has occurred. The Family Liaison explains their role and responsibility of the OSI. They maintain communication with the family throughout the investigation.

The OSI performs the role of the medical examiner investigator and Poorman stated that the manner of death seldom changes. Air Force bases have some mixed jurisdictions; some being state, others joint. Reports are factual and may be as long as 50 to 100 pages with attachments. Mr. Poorman provided an example report to demonstrate the comprehensive nature of the contents.

Case reviews are mandated by DoDI 5505.10. The final review is done by the Forensic Science Consultants at HQ then sent to AFME for review. Mr. Poorman stated the AF uses I2MS, an information management system that is not always reliable. Data captured in DODSER instills more confidence.

SUMMARY OF QUESTIONS AND DISCUSSION:

CMSgt Gabrelcik asked if there was a POC for disseminating information to the family. Mr. Poorman replied, yes, and that the information can be disseminated by talking with the casualty notification folks who then notify the OSI. He also stated OSI provides information when foul play was not involved and follows up with families within 48 to 72 hrs. Mr. Poorman also mentioned that information is provided to the family during the investigation every 30 days. During the last interview with the family, the agent is responsible for informing the family that this is the closure interview for the

investigation and provides instructions and paperwork for filing a Freedom of Information Act request if the family wants to obtain copies of the investigation reports.

CMSgt Gabrelcik asked if OSI recommends autopsies. Mr. Poorman stated that OSI will almost always get an autopsy.

Dr. Holloway thanked Mr. Poorman for his presentation and asked how long it takes to complete an investigation from start to finish. Mr. Poorman stated that some cases can be completed as soon as a week. However, he estimated that most take approximately 6 months. Mr. Poorman also stated that some investigations can remain open for one to three years.

Dr. Holloway commented that long investigations could be difficult for the families to handle and asked how OSI communicates with the families during long investigations for suicide cases. Mr. Poorman replied that OSI provides updates every 30 days for those investigations.

Dr. Litts asked who the Family Liaison works for and what the background and training requirement is for the position. Mr. Poorman stated the policy is to have the unit who is running the investigation reach out to the family and when that is not working well then a clinical psychologist will get involved and discuss better ways to communicate with the families. He also stated bereavement training is very limited.

COL Bradley asked how preliminary results are released. Mr. Poorman stated that preliminary results are released based on the right and the need to know with concern for premature release of info that could result in jury pool contamination. Therefore, the commander, investigator, and clinical psychologists determine what information is to be released.

Col McPherson thanked Mr. Poorman for his presentation.

5. NCIS DEATH INVESTIGATIONS PROTOCOL

Col McPherson introduced Mr. Michael Keleher. (Biography attached)

Mr. Keleher presented, “**NCIS Death Investigations**”. (Briefing attached)

SUMMARY OF PRESENTATION:

Mr. Keleher explained that every case is treated as a homicide at NCIS to prevent loss of evidence. In addition, he commented that NCIS does not establish whether a case is a suicide or a homicide. That is a determination reserved for the medical examiner.

Mr. Keleher explained that upon notification, a case agent is assigned and Major Crime Scene Response Team (MCRT) responds along with forensic consultants similar to OSI. Autopsies are completed for all deaths. The NCIS conducts family interviews to gain insight and to ensure the family feels included in the process. The NCIS Field Office Death Review Panel and HQ Death Review Board review all cases and a three-panel board provides the authorization to close a case.

NCIS special agents receive training at the Federal Law Enforcement Training Center and Major Crisis Response Team members receive advanced training and conduct extensive death scene

examination and packaging of evidence. Physical evidence is reviewed in every case by NCIS Forensic Consultants with a Master's degree.

Mr. Keleher explained NCIS reviews all 911 calls, cyber evidence and all records. In addition, he stated that NCIS checks to see if the deceased had a criminal history and obtains sworn statements from witnesses who found the body. The US Army Criminal Investigative Laboratory (USACIL) and Armed Forces Institute of Pathology (AFIP) are consulted to ensure all information obtained is processed through the appropriate chain of command. Importantly, the HQ Death Desk Officers monitor cases and ensure information received is accurate.

With respect to the autopsy, NCIS Special Agents attend and provide information to the Pathologists and Medical Examiners who perform the procedure. Agents take photographs and document findings of the autopsy. Final autopsy reports and death certificate are obtained by NCIS.

The NCIS uses a Family Liaison as the main point of contact for the family on all questions and information regarding a death investigation. It was noted that FOIA requests can extend the amount of time required to close a case.

SUMMARY OF QUESTIONS AND DISCUSSION:

CDR Werbel asked if having one staff Family Liaison was enough at the headquarters level. Mr. Keleher replied that a new victim project is in development at the Federal level and it includes hiring a second social worker to assist the Family Liaison with the caseload.

Dr Berman asked if aggregated data was requested for the last 72 hours of a decedent's life. Mr. Keleher replied that, yes, he could obtain the data from a database.

6. DEPARTMENT OF THE NAVY ADMINISTRATIVE INVESTIGATIONS INTO SUICIDE AND SUICIDE ATTEMPTS BY SERVICE MEMBERS

Col McPherson introduced LCDR Sara M. Tetreault. (Biography attached)

LCDR Tetreault presented, "**Department of the Navy Administrative Investigations into Suicide and Suicide Attempts by Service Members**". (Briefing attached)

SUMMARY OF PRESENTATION:

Command investigations are conducted to make Line of Duty (LOD)/Misconduct determinations. The reference for these determinations is Judge Advocate General Instruction 5800.7 Echo, commonly called the JAGMAN. Benefits affected by LOD/Misconduct determinations include: 1) Survivor Benefit Plan (SBP), 2) Dependency and Indemnity Compensation (DIC), 3) Disability Retirement and 4) Severance Pay.

With regard to command investigations involving a suicide or suicide attempt, all injuries or deaths are presumed to be in the line of duty and not due to the member's misconduct. Clear and convincing evidence is required to overcome a presumption and that remains the standard. Suicide and bona fide suicide attempts create a strong inference of lack of mental responsibility. Suicidal gestures suggest otherwise. LCDR Tetreault stated that you are in the line of duty unless you have committed

misconduct. The investigation looks at whether a service member's injuries or death are due to the service member's own misconduct.

SUMMARY OF QUESTIONS AND DISCUSSION:

Dr. McKeon gave three scenarios of service members demonstrating suicidal behaviors and asked whether they would be handled similarly or differently with regard to mental responsibility. LCDR Tetreault stated in those circumstances, individuals conducting the investigations would get input from medical experts to get a better understanding of individual's actions and assess the presence or absence of mental responsibility.

Dr. Berman stated it is paradoxical to say that one can have an intentional behavior, but not be mentally responsible for an intentional behavior. A suicide is defined as an intentional behavior, one understands the aim, goal or purpose of the behavior is to produce a suicidal outcome, death, or attempt with a goal of death. Dr. Jobs added that experts virtually do not agree on what constitutes bona fide suicide attempts. LCDR Tetreault further explained that paragraph 0218 of the JAGMAN, under suicide states, "In view of the strong human instinct for self preservation, suicide and bona fide suicide attempts as distinguished from a suicidal gesture creates a strong inference of lack of mental responsibility." Col McPherson pointed out that medics provide guidance but do not make the LOD decision and MG Volpe mentioned that by law, in order for the government to pay benefits to family members, circumstances must support a positive line of duty determination.

CMSgt Gabrelcik asked whether there was a blanket policy covering attempted or actual suicide. For example, if someone is in a vegetative state after attempting suicide and benefits are suspended leaving family members without support. LCDR Tetreault stated that there must be clear and convincing evidence that the individual was not in the line of duty for the family to be ineligible for benefits. This decision is made by the line community and the General Courts Martial Convening Authority within that individual's command. Importantly, the facts and circumstances surrounding the incident dictate the finding and each case is evaluated on its own merits. In cases of malingering or feigning illness, LCDR Tetreault stated the investigation turns to medical experts for review and determination of bona fide suicide attempts.

Dr. Holloway asked about the benefits afforded to the family of someone who attempts suicide. LCDR Tetreault answered that if an individual has a permanent injury and cannot continue military service, they obtain benefits as a retiree. Depending on the injury, the individual may have severance pay which is a lump sum payment. The VA also makes determinations on whether the individual is entitled to medical and dental benefits.

Dr. Holloway asked for data on the suicide related cases. LCDR Tetreault stated that her office provides the procedures for doing the determinations and that the actual determinations are made by the line communities. Dr. Holloway asked for a report that would provide that data and LCDR Tetreault mentioned that she would inquire about it.

Dr. McKeon asked whether it would be a permanent part of the military record if an individual was found guilty of misconduct. LCDR Tetreault replied yes. MG Volpe mentioned there is no "forever in this process" because that finding can be appealed and potentially changed.

CDR Werbel thanked LCDR Tetreault and mentioned that there is no way that current policy can be responsive to potential future nomenclature changes that don't exist yet. He mentioned that the task

force should keep in mind that there are different goals for different pieces of the suicide investigations and appeals processes.

MG Volpe asked whether every suicide or suicide attempt gets an administrative determination. LCDR Tetreault replied yes.

MG Volpe and Col McPherson thanked LCDR Tetreault. Col McPherson concluded the morning session.

7. NAVY & MARINE CORPS AVIATION & SAFETY INVESTIGATIONS

Col McPherson introduced Mr. Kimball Thompson. (Biography attached)

Mr. Kimball Thompson presented, “**Naval Aviation Safety Program**”. (Briefing attached)

SUMMARY OF PRESENTATION:

Mr. Thompson gave a brief background of the Naval Aviation Safety Program and explained the Operational Risk Management (ORM) model. The Commander, Naval Safety Center serves as the Model Manager and ORM is currently being institutionalized across the USN. Under this model, risk management covers on and off duty status. Training is focused on time-critical risk management and methods for assessing ORM readiness are currently being developed at the unit level.

Mishap Notification is initially accomplished through a phone call the Safety Center within 60 minutes of the occurrence. Follow up messages are conducted within 4 hours for a Class A and B incidents. Amended messages can be dispatched within 24 hours if required. Class C messages are dispatched in 24 hours but investigators may launch in 4. In all cases, messages are dispatched in within 24 hours.

A Safety Center investigator is assigned to Class A mishaps and, in some cases, others. They represent the Chief of Naval Operations and control wreckage and all real evidence. They also coordinate engineering investigations. While they are not members of the board, they have full access to proceedings.

At least one recommendation for Mishap Prevention is established for each causal factor with the intention of preventing recurrence. Recommendations are assigned to specific agencies for action and final resolution.

SUMMARY OF QUESTIONS AND DISCUSSION:

Mr. Thompson stated that the ORM program looks at the ABCD model. The ABCD model is broken down as follows: **A**ssess, **B**alance, **C**ommunicate, and **D**o. Assessment requires identification of the problem and resources. Balance corresponds to resources, and Communicate relates to intentions. Communicating intentions is not confined to the cockpit and also includes the entire chain of command. If resources are deemed inadequate for the problem at hand, communicating through the chain of command becomes necessary to secure a higher level of expertise and assistance. The "do" in this model occurs throughout the entire cycle.

Mr. Thompson mentioned a debrief process, where individuals give feedback and determine whether the whole ABCD process worked.

Dr. McKeon asked what training exists and what the decision-making and feedback loops are. Mr. Thompson stated that the feedback becomes recommendations and the recommendations might include additional training in time-critical risk management. The time-critical risk management process is what an individual does to safely get an aircraft out of bad weather conditions and back safely on deck. In-depth risk management is what is done just before flight. It includes some of the human factors involved in ensuring that the people on the mission are fully prepared for that particular flight.

Mr. Thompson mentioned that ORM is a process of time-critical risk management that is applied to processes. “We want our sailors and Marines to use time-critical risk management on their day-to-day activities while they’re on duty and off”.

Col McPherson thanked Mr. Thompson for his presentation.

8. DOD HUMAN FACTORS ANALYSIS AND CLASSIFICATION SYSTEM

Mr. Thompson introduced LCDR Jeff Alton to present more details on HFACS. (Biography attached)

LCDR Jeff Alton presented, “**DoD Human Factors Analysis and Classification System**” (Briefing attached)

SUMMARY OF PRESENTATION:

The rate of mishap reduction has slowed significantly and substantially during the last 10 years. This has led some to conclude that further reductions in accident rates are improbable, if not impossible. Human error is implicated in 60-80% of accidents in aviation and other complex systems. Accidents solely attributable to environmental and mechanical factors have been greatly reduced but those attributable to human error continue to plague organizations. Accident prevention measures must address the primary cause of accidents which in most cases is the human system.

Decision tree-style analysis is integral to understanding contributing factors leading to suicide. The analysis process begins with the end result and traces through the “decisions” and conditions surrounding each case. Conditions can be thought of as layers of Swiss Cheese—some layers have more wholes than others. From a climate perspective, there is apathy and virtually no rules at the command level. Personnel are fatigued, poorly trained, environments vary in complexity and ORM is nonexistent. Ultimately, the goal is to provide more solid cheese or rather countermeasures to mitigate the holes.

LCDR Alton thoroughly explained mishap coding. The USN and USMC apply mishap coding to aviation and Private Motor Vehicle incidents. The plan is to apply it to additional communities such as maintenance, surface and subsurface. In the USA, all air and ground mishaps are coded and in the USAF, air and off-duty Private Motor Vehicle mishaps are coded. Finally, the USCG codes air mishaps only. They are currently exploring the system for surface mishaps.

SUMMARY OF QUESTIONS AND DISCUSSION:

CDR Werbel asked whether the benefits of the human factors model used for safety mishaps is applicable to suicide investigations. LCDR Alton replied the most important aspect is the robustness of the investigation itself and not just the Human Factors Analysis Classification System (HFACS). The HFACS system may be modified for a variety of different domains. LCDR Alton could not say what a suicide investigation would look like using HFACS or how the investigation might benefit from its application.

CDR Werbel asked whether the processes ensure both are actually working together and each side knows exactly what the other has found in an investigation. LCDR Alton replied that there is a very clear, step-by-step method of how to put together an Aircraft Mishap Board and what everybody's roles and responsibilities are. The physician and flight surgeon are both board members and have input into the board. However the board does not have to take the flight surgeon's findings and cannot make the flight surgeon change his or her report. LCDR Alton added that there has not been a suicide in an airplane in the last 10 years.

Dr. McKeon asked for an explanation of Private Motor Vehicles (PMV). LCDR Alton answered that the HFACS model has been modified to reflect specific errors that drivers make, for example: failure to negotiate a curve, too high a rate of speed or deciding to drive home after working 15 hours. From a data quality perspective, PMV reports are often lacking. The robust investigations that follow produce more complete data.

Mr. Thompson stated that Naval Aviation has a Human Factors Council. Every squadron has one, which is run by the safety officer with the executive officer. The Human Factors Council looks at the mental health of every aviator, officer or enlisted within that command.

Dr. Holloway asked who generates recommendations. Mr. Thompson answered that the recommendations are generated by the Mishap Investigation Board.

Mr. Thompson stated that there is a program that underlies the entire Mishap Investigation Program called the Hazard Reporting System. The investigators equate the importance of the Hazard Reporting System as a mishap prevention tool with the investigation of the actual mishap.

CDR Werbel asked how many Class A mishaps are there in the department of the Navy a year. LCDR Alton answered 15 to 20. Over the last 10 years, there were more than 150 cases.

Col McPherson thanked LCDR Alton.

9. AIR FORCE OFFICE OF SPECIAL INVESTIGATIONS & AIR FORCE ACCIDENT INVESTIGATION BOARDS

Col McPherson introduced Mr. Glenn Parr and Maj Brian Musselman, who discussed Air Force Safety and Investigations Board processes. (Biographies attached)

Mr. Glenn Parr presented, "**Air Force Accident Investigation Boards**". (Briefing attached)

SUMMARY OF PRESENTATION:

Mr. Parr discussed the history of Air Force investigations and how new regulations were created through mishaps that happened in the past. Mr. Parr stated that for every Class A mishap, a safety investigation and legal investigation are completed. The legal investigation is what the Air Force calls the accident investigation. Collateral investigations generate reports that can be made available to people outside the safety community.

Mr. Parr discussed suicide aircraft incidents. Class A mishaps are those that involve death, serious personal injury, and destruction of an aircraft or damages in excess of \$2 million. An Accident Investigation Board (AIB) report does not have to be written if there are no claims or litigation, if no one is killed or injured and if only government property is damaged. This eliminates the burden of having to encumber two and four star generals for every investigation.

One of the major differences between a safety investigation report and an accident investigation report is that safety investigators can produce a minority report for a group. There is no minority report or majority report associated with an AIB. The AIB report includes the opinion of the President of the board who signs it.

Safety investigators gather all factual information and put it into Part I of the AIB report. Part II of the report is privileged. The AIB privilege is a common law privilege that does not have a substantial amount of case law supporting it. The report is required to be completed within 30 days of receipt of Part I from the Safety Investigation Board (SIB). An AIB can be used to settle a dispute with contactors concerning how aircrafts are manufactured.

Col McPherson thanked Mr. Parr for his presentation.

SUMMARY OF QUESTIONS AND DISCUSSION:

Questions were held for the Panel Discussion.

10. AIR FORCE SAFETY INVESTIGATION PROCESS

Maj Musselman presented, “**Air Force Safety Investigation Process**”. (Briefing attached)

A description of Class A & B mishaps was presented. It was added that while Class C & D mishaps are investigated, the investigations are not as extensive and the investigation team is smaller in size rendering less comprehensive products. Four-star generals or major command commanders are the convening authorities for Class A mishaps and two-star generals, typically numbered Air Force commanders, are convening authorities for class B mishaps.

Seven steps were described in the safety investigation process. In the first or preparation step, each wing follows a prescribed Mishap Response Plan. The purpose of an Investigation Safety Board (ISB) is to preserve evidence and gather information, not to specifically investigate the mishap.

In the Respond and Collect steps, orders are given establishing the ISB and initiating the inherently intricate evidence collection process. The analyze step in broken down into two areas— Operations and Maintenance and Logistics.

Under Operations and Maintenance, preconditions potentially contributing to the mishap and violations that might have been committed are considered. From a Logistics perspective, aircraft systems and component malfunctions as well as human factors are considered.

Conclusions contain factors, findings and recommendations and products include a formal briefing and accompanying report. Finally, validation is accomplished through an Air Force Safety Review and entered into the Air Force Safety Automated System (AFSAS) and corrective actions include a recommendation for closure. Corrective actions are delivered in the form of recommendations. Once recommendations are implemented, the open item for corrective action can be closed within 45 days.

SUMMARY OF QUESTIONS /PANEL DISCUSSION:

CDR Werbel asked whether developing predictive models with lessons learned from the human factors pieces could lend individual or personality related information. Maj Musselman answered that the intent is to identify the factors in the mishap and then based on the underlying issues make a recommendation.

Maj Musselman mentioned that the DoD Human Factors taxonomy has a psycho-behavioral factors category that would list things like emotional state, confidence level, preexisting psychological conditions; things along those lines. The investigation board then determines whether they were a factor in the mishap.

Col McPherson asked for a copy of what is tracked in the Safety Center's database. Mr. Parr referred her to the Safety Center for the information.

Dr. McKeon reiterated that the Army Criminal Investigative Command's primary responsibility is to rule out foul play in death investigations. Information is collected to focus on how the person died versus the information that you might collect to understand why someone killed themselves.

COL Belcher stated that CID should be the lead investigative agency. CID operates with a criminal investigative strategy and consolidates all investigations into one repository.

Mr. Surian recommended that more money, equipment and staff be used to get the investigations done in a time effective and detailed manner. He also stated that most of the data is available to the local commander and the local health care provider. He explained that in some cases, the immediate commands can take a look at the data to analyze the problems.

Mr. Parr stated that investigator qualifications require further examination. Procedures do exist. However, judgment is required in determining how and with what mechanisms they are employed.

Col McPherson thanked everyone and Col Bader adjourned the meeting.

MEETING ADJOURNED at 4:50 PM