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DEPARTMENT OF THE NAVY
COMMANDER, U.S. NAVAL FORCES CENTRAL COMMAND
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From: Commander, U.S. Naval Forces Central Command
To: Vice Chief of Naval Operations

Subj: COMMAND INVESTIGATION TO INQUIRE INTO THE INCIDENT IN THE
VICINITY OF FARSI ISLAND INVOLVING TWO RIVERINE COMMAND BOATS
(RCB 802 AND RCB 805) ON OR ABOUT 12 JANUARY 2016 (U)

Encl: (Appendix G) COMUSNAVCENT Modifications, Additions and Comments to the
Findings of Facts of the Investigating Officer's Report
(Appendix H) List of additional references and enclosures

INTRODUCTION

1. (U (b) (1)) I commend the investigating officer for the comprehensive review and detailed analysis of the incident and completion of this report in a timely fashion. I formally approve and comment on the Findings of Fact, Opinions and Recommendations with changes as noted below and in Appendix G. First, however, I begin with my assessment of the incident itself, and then highlight the primary causal factors and the missed opportunities to break the error chain and prevent this incident.

2. (U (b) (1)) As the Fleet Commander I highlight up front that I do not assess a broader systemic deficiency in the warrior ethos and fighting spirit of the operating forces under my command. As disappointing as the circumstances surrounding the incident on 12 January 2016 were, I find the failures that were documented in this investigation to be a symptom of a poorly led and unprepared unit thrust into a confusing situation that they were unable to comprehend and react to, until it was too late.

3. (U (b) (1)) Overall the incident that led to the detention of ten Sailors by the Iranian Revolutionary Guards Corp Navy (IRGCN) off Farsi Island, Iran, was wholly preventable. The major factor contributing to this incident was the lack of adherence to Navy standards; specifically, the failure of squadron leadership, an un-professional detachment culture, inadequate oversight by the immediate superior in command (ISIC), combined with significant sustainment and pre-deployment training deficiencies. These failures and deficiencies manifested themselves throughout pre-deployment work-ups and deployment and in particular during the Riverine Command Boat (RCB) mission on 12 January 2016 in the following ways: inadequate overwatch and intervention, poor leadership, non-existent procedural compliance,

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substandard equipment maintenance, insufficient planning, insufficient navigation skills, failed communications, and failure to maintain weapons proficiency, all exacerbated by an “admin move” mentality in the midst of the Arabian Gulf. Considering the lack of discipline and failure to adhere to the basic core values of the United States Navy, it is simply good fortune that prevented an earlier incident in this unit.

4. (U (b) (1)) While this investigation did expose significant problems with how this unit was led and trained, it did not identify a significant problem in the overall Navy methodology and approach to training units, the way we train our leaders nor our core Navy standards. Rather, the behavior exhibited during these chronicled events highlight the importance of proper leadership, adhering to our well-structured training programs, and the inherent danger of ignoring those sound and solid naval/maritime practices developed over many years of safe and successful operational experience. More simply put, it was the deviation from proven Navy standards for leadership, training, and adherence to operational doctrine and tactics, techniques, and procedures (TTPs) that created the conditions for this failure.

5. (U (b) (1)) In priority order the primary causal factors revolve around the failure to provide quality leadership and non-existent sustainment training that was compounded by pre-deployment training that did not meet standards.

a. (U (b) (1)) **Failure to provide quality Leadership at multiple levels.** From the beginning of their preparation for deployment, the leadership of Coastal Riverine Squadron THREE (CRS-3) fostered a command climate that did not implement or enforce basic professional standards. This failure set the conditions for a mishap involving the RCB crews, which could have occurred during their short deployment to Indonesia or at any time during their deployment to FIFTH Fleet. The incident on 12 January 2016 was the outcome.

(1) (b) **CTG 56.7 Command Lapses.** Once in the FIFTH fleet area of responsibility (AOR), the CTG 56.7 (CRS-3) Command team (CO/XO/CMC), based in Jebel Ali, UAE, failed in their obligation to adequately command their subordinate units, including CTU 56.7.3 based in Kuwait. Although voicing concerns to the ISIC (CTF-56) over the RCB transit mission from Kuwait to Bahrain, Commanding Officer (CO) Task Group (TG) 56.7 failed to provide clear direction and oversight in the planning and execution of this mission. CO TG 56.7 also failed to mitigate his own concerns associated with this mission and granted permission to commence without a clear understanding of the readiness of the RCBs and their crews. CO TG 56.7 then failed to ensure and enable effective overwatch by his headquarters' Maritime Operations Center (MOC) or subordinate Tactical Operations Centers (TOCs), in Kuwait, Bahrain, and Jebel Ali, UAE. Indeed the CO TG 56.7's characterization of the transit (the longest range navigation by the unit to date) through the Arabian Gulf where daily interactions with Iranian forces are expected, as an “admin move” set the tone for the RCB crews and their lack of preparedness for their mission, and the lack of vigilance both on the RCBs and at the MOC/TOCs. Compounding these events, throughout the entire deployment, CO TG 56.7 failed to ensure any sustainment training was completed, and did not enforce basic navigation and mission planning standards.

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Worse yet, the command leadership did not believe sustainment training on deployment was required or necessary despite the very clear requirement for CO's to incorporate an aggressive sustainment training plan to maintain combat readiness during deployment.

(2) **Qualification Process and Guidance.** The lack of a well-documented qualification process and lack of a clearly defined tactical level command and control resulted in significant confusion at the task unit level regarding duties and responsibilities of the Senior Boat Captain and the Patrol Leader, and consequently, led to a complete breakdown in command and control and leadership during this incident. The CTG 56.7 command team enabled a command culture that marginalized record keeping and adherence to standards for mission planning, safety, and maintenance. The CTG 56.7 undermanned maintenance support for the CTU in Kuwait upon relocation of the RCBs to Kuwait, which resulted in unsatisfactory maintenance and oversight. Finally, the CTG 56.7 leadership failed to properly ensure that higher echelon guidance on the operational environment, the need for vigilance, and the Commander's Intent and Guidance was received, understood, and trained to by all levels of the command.

(3) **Kuwait CTU.** In Kuwait, the CTU 56.7.3 Officer in Charge fostered an unprofessional detachment culture resulting in an unbriefed mission, undertaken without mission essential equipment, manned by unqualified crews, in a contested maritime environment, on the longest proposed mission of the deployment. Whatever professionalism the RCB crews may have had during their time in Bahrain quickly degraded under the CTU 56.7.3 leadership. The unit had no awareness of overarching operational guidance, such as the OPORD 1000, the OPTASK RCB, or their assigned mission. The CTU 56.7.3 Officer in Charge (OIC) allowed units to operate without required mission patrol briefs. In Kuwait, the absence of deliberate maintenance and readiness oversight led to unauthorized maintenance actions, no pre-operational checks, no engineering logs, and no quality assurance program. The CTU 56.7.3 in Kuwait had no sustainment training plan as required in CORIVFORINST 3530.1 (reference (g)) and failed to comply with the governing instructions on RCB operations. Finally, the CTU 56.7.3 in Kuwait allowed the muddled command and control relationship on board the RCBs to continue with a first class petty officer (E-6) as the Patrol Leader (or Patrol Officer), technically in charge of the overall mission, but "deferring" to a lieutenant (O-3) commissioned officer, who was only qualified for the subordinate position of Boat Captain, for certain things like navigation. Without proper command oversight and leadership, CTU 56.7.3 developed a culture that prioritized convenience over the basic tenets of professional military operations. The incident on 12 January 2016 was a culmination of that flawed tactical leadership.

(4) **CTF 56 and ISIC Oversight.** Finally, Task Force (CTF-56) leadership failed to provide adequate ISIC oversight of CTG 56.7. Despite having voiced his opinion that the CRS community commissioned officers were not "front runners," and concerns over CTG 56.7's performance, CTF-56 failed to take appropriate measures to increase oversight and mitigate the identified weaknesses. The lack of intrusive leadership to correct recognized deficiencies stood in contrast to efforts to increase the RCB mission set in the area of operations during and after . Although CTF-56 has a wide span of responsibility and may rely

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on certain assumptions as to the capabilities of subordinate units, unit integrity, and mission execution, once the deficiencies of the subordinate command became clear, the Commodore had a duty to take corrective action. For example, CTF-56 failed to ensure Commander's intent and appropriate context was provided and understood by the Squadron Commander and Detachment OICs prior to deploying the detachment to Kuwait. Additionally, in the area of maintenance oversight, the CTF-56 CSO "chaired" a weekly Planning Board for Maintenance but only participated in the meeting about once per month and "was not aware of how CTG-56.7 conducted maintenance." A key obligation of Task Force Commanders is to ensure subordinate commands completely understand the mission set and are fully aware of the material readiness of their assigned forces. These are just two examples of several failures to provide oversight in manning, training, equipment readiness, and mission execution. Additionally, the CTF Commodore failed in his duty to notify higher headquarters of a concern in the mission capability and readiness of one of his units. The essence of Task Force leadership is to closely monitor and adjust for subordinate unit mission capability, training, and readiness. In that regard, CTF-56 leadership failed to provide required oversight of CTG 56.7.

b. (U/ (b) (1)) **Lack of Effective and Sustained Training**

(1) (U/ (b) (1)) The second area of concern was the absence of effective and sustained training across the board for the RCB crews. In short, the lack of a measurable standard resulted in an inability for the unit to self-assess or for senior Commanders to assess the unit's capability to execute its assigned missions. Simply put, neither the unit, nor its leadership, could make objective assessments of CTG 56.7's ability to conduct missions. The CTG 56.7 command team failed to implement a command training team, and the basic methodologies required, for an effective squadron training program, prior to and during deployment. As such, the lack of any sustainment training during deployment was predictable and resulted in degraded unit performance and ultimately led to the incident off Farsi Island.

(2) (U/ (b) (1)) As stated in the CORIVFORINST 3502.1 (reference (f)), "In the Sustainment Phase Training, that begins upon completion of the Advanced/Integrated Phase and will include scheduled operational deployments or deployments for training and through the post-deployment period ... training at both the individual and the unit level must be continuous throughout all phases of the FRTP including Sustainment, Deployment, or Post-Deployment Sustainment periods. The requirement is premised upon a need to be able to respond quickly to contingency operations or short fuse requirements. It is expected that continuous training shall be built upon a foundation of the commanders' and leaders' ability to access, develop, and execute effective required training. Commanders train their units on their Navy Mission Essential Tasks. Senior leaders reinforce training by approving and upholding training priorities and providing adequate resources". The requirement for Commanding Officers to incorporate an aggressive sustainment training plan to prevent a loss in combat readiness during deployment is clear. Commanders are to train their units based on core missions. ISICs and senior leaders reinforce training by approving and upholding training priorities and providing adequate resources. Without the Commanding Officer and other unit leaders' direct involvement in

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management and oversight of the training program, including continuous training on deployment, units will fail.

(3) (U) (b) (1) The absence of sustainment training proved costly due to the challenges and deficiencies of CRS-3 pre-deployment training and certification. Naval Expeditionary Combat Command (NECC) lacked RCB-specific schools and needed to realign the training pipeline to match the new CRS mission set following the disestablishment and merger of CRS-3. The failure to shift enough trained and RCB experienced Sailors to the San Diego Training Evaluation Unit (TEU) resulted in the RCB Sailors essentially training themselves on platforms smaller and less capable than RCBs to conduct RCB operations. The Investigating Officer specifically noted the lack of adequate navigation training for the RCB crews by CRS-3 and Coastal Riverine Group ONE. Regarding weapons training, only some of the RCB Sailors fired their weapons underway and the Remote Operated Stabilized Small Arms Mount (ROSAM) weapon system was never employed in a live fire exercise. Finally, the Investigating Officer noted a deficiency in record keeping of pre-deployment unit training, individual skills training, and also a lack of documented qualifications by the RCB Sailors despite "interim" qualification letters. As such, although the RCB Sailors were certified, the records of actual training do not exist to support that certification. The resultant RCB crew "certification" without a formalized training plan and clear assessment standards left these crews unprepared to execute the full spectrum of required missions. This ineffective pre-deployment training set the stage for the 12 January 2016 incident off Farsi Island.

6. (U) (b) (1) I formally approve the Findings of Fact of the investigating officer subject to the modifications, additions, and comments as set forth in detail in Appendix G. The following is my endorsement of the Opinions and Recommendations of the Investigating Officer.

OPINIONS

7. (U) (b) (1) Subject to the following comments, changes or modifications, the opinions of the Investigating Officer are hereby approved:

Pre-Deployment Readiness

VI.A.13. (U) I disapprove the opinion. The fact the CTF-56 pre-deployment order was not "timely" is irrelevant. CRS-3 simply did not fully train and prepare for deployment in accordance with applicable guidance and instructions. [FF (II.K.4), (II.K.5), (II.K.8)-(II.K.10)]

VI.A.14. (U) I disapprove the opinion. The lack of a comeback message from CRS-3 is irrelevant to whether CTF-56 should have assumed CRS-3 was mission capable. The key fact is THIRD FLEET had certified the CRS-3 for deployment to the FIFTH FLEET AOR.

CRS-3 Deployment

VI.B.4. (U) I disapprove the opinion. It is my assessment the geographic distance from the CTG-56.7 HQ in Jebel Ali, UAE to the subordinate units in Bahrain and Kuwait was not the issue; instead, it was the documented and sustained failure of leadership by CTG-56.7.

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VI.B.8. (U) I concur with the opinion that CTF-56 created a command climate of “can’t say no.” I interpret that to mean CTF-56 fostered a command climate that caused subordinates to not raise objections and instead assume unnecessary risk. [FF (III.C.1)-(III.C.2), (III.C.7)-(III.C.9) (III.G.22)-(III.G.23)]

VI.B.9. (U) Modify the opinion as follows to clarify CTF-56 action at issue: “CTF-56 attempted to replicate the Maritime Operations Center/Maritime Headquarters construct, but it was ineffective and created a disconnect between operations and material readiness that contributed to a breakdown in communication in the preparation for the two RCBs’ transit from Kuwait to Bahrain. [FF (III.F.5), (IV.A.29)-(IV.A.30), (IV.E.6)]”

VI.B.17. (U) Modify opinion to read as follows: “CTF-56 Commodore did not allow for adequate planning and did not provide sufficient ISIC oversight for the 12 Jan 16 RCB transit mission from Kuwait to Bahrain. [FF (III.D.5-6), (III.F.7), (III.F.1), (III.F.2)]”

Add Opinion VI.B.18: “(U) The RCBs Leading Chief Petty Officer failed to support CTU 56.7.3 and the RCB 802 Boat Captain (O-3) in not ensuring an environment and culture of adherence to standards, failed to provide forceful back-up to the CRS-3 leadership, and failed to set the example as a Patrol Leader. [FF (III.E.8-17)-(III.F.3-6), (IV.D.1-10)]”

Add Opinion VI.B.19: “(U) CTU-56.7.3 and the RCB crewmembers lacked a fundamental understanding of who had TACON and weapons release authority during the mission. [FF (III.G.29), (IV.A.50-53), (IV.C.10)-(IV.C.14), (IV.C.16-17)]”

Events of 11-13 January 2016: The RCB Transit from Kuwait to Bahrain

VI.C.16. (U) Modify opinion to read: “The RCB 802 and 805 Boat Captains deliberately deviated from the Plan of Intended Movement (PIM) track without approval, planning or due regard for safe navigation, placing their boats and their crews at risk.” [FF (IV.A.17), (IV.A.18), (IV.A.30), (IV.A.37), (IV.A.54), (IV.D.4), (IV.D.5), (IV.E.21), (IV.E.22), (IV.E.23), (IV.E.46), (IV.E.57)-(IV.E.59), (IV.E.61)]

VI.C.17. (U) Modify opinion to read: “The RCB 802 and 805 Boat Captains failed to order an adequate force protection posture for transit through the Central Arabian Gulf.” [FF (IV.D.9), (IV.E.34)-(IV.E.39) (IV.G.11)]

The Iranian Interactions

VI.D.5. (b) (1) I disapprove the opinion. I disagree with the opinion of the IO that this was never a SOLAS situation. I assess the RCB 802 Boat Captain effectively communicated that he had an engineering casualty. As a matter of policy and practice a vessel (b)(1) E.O. 13526 1.4 (A), (b)(5) coming on scene and encountering a Dead in the Water (DIW) vessel and an individual displaying a wrench to indicate engine trouble, should ask whether the DIW vessel needs assistance. I assess that as the better view of state practice under these circumstances.

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VI.D.9. (b) (1) I disapprove the opinion. I disagree with the IO that filming/recording an interaction with IRGCN under these circumstances is “non-innocent” under applicable international law. The US historically films and records interactions with coastal state navies as we transit territorial waters in innocent passage.¹ In this matter, if the RCB crews were properly prepared and did film/record (b)(1) E.O. 13526 1.4 (A); (b)(5) the interaction with the IRGCN, it would have been to capture the IRGCN actions including arguably unlawful actions and/or IRGCN demonstrated hostile intent, and also to justify/document our innocent passage and responsive actions. One Sailor attempted to do so on her personal phone. In any event, we should be cautious in such a limited interpretation of our rights as we execute innocent passage.

VI.D.23. (b) I approve the opinion in part. Although as stated in VI.D.22, the CTG 56.7 Commander should have ensured his personnel (e.g., RCB crews) were aware of and trained on the COMFIFTHFLT 17 December 15 message (and the earlier FIFTH Fleet 14 July 15 message) to ensure his forces had COMFIFTHFLT intent, and such training would have assisted the RCB crews to better understand the current environment and use of force, the investigation shows a basic lack of effective training by CTG-56.7 overall. The failure to train on Fleet Guidance is but one part of the problem. The lack of sustainment training overall by both CTG 56.7 and the RCB crews remains the main issue. [FF (III.F.8)-(III.F.10), (additional FF III.F.12-16, additional FF IV.A.67, IV.H.49, FF IV.H.60-IV.H.70, enclosure (7), enclosure (266)]

CTF-56/CTG-56.7 Response

VI.E.6. Add Opinion: “(U) At all levels of tactical and operational command, there were opportunities missed to both intervene and provide sufficient oversight of this transit mission. [FF (IV.E.52)–(IV.E.54), (IV.E.61), (IV.E.63), (IV.H.71), (IV.K.3)]”

RECOMMENDATIONS

8. (U (b) (1)) Subject to the following comments, changes or modifications, the Recommendations of the Investigating Officer are hereby approved:

Accountability

VI.K.1. (U) I concur and will take administrative action against the CTF-56 Commodore for his lack of leadership, oversight and judgment in the preparation and execution of his duties.

VI.K.2. (U) I concur and will take administrative action against the CTF-56 Chief Staff Officer for his lack of leadership, oversight and support to both his subordinates and his Commodore.

Add Recommendation VI.K.9: “(U) I recommend appropriate action be taken by the cognizant command authority against the RCBs Leading Chief Petty Officer for failure to support CTU

¹ See filming of Soviet Union naval vessels intercepting and shouldering USS YORKTOWN and USS CARON during a FONOPS in Soviet Union territorial waters off of the Crimea in 1988 (“The Black Sea Bumping” incident).

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56.7.4 OIC, failure to foster an environment and culture of adherence to standards, failure to provide forceful back-up to the CRS-3 leadership, and failure to set the example as a Patrol Leader.”

Immediate Recommendations

VI.L.1-4. (U) I have taken action and implemented the Investigating Officer’s recommendation for an immediate operational training and readiness stand down to ensure that CTF-56 Coastal Riverine Forces are fully prepared, trained, and ready to operate in the FIFTH Fleet area of responsibility. See enclosures 274, 275, 276.

VI.L.3. (U) I concur except modify the recommendation to include not just the CTF-56 Commodore, but also the Chief Staff Officer, or a designated representative, conduct a Navigation “Check-Ride” on all deploying units once they arrive in theater as a turnover item during Remain in Place/Transfer of Authority (RIP/TOA).

VI.L.5, 6, and 8 (U) I concur and direct completion of the recommended action.

VI.L.7. (U) I concur and have directed a DEOMI organizational survey. See enclosure 276.

Training and Readiness Recommendations

VI.M.1. (U) I concur except change “no less than six months in advance ” to “prior to intermediate training phase” to publish “pre-deployment” orders for incoming forces, and update with serialized modifications as required.

VI.M.11. (U) I non-concur and modify/limit the action by CTF-56 to in-theatre forces.

Policies, Programs, and Procedures

VI.N.1. (U) Non-concur with the recommendation as I assess Navy Regulations give sufficient authority to the CO, CRS-3 to ensure the crews understand the sovereign immune nature of the vessel.

VI.N.2. (b) (1) I concur in part with the IO’s recommendation. I assess that the Code of Conduct as written is sufficient and provides our Service members a simple set of guidelines to follow. However, the application and training on the Code of Conduct should be streamlined to emphasize the six articles and specific instruction on the behaviors and obligations expected of Service members during captivity, regardless of the applicable “legal context” (e.g., armed conflict, non-international armed conflict, peacekeeping operation, peacetime governmental detention, criminal/terrorist hostage situation). The IO has assessed actions by the RCB Sailors that were inconsistent with the Code of Conduct. I attribute this in part to confusing training on application of the Code of the Conduct. As such I assess the Code of Conduct need not be updated.

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VI.N.3, 4, and 6. (U) Modify and combine the Recommendations to read: I concur with the recommendation regarding an update to applicable instructions and training to include DoD Instruction 1300.21 based on lessons learned from this event.

VI.N.5. (U) I non-concur with the IO's recommendation that Navy Expeditionary Combat Command require Coastal Riverine boat crews complete in-person Search, Evasion, Resistance, and Escape ("SERE") school. The training of the crews should align with similarly situated forces. See also recommendation VI.N.8 below.

VI.N.8. (U) I concur but modify the recommendation to eliminate a distinction between the various operating environments (blue, green, or brown water) to read as follows: (U) Coastal Riverine boat crews due to the diverse operational environments in the Central Command area of operations will be designated as "High Risk of Isolation" and require those crews complete High Risk of Isolation training prior to deployment.

VI.N.9. (U) I non-concur as the CENTCOM pre-deployment theater entry training requirements are sufficient.

Lessons Learned

VI.O.1. (b) I concur and previously directed each CTF to conduct scenario training related to my 17 December 15 message.

VI.O.2. (U) I concur and recommend that this incident should be a case study for not just FIFTH Fleet, but all those who operate in the maritime environment.

Add Recommendation VI.O.3: "(b) (1) Search and Rescue Operation. The Search and Rescue (SAR) and follow-on recovery operations were professionally coordinated and executed by the HARRY S TRUMAN Carrier Strike Group (CTF-58), who had TACON of the operation, and were well supported by the CHARLES DE GAULLE Carrier Strike Group (CTF-50) and HMS DEFENDER. Although I had sufficient authorities (including under international law (b)(1) E.O. 13526 1.4 (A); (b)(5) to conduct SAR in Iranian territorial waters and airspace) and also excellent higher headquarters and interagency support in this incident, I did not have a communication mechanism with the IRGCN. The absence of this communication path created a risk of miscalculation, (b)(1) E.O. 13526 1.4 (A); (b)(5) during the hours we were conducting the SAR with both ships and aircraft inside the territorial waters and airspace of Iran. (b)(1) E.O. 13526 1.4 (A); (b)(5)

9. (U/(b) (1)) Conclusion. The detailed Investigation Report into the incident on 12 January 2016 off Farsi Island clearly shows the need for effective leadership at all levels of command down to the deckplate level, effective pre-deployment and sustainment training, and a mindset

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marked by constant vigilance in the dynamic operational environment in the CENTCOM AOR. While it is abundantly clear that many of the Iranian actions were inconsistent with the customary international law applicable to situations such as this, the proximate cause of this event was an improperly planned transit evolution, conducted by poorly trained Sailors with lack of oversight, in vessels that were not materially ready for the evolution. As indicated by the report, shortfalls in personnel training, failure to adhere to established guidance, lack of oversight, and lack of attention to material and operational readiness contributed to the unpreparedness of RCB 802 and 805 and their crews for this evolution. Regrettably, these failures were avoidable and should have been corrected well before the boats got underway on 12 January 2016. These shortfalls combined with the failure of the crew to take appropriate, authorized action in response to the situation as it developed, resulted in this tactical mistake with potentially strategic consequences.

(b) (6)

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