OPERATION PROVIDE COMFORT

Review of U.S. Air Force Investigation of Black Hawk Fratricide Incident

November 1997

GAO/OSI-98-4
In response to written requests from the Subcommittee and subsequent discussions with your offices, this report presents the results of our review of military investigations made subsequent to the April 14, 1994, shootdown by U.S. Air Force F-15 fighters of two U.S. Army Black Hawk helicopters over Iraq in which 26 individuals died. We were asked to determine if the Air Force’s subsequent Aircraft Accident Investigation Board investigation of the fratricide had met its objectives, if the resulting Uniform Code of Military Justice investigations had followed established guidelines, and if military officials had improperly or unlawfully influenced these investigations. We were also asked to, during our investigation, consider concerns voiced by victims’ family members and others.

We are sending copies of this report to the Secretary of Defense, the Secretaries of the Air Force and the Army, and interested congressional committees. Copies will also be made available to other interested parties upon request.

If you have questions about this report, please call me or Deputy Director for Investigations, Donald G. Fulwider, at (202) 512-7455. Major contributors to this report are listed in appendix III.
Executive Summary

Purpose

On April 14, 1994, two U.S. Army Black Hawk helicopters and their crews assigned to Operation Provide Comfort were transporting U.S., United Kingdom, French, and Turkish military officers; Kurdish representatives; and a U.S. political advisor in northern Iraq. Concurrently, a U.S. Air Force Airborne Warning and Control Systems (AWACS) aircraft was flying over Turkey to provide airborne threat warning and control for Operation Provide Comfort aircraft, including the Black Hawk helicopters. The pilots of two U.S. F-15 fighters patrolling the area misidentified the Black Hawks as Iraqi Hind helicopters and shot them down, killing all 26 individuals aboard.

As a result of questions raised by concerned individuals, including family members of those killed in the fratricide, the House Committee on National Security held a hearing in August 1995 to examine the causes of the incident, the resulting investigation by an Air Force Aircraft Accident Investigation Board, and the judicial actions under the Uniform Code of Military Justice (UCMJ) that followed. After the hearing, the Committee asked GAO to determine if (1) the Board investigation of the shootdown had met its objectives, (2) the subsequent UCMJ investigations had followed established guidelines, and (3) Department of Defense and/or Air Force officials had improperly or unlawfully influenced these investigations. The Committee also requested that, during its investigation, GAO consider concerns of victims’ family members and others, including corrective actions taken to help prevent another accident.

To do so, GAO interviewed over 160 individuals throughout the United States, Europe, and the Middle East. They included family members; involved aircrews; Army and Air Force personnel who had served in Operation Provide Comfort; Board members, legal staff, and technical staff; and command personnel responsible for staff assigned to Operation Provide Comfort. GAO reviewed its previous work concerning Operation Provide Comfort and analyzed Board and UCMJ documentation, including 25 volumes and about 700 pieces of supporting evidence from the Board, thousands of classified documents, hearing and court-martial transcripts, and reports of corrective actions taken. However, the Department of Defense prevented GAO from interviewing key officials in the process, including the Convening Officials and the Inquiry and Investigating Officers. The Department of Defense voiced the belief that “any Congressional intrusion” into the UCMJ deliberative process would compromise the independence of the military justice system. GAO did not evaluate the appropriateness of the disciplinary or corrective actions taken.
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Background

In April 1991, the United Nations Security Council passed Resolution 688 that demanded that Iraq stop repressing the Kurds in northern Iraq and called on member nations to help meet the humanitarian needs of the region. An emergency relief effort was initiated, named Operation Provide Comfort. Military units from the United States and 12 other countries soon joined the effort as a coalition. The air forces of four coalition members, including the United States, began securing the area of northern Iraq above the 36th parallel, prohibiting Iraqi aircraft from flying north of that parallel—the “no-fly zone.” The coalition also established a security zone for the Kurds, inside the no-fly zone, into which no Iraqi military could enter.

The U.S. Commander in Chief, Europe, directed the creation of a Combined Task Force with all coalition members. By September 1991, the Combined Task Force organization, headed by U.S. and Turkish co-commanders, included a Combined Task Force staff; a Combined Forces Air Component (CFAC); and a Military Coordination Center. The CFAC Commander exercised daily control of the Operation Provide Comfort flight mission through his Director of Operations (CFAC/DO), as well as a ground-based Mission Director at the Combined Task Force headquarters and an Airborne Command Element aboard the AWACS. The CFAC/DO was responsible for publishing guidance, including the Airspace Control Order, for conduct of Operation Provide Comfort missions. (The Airspace Control Order was a directive to all Operation Provide Comfort aircrews that provided rules and procedures governing Operation Provide Comfort flight operations.) The Military Coordination Center monitored conditions in the security zone and was supported by a U.S. Army helicopter detachment.

Planes and personnel assigned to Operation Provide Comfort on a temporary duty basis conducted air operations. U.S. air assets included, among others, AWACS aircraft, F-15 fighters, and Black Hawk helicopters. Daily flight operations were referred to as “mission packages.” AWACS aircraft were to (1) control aircraft enroute to and from the tactical area of responsibility (TAOR), or no-fly zone; (2) coordinate air refueling; (3) provide airborne threat warning and control in the TAOR; and (4) provide surveillance, detection, and identification of all unknown aircraft. F-15 fighters, as the first aircraft in the TAOR, were to search—“sanitize”—the area with radar and electronic measures to ensure that it was clear of hostile aircraft and then fly orbit to provide air cover for the rest of the package. The Army’s Black Hawk helicopters flew supply and transport missions for the Military Coordination Center. They
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also provided transport into the TAOR to visit Kurdish villages and maintain a visual presence.

On the day of the incident, two Black Hawks and their crews were transporting officials inside the TAOR. Although the AWACS crew flying support for the day’s mission package were aware that the Black Hawks were in the area, the two F-15 pilots sanitizing the area were not aware of their presence. The F-15 pilots received two radar contacts (helicopters) and stated that they attempted unsuccessfully to identify them by electronic means. They twice reported their unsuccessful attempts to the AWACS but were not informed of the presence of the Black Hawks in the contact area. As required, the F-15 pilots attempted a visual identification of the helicopters. However, their attempt, involving a single pass each, was at speeds, altitudes, and distances at which it was unlikely that they would have detected the helicopters’ markings. This resulted in the lead pilot’s misidentification of the helicopters as Iraqi Hinds and the subsequent shootdown of the Black Hawks.

Later that day, the U.S. Secretary of Defense ordered an investigation that resulted in the convening of an Aircraft Accident Investigation Board, which made information more readily available to the public than would a Safety Board Investigation. The Board report and the required Board President’s opinion (see app. 1)—issued May 27, 1994—identified “a chain of events” as the incident’s cause: beginning with the Combined Task Force’s failure to provide clear guidance to its component organizations, the components’ misunderstanding of their responsibilities, Operation Provide Comfort’s failure to integrate Army helicopter and Air Force operations, AWACS crew mistakes, and ending with the F-15 lead pilot’s misidentification of the helicopters and the wingman’s failure to notify the lead pilot of his inability to positively identify the helicopters.

On the basis of the report, the Secretary of Defense directed applicable military commands to determine if UCMJ violations had occurred. Subsequently, the commands appointed Inquiry Officers and Investigating Officers to investigate 14 officers. The UCMJ process resulted in the following: one officer was tried by court-martial, resulting in an acquittal; one officer received nonjudicial punishment under Article 15, consisting of a letter of reprimand; and nine others received administrative letters of either reprimand, admonition, or counseling. No adverse action was taken against the remaining three officers.
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Results in Brief

The primary purpose of an Aircraft Accident Investigation Board, in accordance with Air Force Regulation 110-14 (since replaced by Air Force Instruction 51-503), is to gather and preserve evidence for claims, litigation, and disciplinary and administrative needs. Within a limited time frame of 42 days, the Board conducted an extensive investigation that complied with the regulation’s evidentiary requirements and guidelines in collecting and preserving evidence. It also produced a “Summary of Facts,” or report, that with a few exceptions provided an overview of the factual circumstances relating to the accident.

The Aircraft Accident Investigation Board report focused on, among other matters, command and control problems, including individuals’ lack of knowledge of specific procedures. The report, however, (1) did not discuss the F-15 pilots’ responsibility, under the Airspace Control Order, to report to the Airborne Command Element when encountering an unknown aircraft in the TAOR and (2) cited a CFAC Commander statement that inaccurately portrayed the Airborne Command Element as not having authority to stop the incident, even though evidence that the Airborne Command Element had the authority was available to the Board. Further, the Board President erroneously concluded that the Black Hawks’ use of an incorrect electronic identification code in the TAOR resulted in the F-15 pilots not receiving an electronic response.

Additionally, at the August 1995 hearing, family members and others raised concerns about a perceived general lack of discipline in the F-15 pilot community in Operation Provide Comfort and a perceived urgency by the F-15 pilots to engage during the shootdown. The Board’s report and opinion did not discuss these issues. While an examination of these issues was not required under Air Force Regulation 110-14, the regulation did not preclude it; and GAO found the issues relevant to its inquiry.

In response to GAO inquiries, Operation Provide Comfort officials stated that the pilots’ failure on April 14, 1994, to contact the Airborne Command Element was the result of a lack of F-15 mission discipline in Operation Provide Comfort at the time of the incident. In addition, Operation Provide Comfort officials stated that, in their view, there was no reason for the F-15 pilots’ urgency to engage. These issues are not inconsistent with the Board President’s conclusion regarding the chain of events that led to the misidentification and shootdown of the Black Hawks. Including them in the Board’s report, however, may have raised additional questions about the actions of the F-15 pilots and the Airborne Command Element that
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could have been useful in subsequent administrative and disciplinary actions.

During its review of the Aircraft Accident Investigation Board process, GAO found no evidence of improper or unlawful command influence. That review included access to, among others, Board members, technical advisers, and investigative staff as well as investigative documents.

Regarding the questions concerning the subsequent UCMJ process and improper or unlawful command influence during that process, GAO determined the following. UCMJ investigations complied with provisions of the UCMJ and the Manual for Courts-Martial. Based on a review of the summary reports of investigation, a statement by the AWACS Investigating Officer, and stipulations by several of the officials involved in UCMJ investigations, GAO found no evidence of improper or unlawful command influence. However, GAO was unable to confirm whether the consideration and disposition of suspected offenses under the UCMJ were the result of improper or unlawful command influence because the Department of Defense, concerned about any congressional intrusion into the deliberative process, denied GAO’s request to interview the applicable UCMJ Convening Authorities, Inquiry Officers, and Investigating Officers.

Finally, immediately following the accident and as the result of additional reviews and analyses, the Department of Defense and the Air Force took hundreds of corrective actions, including insertion of Black Hawk flight times on the daily Air Tasking Order, to help prevent a similar shootdown. The Chief of Staff, Air Force, also took additional personnel actions, including issuing letters of evaluation, after finding that a number of individuals’ performance evaluations had not reflected previous administrative actions taken as a result of the individuals’ failure to meet Air Force standards.

Principal Findings

Aircraft Accident Investigation Met Objective but Report Was Not Complete

The Aircraft Accident Investigation Board was properly convened and met the objective as set forth in Air Force Regulation 110-14 of conducting an extensive investigation that preserved evidence of the facts surrounding the incident. The required report, which included the Board President’s opinion, focused on Combined Task Force command and control.
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problems, among other matters, citing lack of knowledge of command and control guidance as one reason for the deficiencies of the AWACS crew and activity by the incident Black Hawk pilots. However, the Board report did not discuss or did not properly assess relevant information available to it regarding three aspects involving the F-15 pilots and the Airborne Command Element. Further, concerning F-15 pilot discipline, Operation Provide Comfort officials told GAO that mission discipline problems with F-15 pilots did exist at the time of the incident and they saw no reason for the incident F-15 pilots’ urgency to shoot.

F-15 Pilots’ Requirement to Contact Airborne Command Element

The Board’s report did not discuss the F-15 pilots’ responsibility, under the Airspace Control Order, to report any unusual circumstance or occurrence, such as an unidentified aircraft in the TAOR, to the Airborne Command Element aboard the AWACS. The Board had reviewed this provision of the order and evidence that the pilots knew of the provision. The Board report did not discuss the F-15 pilots’ failure to report to the Airborne Command Element because the Board concluded that the Airborne Command Element had been aware of the F-15s’ intercept of the helicopters. Therefore, the Board did not consider the pilots’ nonadherence to be a significant cause of the accident. According to a Board representative, the nonadherence was an example of a general breakdown in command and control, and it “may not have been common practice” for pilots to make this contact. While the Board conducted an extensive investigation, it did not know of a CFAC/DO oral directive given about a week before the shootdown, reemphasizing the requirement for fighter pilots to report to the Airborne Command Element. That directive was the result of an incident in which F-15 pilots had initially ignored directions from an Airborne Command Element, concerned about a possible trap, to “knock off,” or stop, an intercept with an Iraqi aircraft.

Airborne Command Element Had Authority to Stop Encounter

Also, the Board cited a CFAC Commander’s inaccurate testimony that the Airborne Command Element had no decision-making authority with regard to aircraft encounters in the TAOR. Other testimony—gathered during the Board’s investigation—from more knowledgeable individuals, including the CFAC/DO who used the Airborne Command Element as “his eyes and ears” in the TAOR, contradicted that statement. Under the Airspace Control Order, the Airborne Command Element had the authority to stop fighters from engaging hostile or unknown aircraft in the TAOR.

Black Hawks’ Use of Wrong Electronic Code Should Not Have Prevented F-15 Pilots From Receiving Response

The Board President erroneously concluded that the Black Hawks’ use of an incorrect electronic code resulted in the F-15 pilots not receiving a response when using their electronic Air-to-Air Interrogation/Identification...
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Friend or Foe (AAI/IFF) systems. A subsequent Air Force analysis was inconclusive as to why the F-15 pilots did not receive a response. However, that analysis—based on the pilots’ testimony regarding their system interrogation settings—indicated that during certain interrogation sequences, the F-15 pilots should have received a response regardless of the Black Hawks’ code. Although the Board reviewed the pilots’ testimony, as well as other information about the IFF system settings and operation, the Board President drew an erroneous conclusion from the information.

Operation Provide Comfort—Perceived Discipline Problem and Urgency to Fire

Family members and others raised concerns about perceived Operation Provide Comfort discipline issues not described in the report or the opinion: lack of mission discipline by F-15 pilots in general and the incident pilots’ urgency to fire. Although these issues were not required to be in the Board’s report or opinion, the Board was not precluded from probing them; and GAO found the issues relevant to its review.

In response to GAO’s questions, Operation Provide Comfort officials stated that they had experienced a number of mission discipline problems with F-15 pilots. These included the knock-off incident a week before the shootdown. Operation Provide Comfort officials also noted that the rivalry between F-15 and F-16 pilots, normally perceived as leading to a positive professional competition, had become more pronounced and intense at the time of the shootdown. Further, one command official stated that this rivalry may have led to the incident F-15 pilots’ perceived rush to shoot. According to Operation Provide Comfort officials, the Airspace Control Order was specifically designed to slow a situation, allowing CFAC time to check it out. These officials said the F-15 pilots had no need for haste, as the sighted helicopters had posed no threat to the F-15s or the mission package.

Question of Command Influence During the Aircraft Accident Investigation Board Process

Based on GAO’s review of extensive information made available to it and interviews of Board members and technical and legal advisors, GAO found no evidence of improper or unlawful command influence exerted during the Aircraft Accident Investigation Board process.

Military Justice Process and Administrative Actions

The Air Force UCMJ investigations that followed the Aircraft Accident Investigation complied with provisions in the UCMJ and the Manual for Courts-Martial. In accordance with Department of Defense guidelines, charges are ordinarily forwarded to the accuseds’ immediate commander.
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for initial consideration as to disposition. Thus, individuals were considered under UCMJ by two separate commands.

A command under the U.S. Air Combat Command investigated seven officers; one—the AWACS Senior Director—was court-martialed. He was found not guilty. Another—the Commander, 963d Air Control Squadron—retired. Four others received letters of reprimand: one letter was the result of nonjudicial punishment; the others were administrative actions. No action was taken against the CPAC Mission Director because he was judged blameless in the incident.

A command under the U.S. Air Forces in Europe investigated the other seven officers—five Operation Provide Comfort officials and the two F-15 pilots. The pilots received letters of reprimand; two other officers received less severe letters of admonition, with one—the Commander, Operation Provide Comfort Combined Task Force—also being reassigned to a noncommand position; the Director of Operations for Plans and Policy received a letter of counseling and revocation of a medal for meritorious service. No action was taken against the two remaining officers.

**Question of Command Influence During the UCMJ Process**

GAO found no evidence of command influence, based on a review of information made available to it—including (1) summary reports of investigation during the UCMJ process that included the suspected violations, facts considered, and analysis involved in the decisions reached; (2) a statement by the Investigating Officer in the AWACS investigation denying outside influence; and (3) statements by six cognizant officials denying any improper influence. In GAO’s attempt to confirm whether the consideration and disposition of suspected offenses under the UCMJ process were the result of improper or unlawful command influence, GAO requested access to the Convening Authorities, Inquiry Officers, and Investigating Officers. However, the Department of Defense—saying “any Congressional intrusion into the deliberative process . . . endangers the actual and perceived independence of the military justice system”—refused to allow GAO to interview these military officers, thus limiting GAO’s investigation in this area.

**Air Force Corrective Actions and Task Force Findings**

Within 24 hours of the shootdown, European Command and Combined Task Force Commanders instituted corrective actions, including modifications of the Rules of Engagement, addition of helicopter flight
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Since the tragic deaths of 26 men and women on the Black Hawk helicopters were attributable to a series of avoidable errors and the failure of safeguards in place at the time of the shootdown. In July 1994, he ordered a review of Joint Task Force operations with the objectives of strengthening operational oversight, implementing change, and reviewing AWACS training and certification procedures.

An Air Combat Command “Tiger Team” studied AWACS/Airborne command and control, visual identification, and ground command and control and made about 140 recommendations in its September 14, 1994, report. Concurrently, a special Air Force task force composed of more than 120 people in 6 commands concluded that 2 breakdowns in individual performance contributed to the shootdown: (1) The AWACS mission crew did not provide the F-15 pilots an accurate picture of the situation and (2) the F-15 pilots misidentified the target.

Actions by the Flying Evaluation Boards and the Air Force Chief of Staff

Flying Evaluation Boards were convened by the Air Force as a result of the shootdown. Upon review of the Boards’ findings and recommendations, the Commander, 17th Air Force concluded that the lead F-15 pilot and the F-15 wingman should remain qualified for noncombat aviation service. In a subsequent review, the Commander, U.S. Air Forces in Europe (1) concurred with the decisions relating to the lead pilot and (2) determined that the wingman remain qualified for aviation service but directed that he be reassigned to a staff position not involved in flying duties.

At the request of the Secretary of the Air Force, the Air Force Chief of Staff reviewed the administrative actions taken in regard to the Air Force personnel involved in the shootdown. While the Chief of Staff determined that a proper balance had been maintained between command involvement and individual rights, he noted that a number of performance evaluations were inadequate, as they were inconsistent with administrative actions taken by higher level commanders. Accordingly, he prepared letters of evaluation for seven Air Force personnel, noting their failure to meet certain Air Force standards, and took additional action against five of the personnel. The two F-15 pilots were disqualified from
aviation service for 3 years and three members of the AWACS crew were disqualified from assignment to duties involving control of aircraft in air operations for at least 3 years.

Recommendations

GAO is making no recommendations.

Agency Comments

In written comments on a draft of this report, the Department of Defense concurred in GAO’s conclusions that (1) the Board was properly convened, complied with the law, and met its objectives; (2) the military justice investigations that followed the accident investigation also complied with applicable law; and (3) no evidence of unlawful or improper command influence existed with respect to the accident investigation or military justice processes. Defense agreed that the few differences between GAO’s report and the accident investigation report would not have affected the Board President’s conclusions. These comments are reprinted in appendix II.
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Abbreviations

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<td>AAI/IFF</td>
<td>Air-to-Air Interrogation/Identification Friend or Foe system</td>
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<td>Airborne Warning and Control Systems aircraft</td>
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<td>Combined Forces Air Component</td>
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<td>tactical area of responsibility</td>
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Chapter 1

Introduction

Background

Operation Provide Comfort

Mission

In April 1991, and in concert with United Nations Security Council Resolution 688, military units from a coalition of the United States and 12 other countries began providing direct emergency care and assistance to Kurds and other ethnic groups in northern Iraq following a revolt against the Iraqi government. This emergency relief effort was named Operation Provide Comfort.

Coalition forces secured an area of northern Iraq that excluded Iraqi aircraft above the 36th parallel—the tactical area of responsibility (TAOR)—or no-fly zone—and prepared transit camps within Iraq for the return of the people who had fled from the advancing Iraqi army. To provide a secure environment for the returnees, the coalition established a security zone within the TAOR into which Iraqi forces could not enter. Coalition air forces from France, Turkey, the United Kingdom, and the United States were assembled to conduct frequent air operations in the TAOR. A Military Coordination Center was established in Zakhu, Iraq, located inside the security zone, to provide a direct communications link with the Iraqi military, humanitarian relief agencies, and Kurdish leaders. Figure 1.1 illustrates the location of pertinent points in and around the TAOR.

1The U.S. Commander in Chief, Europe, directed the creation of a Combined Task Force with all coalition members. Members at that time were the United States, Australia, Belgium, Italy, Canada, Turkey, the United Kingdom, France, Germany, Spain, the Netherlands, Portugal, and Luxembourg.

2The TAOR was the airspace north of 36 degrees north latitude in Iraq from which Iraqi aircraft were prohibited.
Command Structure

The U.S. Commander in Chief, Europe, delegated operational control of assigned U.S. Army and Air Force units to the Combined Task Force Commander located at Incirlik Air Base, Turkey. The Combined Task Force Commander also had tactical control of participating Turkish, French, and British forces; but operational control of those forces was retained by their parent commands.3

On July 20, 1991, the Combined Task Force Commander issued an operations plan governing the conduct of the Operation Provide Comfort. The plan delineated the command relationships and organizational responsibilities within Combined Task Force Operation Provide Comfort. The Combined Task Force was headed by U.S. and Turkish co-commanders and included a Combined Task Force staff; a Combined Forces Air Component (CFAC); and the Army component, including the Military Coordination Center.

3Tactical control is the detailed, and usually local, direction and control of movements and maneuvers necessary to accomplish the assigned mission. Operational control is the authority to command subordinate forces, assign tasks, designate objectives, and give authoritative direction necessary to accomplish the mission.
CFAC coordinated air operations for Operation Provide Comfort. It had operational control of air assets—such as Airborne Warning and Control System aircraft (AWACS) and F-15 and F-16 fighters—and tactical control of Army helicopters. The Military Coordination Center at Zakhu was supported by a Black Hawk helicopter detachment at Diyarbakir, Turkey. (See fig. 1.1.) Air operations were conducted by planes and personnel assigned to Operation Provide Comfort on a temporary duty basis.

**Fighter Aircraft**

Fighter aircraft performed the bulk of the Operation Provide Comfort flying mission. A typical “mission package” contained as many as 30 to 40 fighter aircraft and a variety of aircraft with specific mission capabilities. The fighters flew two- and four-ship formations and provided the following capabilities: visual and sensor reconnaissance of military targets, defensive counter air operations, suppression of enemy air defenses, and on-call precision-guided munitions delivery. At the beginning of each mission, no other aircraft was supposed to enter the TAOR until fighters with airborne intercept radars had searched, or “sanitized,” the area.

**AWACS**

During the daily operations, the AWACS was responsible for (1) controlling aircraft enroute to and from the TAOR; (2) coordinating air refueling; (3) providing airborne threat warning and control for Operation Provide Comfort aircraft operating in the TAOR; and (4) providing surveillance, detection, and identification of all unknown aircraft. The AWACS took off about 2 hours before the rest of the fixed-wing package and eventually entered an orbit in Turkish air space slightly north of the TAOR. (See fig. 1.1.)

The AWACS mission crew was headed by a Mission Crew Commander who had overall responsibility for the AWACS mission. The Mission Crew Commander directly supervised an Air Surveillance Officer; Senior Director; and various communications, radar, and data processing technicians. The Air Surveillance Officer supervised air surveillance technicians who were responsible for identifying and monitoring non-Operation Provide Comfort aircraft. The Senior Director supervised and directed the activity of the controllers. The Enroute Controller was responsible for Operation Provide Comfort aircraft going to and from the TAOR. The Tanker Controller was responsible for coordinating the refueling of Operation Provide Comfort aircraft. The TAOR Controller was responsible for Operation Provide Comfort aircraft in the TAOR. In addition, a Turkish controller was present on each AWACS mission flight.
Military Coordination Center Black Hawk helicopters stationed at Diyarbakir provided air transportation for the Military Coordination Center liaison team and conducted resupply missions at Zakhu, as required. The Black Hawks also used Zakhu as a stage for flying missions further in the TAOR to visit Kurdish villages, monitored conditions in the security zone, and conducted search and rescue missions.

The Shootdown

On April 14, 1994, two U.S. Army Black Hawk helicopters and their crew assigned to the Military Coordination Center were transporting U.S., United Kingdom, French, and Turkish military officers; Kurdish representatives; and a U.S. political advisor in the TAOR. The Black Hawks had departed Zakhu enroute to Irbil, Iraq. (See fig. 1.1.) At the same time, two F-15s were sanitizing the area that the Black Hawks were in; and the AWACS was over Turkey providing airborne threat warning and control. The AWACS was aware that the Army Black Hawk helicopters had departed Zakhu and were proceeding east into the TAOR. However, the F-15 pilots were unaware that Black Hawk helicopters were already in the area and were not advised of the presence of friendly aircraft. The fighters twice informed the AWACS that they had unknown radar contacts in the TAOR, and the AWACS had access to electronic information regarding the presence of friendly aircraft in the vicinity of the F-15s' reported radar contacts.

Throughout the incident, the helicopters were unable to hear the radio transmissions between the F-15 pilots and the AWACS because they were on a different radio frequency.

According to the Aircraft Accident Investigation Board President’s opinion, when the F-15 pilots were unable to get positive/consistent electronic responses, they performed a visual intercept with each making a single identification pass over the Black Hawks to identify the “unknown” aircraft. However, the Board President concluded that the identification passes were carried out at speeds, altitudes, and distances at which it was unlikely that the pilots would have been able to detect the Black Hawks’ markings. The pilots said that they did not recognize the differences between the U.S. Black Hawk helicopters with wing-mounted fuel tanks and Hind helicopters with wing-mounted weapons. The Board President determined that the pilot in the lead F-15 aircraft had misidentified the U.S. Black Hawks as Iraqi Hind helicopters and the wingman did not confirm, when asked by the lead pilot, that he had been unable to make a positive identification. The flight lead fired a single missile and shot down the trailing Black Hawk helicopter. At the lead pilot’s direction, the F-15 wingman fired a single missile and shot down the
lead helicopter. All 26 individuals aboard the two helicopters were killed in the fratricide.

**Aircraft Accident Investigation**

When the Combined Task Force Commander learned that the Black Hawks had been shot down on April 14, 1994, he appointed the former CFAC Commander to conduct a Safety Board Investigation. The appointee assembled a staff and began to collect relevant information. Later on April 14, the Secretary of Defense ordered an Aircraft Accident Investigation, which provides more disclosure to the public than does a safety investigation. As a result, the safety investigation was discontinued; and an Aircraft Accident Investigation Board was convened under Air Force Regulation 110-14, since replaced by Air Force Instruction 51-503. The investigation's main objectives were (1) to gather and preserve evidence for further investigations and inquiries by conducting a thorough investigation and preparing an accident report and (2) to determine if possible, through the Board President's opinion, the accident's main causes.

**Objectives, Scope, and Methodology**

The House Committee on National Security held a hearing in August 1995 related to the April 14, 1994, incident. Subsequently, the Chairman and Ranking Minority Member of the Committee's Subcommittee on Military Personnel and Representative Mac Collins asked us, not to reinvestigate the shootdown but, to determine whether (1) the Board investigation of the Black Hawk shootdown had met its objectives and goals, (2) subsequent Uniform Code of Military Justice (UCMJ) investigations had followed established guidelines, and (3) any Department of Defense and/or Air Force officials had improperly or unlawfully influenced these investigations. The Subcommittee also requested that we consider concerns raised by victims' families and others. We did not evaluate the appropriateness of resultant disciplinary or corrective actions.

We interviewed family members of the U.S. victims and others with concerns about how the military had handled the incident. In general, they had questions about the process and results of the Aircraft Accident Investigation Board and the UCMJ investigations. We examined thousands

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1Air Force Regulation 127-4 (Safety), since replaced by Air Force Instruction 91-204, establishes the general program for investigating and reporting all U.S. Air Force mishaps. Safety investigations are conducted to find the cause(s) and take preventive actions. Since much of that information is available only from the person(s) directly involved, a promise of confidentiality is given to all witnesses; and privileged information is protected from disclosure outside the Air Force safety community. Therefore, restrictions are placed on the dissemination of the information obtained and the resulting report.
of documents, including over 2,000 classified documents; interviewed over 160 individuals; and visited localities in the United States, Europe, and the Middle East.

To assess compliance with regulations, we reviewed the Aircraft Accident Investigation Board’s report, its exhibits, and applicable regulations. We interviewed Board members, both legal and technical advisors to the Board, accident recovery team members, and many of those interviewed by the Board concerning their role in the incident. In particular, we examined how the Board investigated the incident, conducted its analyses, and produced its report and the Board President’s opinion. We also reviewed information developed by the Inquiry and Investigating Officers under UCMJ and the court-martial trial transcripts and exhibits.

To address questions raised by victims’ family members and others regarding the actions of the two F-15 pilots, the AWACS crew, and command officials, we reviewed the then existing rules of engagement, operations plan, pertinent orders (Airspace Control Order, Air Tasking Order, and Aircrew Read Files), and guidance. We interviewed F-15 pilots and Air Force officials to determine their understanding of the existing orders and guidance for fighters in Operation Provide Comfort. We questioned these individuals regarding the two F-15 pilots’ actions during, and statements concerning, the April 14, 1994, incident. We also interviewed the F-15 pilots involved in the shootdown. Further, we interviewed senior board members of the Flying Evaluation Boards that were convened. We reviewed the two F-15 pilots’ flight and military records and interviewed former instructors and fellow pilots to gain additional insight into their qualifications and abilities.

Regarding the Identification Friend or Foe (IFF) system and its operation on April 14, 1994, we reviewed the (1) Airspace Control Order and the Air Tasking Order authority by which the IFF system was to be employed; (2) statements of the two F-15 pilots regarding their operation and responses received from the systems on April 14, 1994; and (3) subsequent Air Force task force studies. We also interviewed other pilots, IFF technicians, and other technical experts to better understand the limitations and performance of the incident F-15 IFF systems.

With regard to AWACS operations, we reviewed the applicable procedures for AWACS operations on the date of the incident. We interviewed crew members aboard the AWACS during the shootdown to determine their knowledge of the events and their understanding of the roles and
responsibilities of the crew members. We also interviewed other AWACS crew members who had served in Operation Provide Comfort to determine the general understanding among AWACS crew members of their roles and responsibilities; the commanders and other command personnel of the 552d Air Control Wing, which operated the AWACS in Operation Provide Comfort; and Air Combat Command personnel responsible for identifying and instituting changes in AWACS operations following the investigations. To gain an understanding of command and control issues at the Combined Task Force, we interviewed personnel who were stationed at Operation Provide Comfort both before and after the incident.

With respect to Black Hawk operations, we examined the procedures used by Military Coordination Center personnel in scheduling helicopter activities and the Center’s integration with the other Operation Provide Comfort mission components. In addition, we interviewed individuals responsible for developing the procedures for Black Hawk flights; those who prepared the helicopters for their mission on April 14, 1994; and responsible Combined Task Force officials. We also reviewed documents concerning the Combined Task Force and the Black Hawk helicopters at the Center for Army Lessons Learned at Fort Leavenworth, Kansas. Further, we interviewed Combined Task Force and European Command officials and reviewed directives and files at Incirlik, Turkey, and Stuttgart, Germany.

Regarding improper or unlawful command influence during the Board’s investigation process, we interviewed the Board President and Deputy, members, and advisors. We also contacted the Commander, U.S. Air Forces in Europe, who had convened the Aircraft Accident Board Investigation. In addition, we reviewed records that cautioned against unlawful influence.

Regarding improper or unlawful command influence during the UCMJ investigations process, we reviewed the record of decisions made by the Inquiry Officers and Investigating Officers in the UCMJ investigations to determine whether they were in compliance with provisions in the UCMJ and the Manual for Courts-Martial. These records of decisions included the suspected violations, the facts considered, and the analyses used to arrive at the conclusions and recommendations reached. The Department of Defense would not allow us to interview the Convening Authorities or the Inquiry and Investigating Officers.
Chapter 1
Introduction

The Department of Defense provided written comments on a draft of this report. Those comments concur with our primary conclusions and agreed that the few differences between our report and the Board report would not have affected the Board President’s conclusions.

The following chapters discuss the Aircraft Accident Investigation Board report and subsequent findings, subsequent investigations under the UCMJ, the results of Flying Evaluation Boards, and corrective actions taken.
The congressional requesters asked us, among other points, to (1) determine if the Aircraft Accident Investigation Board's investigation had met its objectives, (2) determine whether improper or unlawful command influence had occurred during the investigation, and (3) consider concerns raised by victims' family members and others.

We found that the Board, in a limited time frame, conducted an extensive investigation that fulfilled the requirements of Air Force Regulation 110-14 to obtain and preserve evidence and, with a few exceptions, to report the factual circumstances relating to the accident. Also consistent with the regulation, the Board President stated his opinion of the accident's causes. In addition, our interviews of the Board President and other Board members, as well as technical and legal advisors, disclosed no evidence of improper or unlawful command influence during the Board process.

During our review of the Board's investigation/report and subsequent Department of Defense reviews, plus our interviews of Operation Provide Comfort officials and participants, we noted that the Board report and/or opinion (1) did not discuss the incident F-15 pilots' responsibility, under the Airspace Control Order, to report to the Airborne Command Element aboard the AWACS about the unidentified helicopters; (2) cited a CFAC Commander statement that inaccurately portrayed the Airborne Command Element as not having authority to stop the incident; and (3) erroneously concluded that the Black Hawks' use of an incorrect electronic code prevented the F-15 pilots from receiving electronic responses from the helicopters.

Last, victims' family members and others at the August 1995 congressional hearing raised concerns that included possible discipline problems in the F-15 community in Operation Provide Comfort at the time of the shootdown and the incident F-15 pilots' perceived urgency to engage during the shootdown. While Air Force Regulation 110-14 did not require the Board to examine these issues, it did not preclude the examination; and we determined that the issues were pertinent to our review. Indeed, discipline problems did exist in the F-15 community in Operation Provide Comfort, and some Operation Provide Comfort officials questioned the incident F-15 pilots' haste to engage the unknown helicopters.
Investigation Met Objective but the Report Contained Three Deficiencies

Board Investigation/Report and President’s Opinion

At the direction of the Secretary of Defense on the day of the shootdown, the U.S. Commander in Chief, Europe, ordered the Commander, U.S. Air Forces in Europe, to conduct an Aircraft Accident Investigation. The Aircraft Accident Investigation Board was properly convened under Air Force Regulation 110-14. The Board’s investigation met its goal to obtain and preserve documentary, testimonial, and physical evidence for possible claims, litigation, and disciplinary and administrative needs.

On May 27, 1994, also in accordance with Air Force Regulation 110-14, the Aircraft Accident Investigation Board issued a 60-page summary report including the Board President’s opinion that, with three exceptions, provided a summary of the most important facts and circumstances of the incident. Those deficiencies—involving the incident F-15 pilots, the incident Airborne Command Element, and the Black Hawks’ use of an incorrect electronic identification code—are discussed later in this chapter.

The Board President’s opinion, which was also required by the regulation and was included in the summary, identified the accident’s causes as a chain of events that began with the lack of a clear understanding among the Operation Provide Comfort organizations about their respective responsibilities and culminated with the F-15 lead pilot’s misidentification of the Black Hawks as Iraqi Hinds and the F-15 wingman’s failure to notify the lead pilot that he had not positively identified the helicopters. (The Board President’s opinion appears as app. I.) The Board report was transmitted through the Chairman of the Joint Chiefs of Staff to the Secretary of Defense.

Composition of the Board

On April 15, 1994, the Commander, U.S. Air Forces in Europe, appointed the Commander, 3d Air Force (a major general), as President of the

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1 A supplement to the Board’s report was prepared at the request of the U.S. Commander in Chief, Europe. It was a synopsis of interviews of individuals who had been AWACS mission crew members in Operation Provide Comfort before the incident. The Board President reviewed the interviews and related documents but did not change his opinion.

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Aircraft Accident Investigation Board. The other Board members included a Deputy Board President (an Army colonel), a Chief Investigator who was an F-15 pilot, an AWACS expert, a Black Hawk pilot, a Black Hawk maintenance officer, a flight surgeon, a Board recorder, and a public affairs officer. The Board also included 13 technical advisors and 4 legal advisors (3 Air Force and 1 Army).

Scope of Board's Investigation

The Board conducted its investigation from April 15 to May 27, 1994, when it issued its report, including 25 volumes of evidence containing testimony from 137 witnesses. The Board reviewed directives on command and control; rules of engagement, pertinent orders (Airspace Control Order, Air Tasking Order, and Aircrew Read Files), aircrew preparation, and scheduling; aircraft maintenance documentation on the involved aircraft; aircrew qualification and training records and materials; physical and medical examinations; data on the sequence of events for each of the aircraft, such as flight plans, communications tapes, and briefing and preflight preparations; search and rescue activities; and integration of Army and Air Force operations. The Board also reviewed classified documents, video tapes, and magnetic tapes relating to the accident. To assess the possible malfunction of the Air-to-Air Interrogation (AAI) and Identification Friend or Foe (IFF) system components, the Board commissioned testing of the incident fighters’ AAI systems and the helicopters’ transponders. It also commissioned a filmed re-creation of the incident with an F-15 fighter approaching a Black Hawk helicopter at various elevations, distances, and approaches.

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2The Board President and the Chief Investigator had previous accident investigation experience.

3Accident investigations are normally completed within 30 days unless, as in this case, the appointing authority grants an extension.

4The Deputy Board President (Army), a former Black Hawk commander, was present at the interviews of the two F-15 pilots. Although a second Army Board member and the Army legal advisor were not invited to be present during these interviews, they were advised that, if they had questions, they would be asked. The Black Hawk Board member recalled reviewing the transcript of the interviews and stated that all the questions that he would have asked had been addressed.

5(1) The Airspace Control Order provided rules and procedures for aircrews. (2) Combined Task Force flying operations for all aircraft were scheduled in a daily Air Tasking Order, which listed information pertinent to each day’s flight operations, or “mission package,” such as flying times and IFF codes. In the case of the Black Hawk helicopters, the notation “as required” was included rather than specific flying times due to the uncertainty of their schedules. (3) Aircrew Read Files, prepared by the CFAC/DO, contained Operation Provide Comfort policy and guidance information.

6In the AAI/IFF system, the AAI component interrogates an airborne aircraft to determine its identity; and the IFF component answers. A challenging aircraft transmits an interrogation signal via the AAI component to a target aircraft. The target aircraft’s transponder system, part of the IFF component, sends back a coded signal. The challenging aircraft receives the return signal and processes it internally. If the return signal is valid, it appears on the challenging aircraft’s visual display.
No Improper/Unlawful Command Influence Found

Section 104 (a)(2) of the Rules for Court-Martial (RCM), Manual for Courts-Martial, defines unlawful command influence as an attempt to coerce or, by any unauthorized means, influence the action of a court-martial or any other military tribunal or any member thereof, in reaching the findings or sentence in any case or the action of any convening, approving, or reviewing authority with respect to such authority’s judicial acts.

We found no evidence of improper or unlawful command influence exerted during the Aircraft Accident Investigation Board process. The Board members and technical and legal advisors we interviewed stated that they had had free rein to examine all facets during the investigation.

According to the Commander, U.S. Air Forces in Europe, when the U.S. Commander in Chief, Europe, tasked him to convene the Aircraft Accident Investigation Board, he was told to uncover the facts and get all the details. Also according to the Commander, when he assigned the Board President, he told the president to leave no rock unturned and bring up every fact during the investigation. According to the Board President, his directions to the Board members were to let the “chips fall” where they may and to hold back nothing. He stated that there was “absolutely no command influence” and that the Board was extremely careful to avoid even the appearance of any influence.

No Discussion of F-15 Pilots’ Requirement to Report to Airborne Command Element Who Had Authority to Stop Encounter

Although the Aircraft Accident Investigation Board reported that incident participants, including the Black Hawk pilots, lacked knowledge of command and control guidance, such as portions of the Airspace Control Order, it did not discuss the F-15 pilots’ responsibility under the Airspace Control Order to report to the Airborne Command Element when encountering an unknown aircraft during Operation Provide Comfort missions. Further, although it had evidence to the contrary, the Board, through its report, cited a CFAC Commander’s inaccurate testimony that the Airborne Command Element had no decision-making authority regarding aircraft encounters in the TAOR.

According to the Board’s Senior Legal Advisor, the Board did not report the F-15 pilots’ nonadherence to that aspect of the order because the Airborne Command Element was aware of the intercept; thus the Board did not consider the pilots’ nonadherence to be a significant cause of the

7The report did state that the F-15 pilots had adhered to the order’s requirement to contact the Airborne Command Element before entering the TAOR.
shooting. The Senior Legal Advisor stated that, in the Board’s opinion, Operation Provide Comfort management had allowed operations to degrade to such a point that the Board report, partly for this reason, focused on command and control problems.

Command and Control of Airspace Operations in Operation Provide Comfort

Combined Task Force flying operations were conducted according to an Airspace Control Order published by the CFAC Director of Operations (CFAC/DO). The two-volume Airspace Control Order, which provided the rules and procedures governing all Operation Provide Comfort aircrews, was required reading for those aircrews. Volume II augmented volume I by providing detailed and specific guidance and procedures for conducting Operation Provide Comfort air operations.

The CFAC/DO directed the Operation Provide Comfort flight operations through a ground-based Mission Director at Incirlik Air Base and an Airborne Command Element aboard the AWACS. The Airborne Command Element, according to the Board report, was to act as the “eyes and ears” of the CFAC/DO aboard the AWACS. In support of this, as excerpted from the Airspace Control Order, “[the Airborne Command Element] will contact [the Mission Director] who will then pass the information to the CFAC/DO” concerning any unusual circumstances, such as an unidentified aircraft in the TAOR.

Requirement to Report to Airborne Command Element

The Board report and Board President’s opinion did not address that the pilots were required to report to the Airborne Command Element in an “unusual circumstance” as specified by the following excerpt from volume II of the Airspace Control Order. (For the sake of clarity, we have used titles in place of code names.)

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8The CFAC/DO was responsible for updating the Airspace Control Order; briefing incoming aircrews on its application; and holding Detachment Commander meetings twice a week to discuss air-operation problems and corrective actions.

9In Operation Provide Comfort, the Airborne Command Element was called the “Duke.” During wartime situations, such as Desert Storm, the Airborne Command Element was a colonel or a general and operated as the air battle manager. In Operation Provide Comfort, the Airborne Command Element was a lieutenant colonel or major and operated in a reactive mode.

10Volume I of the Airspace Control Order states, “Aircrews experiencing unusual circumstances/occurrences will pass details to [the Airborne Command Element] or AWACS.” Volume II clarifies the statement by (1) directing aircrews to first contact the Airborne Command Element and, if that individual is unavailable, to then contact AWACS and (2) defining “unusual circumstances/occurrences.”
“Aircrews experiencing any unusual circumstances/occurrences while flying [Operation Provide Comfort] missions will report the incident [as soon as possible] to [the Airborne Command Element] or [the AWACS crew] if [the Airborne Command Element] is unavailable.”

The list of six such unusual circumstances/occurrences contained in the Airspace Control Order included “[a]ny intercept run on an 'Unidentified aircraft.'” According to Operation Provide Comfort officials, the Airspace Control Order was specifically designed to slow down a potential engagement to allow CFAC time to check things out.

In response to questions we raised, the Board’s Senior Legal Advisor said that the Board had reviewed that provision and evidence showing that the F-15 pilots had read both volumes of the Airspace Control Order containing the requirement to contact the Airborne Command Element for guidance. He added that the contact-requirement issue was not significant to the Board because the Airborne Command Element was aware of the discussion between the F-15 pilots and the TAOR controller about the intercept. He also said that the Board concluded that the F-15 pilots had reason to believe that the Airborne Command Element was monitoring the conversation and that the Airborne Command Element was, in fact, aware of the intercept and did not intervene. In further, the Operation Provide Comfort management, in the Board’s opinion, had allowed operations to degrade to such a degree that it “may not have been common practice” at the time for F-15 pilots to contact the Airborne Command Element. He said that partly because of this degradation, the Board’s focus turned to the command and control failures that had created an environment that allowed the incident to occur.

However, this duty to contact the Airborne Command Element for directions concerning unusual circumstances had been reemphasized by an oral directive issued because of an incident about a week before the shootdown. In that incident, F-15 pilots had initially ignored an Airborne Command Element’s directions to “knock off,” or stop, an engagement with a hostile fighter aircraft they thought was in the no-fly zone. The Airborne Command Element overheard the pilots preparing to engage the

11The Airborne Command Element testified to the Board that once he heard the visual identification call, he was trying to put together a plan because he was considering the threat of an Iraqi trap. He testified that he did not intervene because, in his view, the F-15 pilots were not committed to “anything [engaging the targets]” at the visual identification point and he had no idea they were going to react so quickly.

12According to Operation Provide Comfort documents and statements from Operation Provide Comfort officials, it appears that this incident occurred on April 7, 1994.
aircraft and contacted them, telling them to stop the engagement because he had determined that the hostile aircraft was outside the no-fly zone and that he was also leery of a “bait and trap” situation. After several unsuccessful attempts to call off the engagement during which the F-15 pilots did not respond to him, he ordered the pilots to return either to their assigned patrol point or to base. The F-15s returned to their assigned patrol point.

The CFAC/DO issued the resultant oral directive to the F-15 detachment representative at the next Detachment Commander meeting following the incident. At the meeting, the CFAC/DO listened to the complaints of the F-15 representative and then told him that the word of the Airborne Command Element was final. He also told the F-15 representative that the Airspace Control Order was very clear and must be followed. While the Board did an extensive investigation, it was unaware of this oral directive.

Discussion of Airborne Command Element’s Authority

The Aircraft Accident Investigation Board report cited as fact the former CFAC Commander’s testimony that the Airborne Command Element “had no decision-making authority.” The Board justified citing the statement as fact in its report because it was made by the Commander, from whom the Board believed all authority for CFAC operations stemmed. The Board did not include in its report, testimony from the CFAC Commander at the time of the shootdown, the CFAC/DO, a Mission Director, and others with more

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13In such a strategy, a fighter aircraft is lured into an area by one or more enemy targets and then attacked by other fighter aircraft or surface-to-air missiles.

14The twice-weekly Detachment Commander meetings were attended by Detachment Commanders (including fighter squadron Commanders) or their representatives to discuss operational issues and problems.


16We were unable to substantiate that the F-15 wingman (who was also the Squadron Commander) involved in the shootdown was at the Detachment Commander meeting. At that time, he was the Squadron Commander/Detachment Commander. Operation Provide Comfort officials told us, on the other hand, that the knock-off incident and subsequent guidance by the CFAC/DO were well known throughout the Operation Provide Comfort fighter community.

17The testimony cited was that of the CFAC Commander who had been reassigned several days before the shootdown. The testimony of the CFAC Commander at the time of the shootdown was that the CFAC/DO supervised day-to-day Operation Provide Comfort flight operations and monitored these operations through the Mission Director and Airborne Command Element, which he characterized as command and control positions.

18Because the CFAC Commander also served as the 39th Wing Commander and the 7440th Composite Wing (Provisional) Commander, the CFAC/DO was, in fact, acting as the CFAC Commander according to the Combined Task Force Commander.
knowledge of actual Operation Provide Comfort air operations that contradicted the former CFAC Commander’s reported testimony concerning Airborne Command Element authority.

The CFAC/DO told the Board and us that he had delegated time-sensitive decision-making authority to his Mission Directors and Airborne Command Elements. He testified to the Board that he had given the authority to the Airborne Command Element to terminate the mission package “and bring the entire operation back.” He further told us that the week before the shootdown he had supported the Airborne Command Element’s decision to knock off the F-15 pilots’ intercept and had commended the Airborne Command Element on his actions. The Combined Task Force Commander also supported the Airborne Command Element’s decision.

Board President’s Erroneous Conclusion That Black Hawks’ Use of Wrong Code Prevented F-15 Pilots From Receiving Response

The Board President’s opinion erroneously concluded that the Black Hawks’ use of a wrong code prevented the F-15s from receiving a response in one of the electronic identification modes. We agree with an Air Force analysis, using information that was also available to the Board, that determined that the F-15 pilots should have received a response despite the wrong code. The analysis based its finding on the manner in which the pilots testified that they had interrogated the helicopters.

Background

During their sanitization sweep, the F-15 pilots, using radar, located unknown, slow-moving contacts in the TAOR that were subsequently identified as helicopters. In an attempt to identify if the helicopters were friendly, the F-15 pilots interrogated the aircraft with their AAI/IFF systems. An F-15’s AAI/IFF system can interrogate using four identification signals, or modes: I, II, III, and IV. In the TAOR, the transponders on Black Hawk helicopters transmit Modes I, II, and IV. However, two Mode I codes were designated for use in Operation Provide Comfort at the time of the incident: one inside, the other outside the TAOR. As stated in the Board

19A lieutenant colonel and three majors rotated between the Mission Director and Airborne Command Element positions.

20Mode I was the general identification signal that permitted the selection of 32 codes. Mode II was an aircraft-specific identification mode allowing the use of 4,096 possible codes. Mode III provided a nonsecure friendly identification of both military and civilian aircraft and was not used in the TAOR. Mode IV was secure and provided high-confidence identification of friendly targets. A compatible code had to be loaded into the cryptographic system of both the challenging and the responding aircraft to produce a friendly response.
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report, the Black Hawk pilots were using the Mode I code for outside the TAOR,\(^1\) and the F-15 pilots' systems were set to the Mode I code for inside the TAOR. The Board report and its President's opinion noted that the Black Hawks' use of the wrong Mode I code had resulted in the F-15 pilots' failure to receive a Mode I response.

The Aircraft Accident Investigation Board took testimony from the pilots who had flown the same F-15s on flights immediately before and after the shootdown, in addition to testimony from the incident lead pilot and wingman, to determine whether they had experienced any problems with the IFF systems. All said that they had had no problems and had successfully interrogated other aircraft using Modes I and IV.\(^2\)

The Board also had operational tests performed on the F-15s' AAI/IFF components a few days after the incident. The tests revealed no problem that would have prevented the lead aircraft from interrogating and displaying Modes I, II, and IV. The wingman's AAI system was found to be capable of interrogating Modes I, II, and IV and of displaying Mode I and II signals. However, it could not display Mode IV signals generated by the test set. After the operational testing, the Board removed the AAI components from the F-15s and sent them to two Air Force laboratories for teardown analysis. The laboratory tests were performed without recalibrating the components, and the reports showed no problems that would have affected the performance of the equipment.

Because of weapons impact, the resulting crash, and/or the subsequent fire, the transponder on one helicopter was completely destroyed. The transponder in the other helicopter was partly destroyed and was sent to a

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\(^1\)Other Black Hawk pilots told us, as was also mentioned in the Board report, that they routinely used the Mode I code for outside the TAOR while operating in the TAOR and no one had advised them that it was incorrect to do so.

\(^2\)The lead pilot stated on April 14, 1994, that the initial AAI contact on the unknown helicopters in the TAOR was a negative Mode I and a positive Mode IV. When he testified before the Board, on April 23, 1994, he described the initial positive Mode IV contact as lasting only a second and attributed it to an AAI system "anomaly." The Aircraft Accident Investigation Board was unable to determine why the F-15s reportedly did not receive a Mode IV response from the Black Hawks based on the AAI interrogation of the helicopters that the F-15 pilots said they made. We were also unable to make this determination.

The Commander, U.S. Army in Europe, after reviewing the Board report and its president's opinion, objected to one sentence in the opinion that attributed the unsuccessful Mode IV interrogation to one or more things, including "both helicopter IFF transponder codes may have been loaded incorrectly." He added that nothing in the Board report supported the possibility that the codes had been loaded improperly and that it was clear the Army crews were not at fault in this matter. The U.S. Commander in Chief, Europe, agreed with his view. Although the language in the opinion was not changed, the Commander, U.S. Army in Europe, said his concerns were addressed because his complaint had been included as an attachment to the Board report.
Department of Defense laboratory. The report of the teardown analysis of this transponder concluded that it had been on at the time of the incident but that the testing could not determine conclusively whether the system had been fully operational at the time.

F-15 Pilots Should Have Received Mode I Response

The Board President’s opinion concluded that the Black Hawks had been using the wrong Mode I code inside the TAOR after they departed Zakhu for Irbil, Iraq, and that the incorrect code was responsible for the F-15 pilots’ failure to receive a Mode I response when they interrogated the helicopters. However, the Air Force special task force’s subsequent review of the IFF component revealed that, based on the descriptions of the system settings that the pilots testified they had used on several interrogation attempts, the F-15s should have received and displayed any Mode I or II response, regardless of code. Thus, the helicopters’ use of the wrong Mode I code should not have prevented the F-15s from receiving a response.

In reaching his conclusion, the Board President relied on the evidence collected by the Board, which included the pilots’ testimony as well as other information about the IFF system settings and how the system should perform. In its report, the Board cited three of four interrogation attempts about which the lead pilot had testified on April 23, 1994. One of the three was performed in a way that should have displayed any Mode I or II response, as later noted by the Air Force special task force. The task force also found that the additional interrogation attempt described on April 23 was identical to the one that should have displayed any Mode I or II response. The additional interrogation, not reported by the Board, took place during the period in which the AWACS was receiving friendly Mode I and II returns from the helicopters at an increasingly frequent rate and

23The Air Force Air Combat Command assembled a task force to review, among other issues, visual and electronic identification systems and procedures.

24According to the Airspace Control Order, the primary means of identifying friendly aircraft in the TAOR were through Modes II and IV in the IFF interrogation process. According to the Board report, the F-15 lead pilot, in his preflight briefing, specified that the fighter pilots would use Modes I and IV.

25The Board report found that the Black Hawks’ transponders were transmitting the correct Mode II codes specified in the day’s Air Tasking Order.

26According to the AWACS magnetic tape replay of the shootdown, the AWACS received IFF returns (Modes I and II) from the helicopters at the same time that the F-15s received no response. The Board report stated that beginning approximately 7 minutes before the shootdown, the AWACS was receiving intermittent IFF returns that increased in frequency for the next 3 minutes. The returns then continued uninterrupted for 2 minutes. During the final 2 minutes before the shootdown, according to the Board report, the F-15 and Black Hawk returns appeared too close together on the AWACS consoles for the crew to identify the helicopters.
when the lead pilot was closer to the helicopters than during his initial interrogation attempt at the same settings.

The Board President recalled discussions about the F-15 IFF-system settings and said the Board report had included the interrogation attempts about which the Board was certain. He told us that because of the difference between the lead pilot’s incident-day statement and his testimony, it was difficult to determine the number of times that the lead pilot had interrogated the helicopters.

A Perceived Discipline Problem and a Perceived Rush to Engage

Victims’ family members and others raised concerns about the lack of discussion in the Board report concerning the discipline of F-15 pilots in general in Operation Provide Comfort and the F-15 pilots’ perceived urgency to engage during the shootdown. Although Air Force Regulation 110-14, under which the Board’s investigation was conducted, did not require the Board to examine such environment issues, neither did the regulation rule out an examination. However, the two issues were relevant to our review.

According to Operation Provide Comfort officials, the pilots’ failure on April 14, 1994, to contact the Airborne Command Element was a product of a lack of F-15 mission discipline, as demonstrated by the incident a week before the shootdown when F-15 pilots initially ignored Airborne Command Element instructions to “knock off” an engagement with an Iraqi aircraft. According to the Combined Task Force Commander, the pilots’ failure was also related to a rivalry-induced urgency to engage “hostile” aircraft.

F-15 Pilots’ Previous Problems With Mission Discipline Issues

The Mission Director during the shootdown and the Airborne Command Element involved in the knock-off incident told us that they had had problems with mission discipline issues involving F-15 pilots assigned to Operation Provide Comfort during the time period leading up to the shootdown. The Airborne Command Element stated that on the evening of the knock-off incident, several F-15 pilots, including the pilots whom he had ordered to cease their proposed engagement, approached him and questioned whether he was a “combat player” and whether Airborne Command Elements were perhaps too conservative.

According to CFAC officials, the F-15 pilot community was “very upset” about the intervention of the Airborne Command Element during the
knock-off incident and felt he had interfered with the carrying out of the F-15 pilots’ duties.

The Airborne Command Element from the knock-off incident also told us that so many flight discipline incidents had occurred that CFAC held a group safety meeting in late February or early March 1994 to discuss the need for more discipline. The flight discipline issues included midair close calls, unsafe incidents when refueling, and unsafe takeoffs. The Combined Task Force Commander said that he had recognized a potential supervisory problem with the F-15 Detachment because no F-15 pilots were on the Combined Task Force staff.\(^\text{27}\) He had made several unsuccessful requests to the Commander, 17th Air Force, to have an experienced F-15 pilot—on flying status—assigned to the Combined Task Force staff. According to the Combined Task Force Commander, the 17th Air Force Commander told him that the available number of F-15 slots was limited and one could not be spared for Operation Provide Comfort. We noted, however, that as part of the corrective actions taken following the shootdown, an F-15 pilot was assigned to the Combined Task Force staff.

Further, the shootdown occurred, according to the CFAC/DO’s statement to us, because of a lack of training and aircrew discipline in following established guidelines on the part of the two F-15 pilots involved in the incident. He stated, “[t]he pilots made a terrible mistake” and with greater discipline—coupled with the multiple safeguards designed to prevent such an incident—this fratricide may have been avoided.

**Pilots’ Perceived Urgency to Engage**

The Combined Task Force Commander and other Operation Provide Comfort officials acknowledged that a rivalry existed between the F-15 and F-16 communities, including those in Operation Provide Comfort detachments. Operation Provide Comfort officials told us that while such rivalry was normally perceived as healthy and leading to positive professional competition, at the time of the shootdown the rivalry had become more pronounced and intense. The Combined Task Force Commander attributed this atmosphere to the F-16 community’s having executed the only fighter shootdown in Operation Provide Comfort and all shootdowns in Bosnia.

\(^{27}\)The CFAC Assistant Director of Operations told us there was very little F-15 oversight in Operation Provide Comfort at the time of the shootdown. He explained that an F-15 pilot was needed on the Combined Task Force staff to help communicate with the F-15 group because contentious issues involving F-15 actions had become common topics of discussion at Detachment Commander meetings. He said that CFAC tried to have a certified F-15 pilot assigned to the Combined Task Force staff, but U.S. Air Forces in Europe did not support such an assignment. He also said that an F-15 pilot was assigned to the staff after the shootdown, which “paid big dividends.”
In the opinion of the Combined Task Force Commander, the shootdown pilots' haste was due in part to the planned entry of two F-16s into the TAOR 10 to 15 minutes after the F-15s. He said that if the F-15 pilots had involved the chain of command, the pace would have slowed down, ruining the pilots' chances for a shootdown.

Further, CFAC officials stated that the Airspace Control Order was specifically designed to slow down a potential engagement to allow CFAC time to check things out. They said that the presence of the helicopters, which were flying southeast away from the security zone, posed no threat to the mission and there was no need for haste. For example, the Mission Director stated that, given the speed of the helicopters, the fighters had time to return to Turkish airspace, refuel, and still return and engage the helicopters before they could have crossed south of the 36th parallel. According to the F-15 Squadron Operations Officer at the time of the shootdown and the Board’s Senior Legal Advisor, the tactical environment did not warrant a rush to judgment. The Operations Officer added that the F-15 pilots had acted too hastily and should have asked more questions. The Senior Legal Advisor said that, in his opinion, the pilots had an unnecessarily aggressive attitude toward the intercept and shootdown.

The lead incident pilot told us that he was concerned about going low to check out the unknown aircraft. His primary concerns at the time were (1) being fired on from the ground, (2) flying into the ground, and (3) a possible air threat. Because of these concerns, he remained high for as long as possible and dropped down briefly for a visual identification that lasted, according to the lead pilot, “between 3 and 4 seconds.” He told us that he saw no Iraqi flag on the helicopters and that the helicopters were not acting in a hostile manner. He assumed they were Iraqi Hinds because they were in the middle of Iraq, although he acknowledged that they could have been Syrian or Iranian Hinds.

The incident wingman told us that his visual identification was not as close to the helicopters as was the lead pilot’s. His visual identification

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28The Airborne Command Element at the time of the shootdown testified to the Board that he was surprised at the speed of the engagement, noting that he thought the F-15 pilots would have at least told the AWACS of their intentions or asked for guidance. This testimony was not included in the Board report. Also, not included in the Board report was testimony from the former CFAC Commander that decisions concerning “out of the ordinary” occurrences while on missions were to be pushed up the chain of command, to the CFAC/DO level or higher.

29The Board report found that the F-15s’ identification passes had been accomplished at speeds, altitudes, and distances where it was unlikely that the pilots would have been able to detect the Black Hawks’ markings.
lasted “between 2 and 3 seconds.” He said, in hindsight, “We should have taken another pass; but at the time, I was comfortable with the decision.”

Conclusions

The Board report and Board President’s opinion would have presented a more complete record of the incident’s events had they discussed the incident F-15 pilots’ requirement to report to the Airborne Command Element, accurately assessed the Airborne Command Element’s authority, not concluded that the Black Hawks’ use of an incorrect code had prevented Mode I electronic responses from the helicopters, and addressed F-15 pilot discipline issues. This more complete information, in turn, may have raised additional questions about the actions and inaction of the F-15 pilots and the Airborne Command Element and, therefore, could have influenced subsequent disciplinary or corrective actions. However, if the information had been included, it would not have affected the Board President’s conclusion: that a chain of events, whose final actions were the lead pilot’s incorrect identification and the wingman’s failure to clarify his lack of identification, caused the fratricide. Further, it is difficult to predict if the incident’s outcome would have differed had the F-15 pilots contacted the Airborne Command Element directly.
The congressional requesters also asked us to (1) determine whether military justice investigations, conducted after the Aircraft Accident Investigation Board completed its work, had complied with provisions in the Uniform Code of Military Justice (UCMJ);

The congressional requesters also asked us to (2) determine if improper or unlawful command influence had been exerted during the UCMJ process; and (3) answer general questions raised by family members and others regarding actions taken following the investigations.

First, we found that the subsequent UCMJ investigations complied with provisions in the UCMJ and the Manual for Courts-Martial. Preliminary inquiries, under the Rules for Court-Martial (RCM), were conducted into the actions of 14 officers. The Air Force used two separate investigative paths, one for seven AWACS-related officers and the other for the two F-15 pilots and five Operation Provide Comfort officials. The former were investigated by a command separate from the one to which they were assigned. This command developed evidence beyond the material contained in the Board’s report. As a result of the preliminary inquiry, charges were preferred against four AWACS crew members and the Airborne Command Element. An Investigating Officer investigated these charges under Article 32, UCMJ; one officer was determined to be blameless; and the Commander, 963d Air Control Squadron retired as a Lieutenant Colonel although he had been selected for promotion. After the Article 32 investigation, one officer—the Senior Director of the AWACS crew—was tried by general court-martial and acquitted, and one officer received nonjudicial punishment in the form of a letter of reprimand. The remaining three officers received administrative letters of reprimand.

On a separate path, the actions of the two F-15 pilots and five Operation Provide Comfort officials were reviewed under RCM in a preliminary inquiry conducted by the pilots’ Wing Commander. The Wing Commander relied on the Board report and filed dereliction-of-duty and negligent homicide charges against the F-15 wingman that were the focus of an Article 32 investigative hearing. Subsequently, charges against this pilot were dropped; however, he later received a letter of reprimand. Administrative action was taken against four other officers: the lead pilot received a letter of reprimand, two other officers received letters of

1UCMJ, 10 USC § 801 et seq., governs the conduct of military personnel. It contains both substantive and procedural law applicable to the military justice process and administration. It also describes the system of military courts, defines offenses, authorizes punishment, and provides statutory due-process safeguards.

2The Wing Commander also preferred charges against two of the five Operation Provide Comfort officials. Following further analysis, these charges were not investigated at an Article 32 investigative hearing.
admonition, and one received a letter of counseling. No action was taken against the remaining two officers.

The Air Force also convened Flying Evaluation Boards for the two F-15 pilots involved in the shootdown. In addition, 16 months after the incident and 6 days after the House Committee on National Security hearing, the Chief of Staff of the Air Force found that a number of performance evaluations of personnel involved in the incident (1) were inconsistent with administrative actions taken by higher-level commanders and (2) failed to reflect that some officers had not met Air Force standards. Accordingly, the Chief of Staff prepared negative letters of evaluation regarding seven officers involved in the shootdown and implemented additional actions against five of them.

Second, based on our review of the summary reports of investigation and statements made by cognizant officials, we found no evidence of improper or unlawful command influence in the investigative or judicial process. However, we were unable to complete our investigation and determine whether the consideration and disposition of suspected offenses under the UCMJ were the result of improper or unlawful command influence. Department of Defense officials would not allow us to interview the key officials—Convening Authorities, Inquiry Officers, and Investigating Officers—involved in the UCMJ investigations.

**UCMJ Process**

On July 12, 1994, the Secretary of Defense approved the Aircraft Accident Investigation Board report. The Secretary of the Air Force thereafter forwarded the report to the Commander, Air Combat Command, and the Commander, U.S. Air Forces in Europe, as well as to the Commander, U.S. Army in Europe, for appropriate action under the UCMJ and any administrative actions. Thus, the Air Force UCMJ investigations followed two separate paths—through Air Combat Command (AWACS-related personnel) and U.S. Air Forces in Europe (Combined Task Force Operation Provide Comfort personnel and F-15 pilots).

The AWACS mission crew and 963d Squadron Commander involved in the shootdown were assigned to the 552d Air Control Wing, which was under the jurisdiction of the 12th Air Force. However, the Staff Judge Advocate to the 12th Air Force had served as Legal Advisor to the Aircraft Accident Investigation Board. As a result, the Air Force considered him disqualified from conducting an RCM investigation or serving as staff judge advocate to the Convening Authority during the disciplinary review.
Therefore, the Commander, Air Combat Command, designated the Commander of the 8th Air Force as the court-martial Convening Authority. The Commander, 8th Air Force, appointed an Inquiry Officer to conduct an RCM 303 inquiry regarding the actions of seven officers under Air Combat Command’s command. The seven officers were the CFAC Mission Director, Airborne Command Element, 963d Squadron Commander, AWACS Mission Crew Commander, AWACS Senior Director, AWACS Enroute Controller, and AWACS TAOR Controller. On July 18, 1994, the Convening Authority appointed an Inquiry Officer to conduct the RCM 303 investigation.

The Commander, U.S. Air Forces in Europe, designated the Commander of the 17th Air Force as the court-martial Convening Authority. On July 22, 1994, the Convening Authority appointed an Inquiry Officer to conduct a preliminary inquiry under RCM 303 into the roles of the following seven officers in the shootdown: Combined Task Force Commander, CFAC Commander, CFAC/DO, Combined Task Force Director of Plans and Policy, Combined Task Force Intelligence Officer, and the two F-15 pilots. The F-15 pilots were assigned to the 53d Fighter Squadron at Spangdahlem Air Base, Germany. The Inquiry Officer was the Commander of the 52d Fighter Wing at Spangdahlem Air Base to whom the F-15 pilots’ squadron reported.

The Commander, U.S. Army in Europe, directed the Judge Advocate, U.S. Army in Europe, to determine whether administrative or disciplinary action was warranted against any Army personnel for their role in the incident. The actions of one person—the Combined Task Force Chief of Staff (an Army colonel)—were considered as possible for review.

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3The Convening Authority is a commissioned officer in command who is authorized to convene courts-martial. A commander may administer nonjudicial punishment upon military personnel of that command under Article 15, UCMJ. (Nonjudicial punishment under Article 15 is generally appropriate when administrative corrective measures are inadequate and a trial by court-martial is not necessary.) Charges are ordinarily forwarded to the accuseds’ immediate commander for initial consideration as to disposition. However, a superior commander may withhold a subordinate commander’s disposition authority. Unless the authority is withheld by a superior commander, each commander has independent discretion to determine disposition under RCM 306.

4An RCM 303 is a preliminary inquiry into suspected offenses to gather all reasonably available evidence that bears on guilt or innocence and that relates to mitigating, extenuating, or aggravating circumstances. The appropriate commander determines what, if any, adverse administrative or judicial actions should be taken against personnel accused or suspected of committing offenses, triable by court-martial, that are referred for consideration under RCM 306.
On July 18, 1994, the Convening Authority appointed legal, F-15, and AWACS advisors to assist the Inquiry Officer. The investigation was conducted from July 18 to August 18, 1994. The inquiry team obtained testimony from AWACS personnel, flew in an AWACS, observed simulated Operation Provide Comfort missions, and interviewed senior directors and controllers not on the incident flight.

The Inquiry Officer prepared a 77-page report, largely consisting of an analysis of the charges against the officers, with 2 volumes of supporting material. The report also reflected the Inquiry Officer’s logic for selecting the appropriate articles of the UCMJ that might be applicable to the actions of the AWACS-related personnel, including manslaughter, negligent homicide, and dereliction of duty. The Inquiry Officer said that voluntary or involuntary manslaughter charges would be inappropriate against the AWACS-related officers for their involvement in the shootdown. The Inquiry Officer concluded that negligent homicide charges could be made against some of them for their involvement in this matter; but he recommended against this course of action, because “the occurrence of an independent, unforeseeable, intervening act, namely the incorrect identification of the helicopters by the F-15 pilots . . .” would not support a conviction for negligent homicide.

On August 30 and 31, 1994, the Inquiry Officer preferred dereliction-of-duty charges against the following AWACS-related officers: the Airborne Command Element, the Mission Crew Commander, the Senior Director, the Enroute Controller, and the TAOR Controller. No charges were preferred against the 963d Airborne Air Control Squadron Commander or the Mission Director. The Inquiry Officer concluded that no adverse action should be taken against the Mission Director because he had not failed to take any required actions.

On September 7, 1994, the Convening Authority appointed an Article 32, UCMJ, Investigating Officer, who was assigned to the U.S. Air Force Trial Judiciary, to examine the charges against the five charged officers, in accordance with RCM 405. The Convening Authority directed the Investigating Officer to inquire into the truth of the matters set forth in the charges, secure information to determine what their disposition should be, and issue a report and advisory recommendations. The Investigating Officer held a joint Article 32 investigative hearing involving all five officers from October 11 to October 26, 1994. Forty-eight witnesses

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5Investigating officers should be an officer in the grade of major, lieutenant commander, or higher, or one with legal training. In this case, a military judge outside the chain of the Convening Authority’s command was appointed.
testified at the hearing; and the government and defense attorneys entered 271 exhibits, including 54 classified exhibits, into the hearing record. The Investigating Officer issued his report on November 12, 1994, and recommended that the dereliction-of-duty charge against the Senior Director be referred to a general court-martial. He also recommended that the Enroute Controller receive nonjudicial punishment under Article 15, UCMJ, and that the charges against the remaining three officers be dismissed.

In his appointment letter, the Commander, 17th Air Force, directed the RCM 303 Inquiry Officer to (1) determine if any of the seven officers (Combined Task Force Commander and staff and two F-15 pilots) had committed acts related to the shootdown that amounted to offenses punishable under the UCMJ, (2) recommend disposition of any offense and whether administrative actions were warranted, and (3) file charges if warranted. He also appointed two legal advisors and a technical advisor to assist the Inquiry Officer. The Inquiry Team reviewed the Aircraft Accident Investigation Board report and supporting documentation. It neither obtained oral testimony nor collected any additional evidence; instead, it relied on witness interviews conducted by the Board.

On August 29, 1994, the Inquiry Officer issued a 66-page report on his investigation. The report identified the following as “possible” offenses: dereliction of duty by all seven officers, involuntary manslaughter by the F-15 pilots, and negligent homicide by all the officers except the Intelligence Officer. After concluding that three officers had committed violations under the UCMJ, the Inquiry Officer preferred dereliction-of-duty charges against two Operation Provide Comfort senior officers and dereliction-of-duty and negligent homicide charges against one F-15 pilot, the wingman.

On September 8, 1994, the Commander, U.S. Air Forces in Europe, appointed an Article 32 Investigating Officer, who was assigned to the U.S. Air Force Trial Judiciary, European Circuit, to investigate the charges against the F-15 wingman. In accordance with RCM 405, Manual for Courts-Martial, the Commander directed the Investigating Officer to inquire into the truth of the matters set forth in the charges by the Inquiry

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6In this case, a military judge outside the chain of the Convening Authority’s command was appointed as Investigating Officer.

7The charges against the two senior officers were dismissed; and, thus, Article 32 investigations were not conducted.
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Officer, secure information to determine what disposition should be made of the charges, and issue a report with advisory recommendations. The Investigating Officer held an Article 32 hearing on November 7-9, 1994. The government attorneys called one witness—the F-15 flight leader—and entered 18 exhibits into the hearing record. The exhibits included (1) the transcript of the F-15 wingman’s taped account of the shootdown made in the cockpit approximately 45 minutes after the shootdown, (2) the wingman’s testimony before the Aircraft Accident Investigation Board, and (3) the flight leader’s testimony during the investigation of the aircraft accident and the AWACS Article 32 hearing. The defense attorneys called no witnesses and entered 116 exhibits into the hearing record, including a prepared statement read by the wingman during the hearing and a detailed, 102-page factual and legal presentation of his theory of the case.

The Investigating Officer issued his report on November 12, 1994, and recommended dismissal of the charges against the wingman. His analysis focused on whether the lead pilot had called the AWACS announcing the engagement before or after the wingman responded to the lead pilot’s directive to confirm whether the helicopters were Iraqi Hinds. He concluded that if the call was made before the wingman’s response, the lead pilot had relieved the wingman of the duty to independently identify the helicopters. Based on his review of the pilots’ testimony and the wingman’s experience, he concluded that it was more likely that the lead pilot’s engagement announcement had preceded the wingman’s alleged “nonresponsive” confirmation.

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8Captain Eric A. Wickson, the flight leader, was granted testimonial immunity for the purpose of testifying at the wingman’s (Lieutenant Colonel Randy W. May) Article 32 investigative hearing. Captain Wickson could still be charged, based on all evidence obtained from sources other than his testimony at these proceedings.

9The Investigating Officer found that the wingman consistently stated on three occasions (in the cockpit 45 minutes after the incident, in his Aircraft Accident Investigation Board testimony, and in his Article 32 hearing) that the lead pilot had overridden the confirmation directive. He also considered that the lead pilot, during his Article 32 testimony, had begun to discount significantly his need for the wingman’s confirmation.

10The Aircraft Accident Investigation Board and the RCM Inquiry Officer concluded that the wingman’s “Tally two” response led the lead pilot to believe reasonably that the wingman had independently seen two Iraqi Hind helicopters. The wingman has stated that the “Tally two” response merely confirmed his sighting of two helicopters, not identification of the helicopters.
UCMJ Activities Concerning Combined Task Force Chief of Staff

On September 30, 1994, the Judge Advocate, U.S. Army in Europe, advised the Commander, U.S. Army in Europe, that consideration was warranted concerning whether the Combined Task Force Chief of Staff was responsible for the breakdown in staff communication that had been cited in the Board report. After reviewing the relevant Board testimony and other evidence, however, he recommended that no adverse action be taken against the officer because he had (1) focused his attention according to the Combined Task Force Commander’s direction, (2) had neither specific direction nor specific reason to inquire into the transmission of information between his Director of Operations for Plans and Policy and the CFAC, (3) been the most recent arrival and the only senior Army member of a predominately Air Force staff and therefore generally unfamiliar with air operations, and (4) relied on experienced colonels under whom deficiencies had occurred.

Actions by Flying Evaluation Boards and Air Force Chief of Staff

The Flying Evaluation Boards\(^\text{11}\) convened as a result of the shootdown, made findings concerning the proficiency, professionalism, care, and judgment of the two pilots, and made recommendations concerning their suitability for future aviation responsibilities. Upon review of the Boards’ findings and recommendations, the Commander, 17th Air Force determined that both pilots should be reassigned to noncombat aircraft. He further recommended that the F-15 lead pilot, Captain Eric A. Wickson, should be assigned next as an instructor pilot in basic flight training. The Commander, U.S. Air Forces in Europe concurred with this determination and also concluded that the F-15 wingman, Lieutenant Colonel Randy W. May\(^\text{12}\) should be reassigned to a nonflying aviator staff position.

On the basis of his review of administrative actions taken by higher-level authorities regarding Air Force personnel involved in the shootdown, the Air Force Chief of Staff determined that the personnel records of some involved personnel did not reflect their failure to meet Air Force standards. Accordingly, for seven of those involved in the incident, he wrote letters of evaluation that addressed how each of the officers had failed to meet these standards and took additional action against five officers.

\(^{11}\)If questions arise regarding a pilot’s fitness to continue flying, a commander may convene a Flying Evaluation Board. That board conducts a hearing in which the pilot can present evidence and cross-examine witnesses. After considering evidence concerning the pilot’s professional qualifications and evaluating the pilot’s ability to perform future flying duties, the Flying Evaluation Board issues an advisory recommendation to the convening commander. (Air Force Regulation 60-13)

\(^{12}\)Lieutenant Colonel May retired as a Major, the last grade at which, as determined by the Secretary of the Air Force, he had performed satisfactorily.
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Flying Evaluation Boards
On January 20 and 25, 1995, the Commander, 17th Air Force, appointed separate Flying Evaluation Boards for Captain Wickson and Lieutenant Colonel May. Each board consisted of a senior board member and two board members, all of whom were pilots; a legal advisor; a recorder; and a reporter. The Commander, 17th Air Force, directed the two senior board members to make special findings on whether the pilots had shown lack of judgment in performing their duties on April 14, 1994, and whether they were unsuited for duty in a combat aircraft role. The Commander, 17th Air Force, also directed the boards to make recommendations on whether the pilots had potential to continue flying.

Evidence
Captain Wickson’s Flying Evaluation Board was held on February 6, 1995; and Lieutenant Colonel May’s, on February 9-10, 1995. The pilots were the only witnesses in their Flying Evaluation Board hearings. The government and defense attorneys submitted eight volumes of evidence in the Wickson hearing and seven volumes of evidence in the May hearing, including the Aircraft Accident Investigation Board summary of facts and executive summary; the Operation Plan for Operation Provide Comfort; the Aircrew Read File; each pilot’s testimonies before the Aircraft Accident Investigation Board and Article 32 hearings; the transcript of Lieutenant Colonel May’s aircraft videotape of the incident; a Kurdish citizen’s videotape of the incident; and each pilot’s medical and training records, ratings, and awards.

On April 5, 1995, the Commander, U.S. Air Forces in Europe, concurred with the boards’ recommendations that Lieutenant Colonel May and Captain Wickson remain qualified for aviation service. He also directed that Lieutenant Colonel May be reassigned to a staff position not involving flying duties and that Captain Wickson be reassigned to flying duties (1) as an instructor in basic flying training or (2) in other noncombat aircraft.

Air Force Chief of Staff Actions
On July 25, 1995, the Secretary of the Air Force requested that the Air Force Chief of Staff review the administrative actions taken in regard to the Air Force personnel involved in the shootdown. On August 9, 1995, the Air Force Chief of Staff advised the Secretary of the Air Force of the actions he had taken.

The Chief of Staff said that the military justice process had worked as it was supposed to after the incident and that he was comfortable with the military justice actions taken. He concluded that a proper balance between
command involvement and individual rights had been maintained throughout the military justice process. Further, the administrative actions taken by commanders were within an appropriate range of options available to them. However, he said that a number of performance evaluations of involved personnel were inadequate because they were inconsistent with administrative actions taken by higher-level commanders and failed to reflect that the ratees had not met Air Force standards. Accordingly, pursuant to authority granted him by the Secretary of the Air Force, he prepared the following letters of evaluation regarding seven of the Air Force personnel involved in the shootdown and implemented additional actions against five.

- Combined Task Force Commander, Brigadier General Jeffrey S. Pilkington. A letter of evaluation addressed his failure to meet Air Force standards and became a permanent part of his record.
- CFAC Commander, Brigadier General Curtis H. Emery. A letter of evaluation was placed in his permanent record to reflect his failure to meet Air Force standards.
- F-15 Wingman, Lieutenant Colonel Randy W. May. A letter of evaluation was placed in his officer selection record to reflect his failure to meet Air Force standards. He was disqualified from aviation service for 3 years.
- F-15 Lead Pilot, Captain Eric A. Wickson. A letter of evaluation was placed in his officer selection record to reflect his failure to meet Air Force standards. He was disqualified from aviation service for 3 years based on his demonstrated lack of judgment associated with flight activities.
- AWACS Senior Director, Captain Jim Wang. A letter of evaluation detailing his failures to meet Air Force standards was included in his officer selection record and disqualified him from assignment to duties involving control of aircraft in air operations for at least 3 years.
- AWACS Enroute Controller, Captain Joseph M. Halcli. A letter of evaluation reflecting his failure to meet Air Force standards was placed in his officer selection record and disqualified him from assignment to duties involving control of aircraft in air operations for at least 3 years.
- AWACS TAOR Controller, First Lieutenant Ricky L. Wilson. A letter of evaluation reflecting his failure to meet Air Force standards was placed in his officer selection record. It recommended that he not be assigned to duties involving control of aircraft in air operations for at least 3 years.

13At the time of the incident, Brigadier General Emery was a Colonel.

14At the time of the incident, the AWACS Enroute Controller was a First Lieutenant.

15At the time of the incident, the AWACS TAOR Controller was a Second Lieutenant.
The Question of Command Influence

Our review of the summary reports of investigation during the UCMJ process and statements by officials knowledgeable of that process revealed no evidence of command influence. However, we were unable to confirm that the consideration and disposition of suspected offenses under UCMJ had not been subject to unlawful command influence because we were denied our request to interview applicable UCMJ Convening Authorities, Inquiry Officers, and Investigating Officers.

The Investigating Officer in the AWACS Article 32 hearing stated that he had not been subject to command influence during the proceedings. The counsel for the Senior Director, Captain Wang, had filed a motion to dismiss the charges against the Senior Director based on an allegation of unlawful command influence by the Secretary of Defense on the Secretary of the Air Force. In response to that motion, six officials provided either a Stipulation of Expected Testimony, a memorandum, or an affidavit stating that they had neither been the subject of improper command influence nor taken action to improperly influence military justice officials. These officials were the Secretary of the Air Force; Air Force Chief of Staff; Commander, Air Combat Command; Deputy Staff Judge Advocate, Headquarters Air Combat Command (Legal Advisor to the RCM 303); the RCM 303 Inquiry Officer; and the General Court-Martial Convening Authority, the Commander, 8th Air Force. The convening judge denied the motion, ruling that the defense had failed to meet its burden of establishing at least the appearance of unlawful command influence. Further, to address the question of command influence in the case of the Senior Director, Captain Wang’s military attorney told us that he interviewed the Secretary of the Air Force about whether she or the Secretary of Defense had intervened in the court-martial. The attorney was satisfied that neither of them had exercised command influence during the UCMJ process.

However, our request to the Air Force and the Department of Defense to interview military officials involved in the Black Hawk UCMJ proceedings was denied. These officials included the Convening Authorities, RCM 303 Inquiry Officers, and Article 32 Investigating Officers for investigations by both the Air Combat Command and the U.S. Air Forces in Europe. The Department of Defense voiced the belief that “any Congressional intrusion into the deliberative process ... endangers the actual and perceived independence of the military justice system.” We assured the Air Force that we would ask those officials only about the presence of unlawful

16Similar stipulations were not provided by the three officials involved in the U.S. Air Forces in Europe UCMJ investigations of five Operation Provide Comfort officials and two F-15 pilots.
command influence and would not intrude into the deliberative processes they had used in the proceedings, but we were denied access to those decision-makers who might have knowledge of possible influence. Consequently, we were unable to confirm whether the consideration and disposition of suspected offenses under the UCMJ were the result of improper or unlawful command influence.
Corrective and Other Actions by the Department of Defense and the Air Force After the Shootdown

In accord with concerns voiced by victims’ family members and others, we also looked at the corrective and other actions taken after the shootdown. Military officials took immediate actions to help ensure that the Black Hawk accident was not repeated. Further, after the issuance of the Aircraft Accident Investigation Board report, the European Command; the Chairman, Joint Chiefs of Staff; the Air Combat Command; and the Air Force instituted a large number of corrective actions. These actions included modification of the Rules of Engagement; inclusion of Black Hawk flight times on the Air Tasking Order; reviews of command structure and operations, plus operating doctrines and procedures; revision of AWACS training programs and certification procedures; and modifications of visual and electronic identification training.

In transmitting the Board report to the Secretary of Defense, the Chairman of the Joint Chiefs of Staff made the following observation:

“For over 1,000 days, the pilots and crews assigned to Operation Provide Comfort flew mission after mission, totalling over 50,000 hours of flight operations, without a single major accident. Then, in one terrible moment on the 14th of April, a series of avoidable errors led to the tragic deaths of 26 men and women of the American Armed Forces, United States Foreign Service, and the Armed Forces of our coalition allies. In place were not just one, but a series of safeguards—some human, some procedural, some technical—that were supposed to ensure an accident of this nature could never happen. Yet, quite clearly, these safeguards failed.”

According to an Air Combat Command official who was familiar with the Board’s report and who participated in the Command’s UCMJ investigations, over 130 separate mistakes were involved in the shootdown. A discussion follows of some corrective actions spawned by the shootdown and the Aircraft Accident Investigation report.

Immediate Corrective Actions

Beginning April 15, 1994, the European Command and Combined Task Force Commanders instituted immediate corrective actions designed to prevent a recurrence of the shootdown. The actions included, among others, modification of the Rules of Engagement, to restrict procedures for engaging Iraqi helicopters; inclusion of Black Hawk flight times on the Air Tasking Order; requirement for verbal confirmation of a positive IFF Mode IV check on all Operation Provide Comfort aircraft prior to their entry into the TAOR; reorganization of the Combined Task Force to designate one U.S. Air Force Colonel exclusively as the Commander, CFAC; further definition
Corrective and Other Actions by the Department of Defense and the Air Force After the Shootdown

of AWACS responsibilities for coordination of air operations; placement of radios on Black Hawk flights to enable communication with fighter aircraft; and painting of white recognition stripes on the Black Hawk rotor blades to enhance their identification from the air.

European Command’s Operations Assessments and Corrective Actions

In response to a directive from the Deputy U.S. Commander in Chief, Europe, an Air Force/Army team assessed Operation Provide Comfort’s mission, organization, and operations. The assessment was conducted from May 31 to June 8, 1994, and placed particular emphasis on the adequacy of European Command guidance and oversight; the Combined Task Force command structure and organization, manning, and support; and operating doctrine and procedures. The assessment team flew missions with F-15, Black Hawk, and AWACS units; interviewed key personnel and random unit personnel; and reviewed organizational plans, procedures, and directives. The team issued a 59-page classified report that contained over 40 recommendations for operations improvements. During October 14-22, 1995, a second team conducted another operational assessment of Operation Provide Comfort and made 166 additional recommendations in a classified report. A number of recommendations made by both teams have been implemented.

Joint Chiefs of Staff’s Corrective Actions

On July 7, 1994, the Chairman of the Joint Chiefs of Staff, with the approval of the Secretary of Defense, directed that (1) all Commanders in Chief review their Joint Task Force operations to ensure that they were conducted in accordance with published joint doctrine; (2) the Commanders in Chief establish a program of regular oversight of all their Joint Task Force operations; and (3) his staff review the curricula of all appropriate professional military education institutions to ensure proper emphasis on Joint Task Force organization, procedures, and operations. The Chairman also recommended that the Secretary of Defense direct the Air Force Chief of Staff to review the adequacy of AWACS training programs and certification procedures, develop a retraining program based on the lessons learned from the shootout, and ensure that all mission aircrews underwent this training. The Chairman further convened a conference of the Joint Chiefs and all Commanders in Chief on September 15, 1994, to discuss actions being taken to prevent a recurrence of the shootout.

On October 6, 1994, the Chairman advised the Secretary of Defense that all Commanders in Chief had completed reviews of their joint operations, aggressively implemented changes where required, and established
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programs to ensure regular oversight of those operations. Further, the Joint Staff found shortcomings in how Joint Task Force operations had been addressed in professional military education systems. According to the Chairman, each of the shortcomings was being addressed and corrections implemented.

Air Combat Command’s—Tiger Team’s—Corrective Actions

At the direction of the Secretary of Defense and the Chairman of the Joint Chiefs of Staff, the Secretary of the Air Force tasked the Air Combat Command to investigate the specific operational issues identified in the Aircraft Accident Investigation Board report. The Air Combat Command assembled a “Tiger Team” consisting primarily of Air Combat Command headquarters staff augmented with representatives from the 8th Air Force, Air Force Weapons Center, Air National Guard, and the 552d Air Control Wing. The team divided into three groups: AWACS/Airborne command and control, visual and electronic identification, and ground command and control. The three groups used the Aircraft Accident Investigation Board report as a frame of reference and identified 90 issues, which they studied in depth. The Air Combat Command Tiger Team issued its report on September 14, 1994, making about 140 recommendations, most of which had been completed or were underway when the report was issued. The report also proposed six recommendations for consideration by the Air Staff or the Joint Chiefs of Staff.

Air Force Special Task Force

Concurrent with the Air Combat Command tasking, the Secretary of the Air Force appointed an Air Force special task force to assist all Air Force commands in identifying potential problem areas and implementing appropriate corrections. The task force effort, which included the Air Combat Command Tiger Team work, involved over 120 people and over 30,000 hours in 6 major Air Force commands and Air Force Headquarters. The task force’s primary emphasis was to determine if the shootdown was an isolated incident or indicative of a bigger problem. It issued its report to the Secretary of Defense on September 30, 1994. The report concluded that the incident was not indicative of a larger Air Force problem and that the following two breakdowns in individual crew performance had contributed to the incident: (1) the AWACS failed to build and provide an accurate air picture and (2) the F-15 pilots misidentified the target.

The report also recommended a one-time retraining and recertification program for all AWACS aircrews and a plan to reduce the temporary duty of AWACS crews to 120 days per year. The report concluded that the Air Force
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had corrected, or was in the process of correcting, training programs to address the shortcomings noted.

Air Combat Command Updates on Corrective Actions

On July 27, 1995, the Commander, Air Combat Command, informed the Air Force Chief of Staff that the Air Combat Command had completed a majority of the Tiger Team recommendations and that efforts were on target in achieving the desired results. He said that all AWACS crews had been recertified by October 13, 1994, and that the certification process was being applied to all AWACS crews deploying to any location. He further stated that AWACS temporary duty rates had been decreased from 166 to 135 days per year from January 1995 to July 1995. He also said that Air Combat Command planned to increase the number of AWACS crews.

However, he noted that the Air Combat Command was continuing to work on the following three areas: computer-based training devices, visual identification, and electronic identification. For example, he stated that the Air Combat Command had updated visual identification training material, provided computer hardware for the Air Force-improved computer-based training developed by an Air Force contractor, and distributed the material to all Air Combat Command fighter units. The Commander, Air Combat Command, noted that the new product was an improvement over previous training materials (35MM slides and video) but that it did not fully meet the Command's needs. He said that the Air Combat Command, in conjunction with the Air Education and Training Command, was pursuing an enhanced visual training program that would expand capabilities and allow aircrews to view three-dimensional or animated images against a variety of backgrounds from multiple aspects in all configurations and camouflage paint schemes. This new program was distributed to all Air Combat Command units in January 1996.

1By August 1996, the number of AWACS crews had been increased to 40 from the 28 available at the time of the shootdown.
3. Statement of Opinion

Under 10 U.S.C. 2254 (D) any opinion of accident investigators as to the cause of, or the factors contributing to the accident set forth in the accident investigation report, may not be considered as evidence in any civil or criminal proceeding arising from an aircraft accident, nor may such information be considered an admission of liability by the United States or by any person referred to in those conclusions or statements.

Operation PROVIDE COMFORT has been a successful coalition effort in response to human rights abuses against the Kurdish population in northern Iraq. The operation has effectively deterred Iraq from disrupting peace and order in the UN-established security zone.

The 14 April 1994 shoot-down of two US Black Hawk helicopters by two US F-15C aircraft in northern Iraq was caused by a chain of events which began with the breakdown of clear guidance from the Combined Task Force to its component organizations. This resulted in the lack of a clear understanding among the components of their respective responsibilities. Consequently, CTF component organizations did not fully integrate Military Coordination Center helicopter activities with other OPC air operations in the Tactical Area of Responsibility. Additionally, OPC personnel did not receive consistent, comprehensive training to ensure they had a thorough understanding of the USEUCOM-directed ROE. As a result, some aircrews’ understanding of how the approved ROE should be applied, became over-simplified.

MCC personnel were given a high degree of independence in helicopter operations, without an adequate consideration for the threat of engagement from other OPC aircraft. Neither the CTF staff nor the Combined Forces Air Component staff requested or received timely, detailed flight information on planned MCC helicopter activities in the TAOR. Consequently, the OPC daily Air Tasking Order was published with little detailed information regarding US helicopter flight activities over northern Iraq. Specific information on routes of flights and times of MCC helicopter activity in the TAOR was normally available to the other OPC participants only when AWACS received it from the helicopter crews by radio and relayed the information on.

The AWACS mission crew commander on 14 April 1994, who had flown only one sortie in the previous three months, was not currently qualified in accordance with Air Force regulations. The AWACS weapons controllers, under his supervision, did not have a clear understanding of their individual responsibilities to provide support to MCC helicopters. They shared the common view, along with the CFAC airborne command element officer, that MCC helicopter activities were not an integral part of OPC air operations. There was general misunderstanding throughout OPC organizations regarding the extent to which the provisions of the Airspace Control Order applied to MCC helicopter activities. AWACS personnel did not routinely monitor the Black
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Aircraft Accident Investigation Board
President's Opinion

Hawk helicopter flights or pass information on those flights to other OPC aircraft. The result was that there was no effective coordination of OPC fixed-wing and helicopter operations within the TAOR.

On 14 April 1994, AWACS controllers were aware that the Black Hawk helicopters had departed Zakhu, and were proceeding east into the TAOR. The F-15 pilots were not aware of the Black Hawk helicopters already in the area. The fighters twice informed AWACS that they had unknown radar contacts in the TAOR. The AWACS mission crew commander, senior weapons director, enroute controller and TAOR controller had access to electronic information regarding the presence of friendly aircraft in the vicinity of the F-15s' reported radar contacts. However, there is no evidence that they were aware of, recognized, or responded to this information. They did not advise the F-15 pilots of the presence of friendly aircraft. The helicopters were unable to hear the radio transmissions between the F-15 flight and AWACS because they were on a different radio frequency.

The F-15 pilots attempted to electronically identify the radar contacts by interrogating the ATO-designated IFF Mode I and Mode IV aircraft codes. The helicopter crew members were apparently not aware of the correct Mode I code specified for use within the TAOR and had the Mode I code specified for use outside the TAOR in their IFF transponders. The result was that the F-15s did not receive a Mode I response. When the lead F-15 pilot interrogated the IFF Mode IV code, he received a momentary friendly response. However, on two subsequent attempts, no Mode IV response was received. The F-15 wingman attempted one Mode IV interrogation and received no response.

The reason for the unsuccessful Mode IV interrogation attempts cannot be established, but was probably attributable to one or more of the following factors: both F-15 pilots may have selected the incorrect interrogation mode; both F-15 Air-to-Air Interrogators (AAIs) may have incorrectly processed the Black Hawks' transponder signals; both helicopter IFF transponder codes may have been loaded incorrectly, there may have been "garbling" of the friendly Black Hawks' IFF responses, produced by two helicopters using the same code in close proximity to each other; there may have been intermittent loss of line-of-sight radar contact between the F-15s and the helicopters, due to mountainous terrain and the Black Hawks' low-altitude, which could have precluded a successful Mode IV interrogation.

When the F-15 pilots were unable to get positive/consistent IFF responses they performed an intercept in order to visually identify the "unknown" aircraft. They each made a single identification pass on the Black Hawks. However, the identification passes were accomplished at speeds, altitudes and distances where it was unlikely that the pilots would have been able to detect the Black Hawks' markings. Neither F-15 pilot had received recent, adequate visual recognition training. The pilots did not recognize the differences between the US Black Hawk helicopters with wing-mounted fuel tanks and Hind helicopters with wing-mounted weapons. The F-15 flight lead misidentified the US Black Hawks as Iraqi Hind helicopters. Following his identification pass, he asked his wingman to confirm the identification. The wingman, who was a senior squadron supervisor and instructor pilot, saw two helicopters, but did not positively identify them as Hinds. The wingman did not notify the flight lead that he had been unable to make a positive
identification, and allowed the engagement to continue. The flight lead, acting within the specified ROE, fired a single missile and shot down the trail Black Hawk helicopter. At flight lead’s direction, the F-15 wingman also fired a single missile and shot down the lead Black Hawk helicopter.

JAMES G. ANDRUS
Maj Gen, USAF
Board President
October 24, 1997

Mr. Donald J. Wheeler  
Acting Director  
Office of Special Investigations  
U.S. General Accounting Office  
Washington, D.C. 20548

Dear Mr. Wheeler:


We appreciate the perspective GAO has added at the conclusion of its two-year investigation.

The Department of Defense concurs in the GAO's conclusions that (1) the Air Force Accident Investigation Board was properly convened, complied with the law, and met its objectives; (2) the military justice investigations that followed the accident investigation also complied with applicable law; and (3) there is no evidence of unlawful or improper command influence with respect to the accident investigation or military justice processes. In addition, we agree that in the few instances where GAO's report varied from the accident investigation report, those differences would not have affected the Board President's conclusions. We also concur with GAO's report of the extensive corrective actions taken by DoD since the incident in April 1994.

The Department appreciates the opportunity to comment on the draft report. In light of GAO's decision that no recommendations are warranted in this matter, we offer no further substantive comments.

Sincerely,

Judith A. Miller

[Signature]
Appendix III

Major Contributors to This Report

Barbara W. Alsip; Neyla Arnas; Fred Chasnov; Richard E. Chervenak; Barbara C. Coles; Donald G. Fulwider; Robert J. Gettings; Joan M. Hollenbach; M. Jane Hunt; Woodrow H. Hunt, Jr.; Shelia A. James; Paul E. Jordan; James M. Lager; William E. McDaniel, II; Richard C. Newbold; and Carin M. Wyche.
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