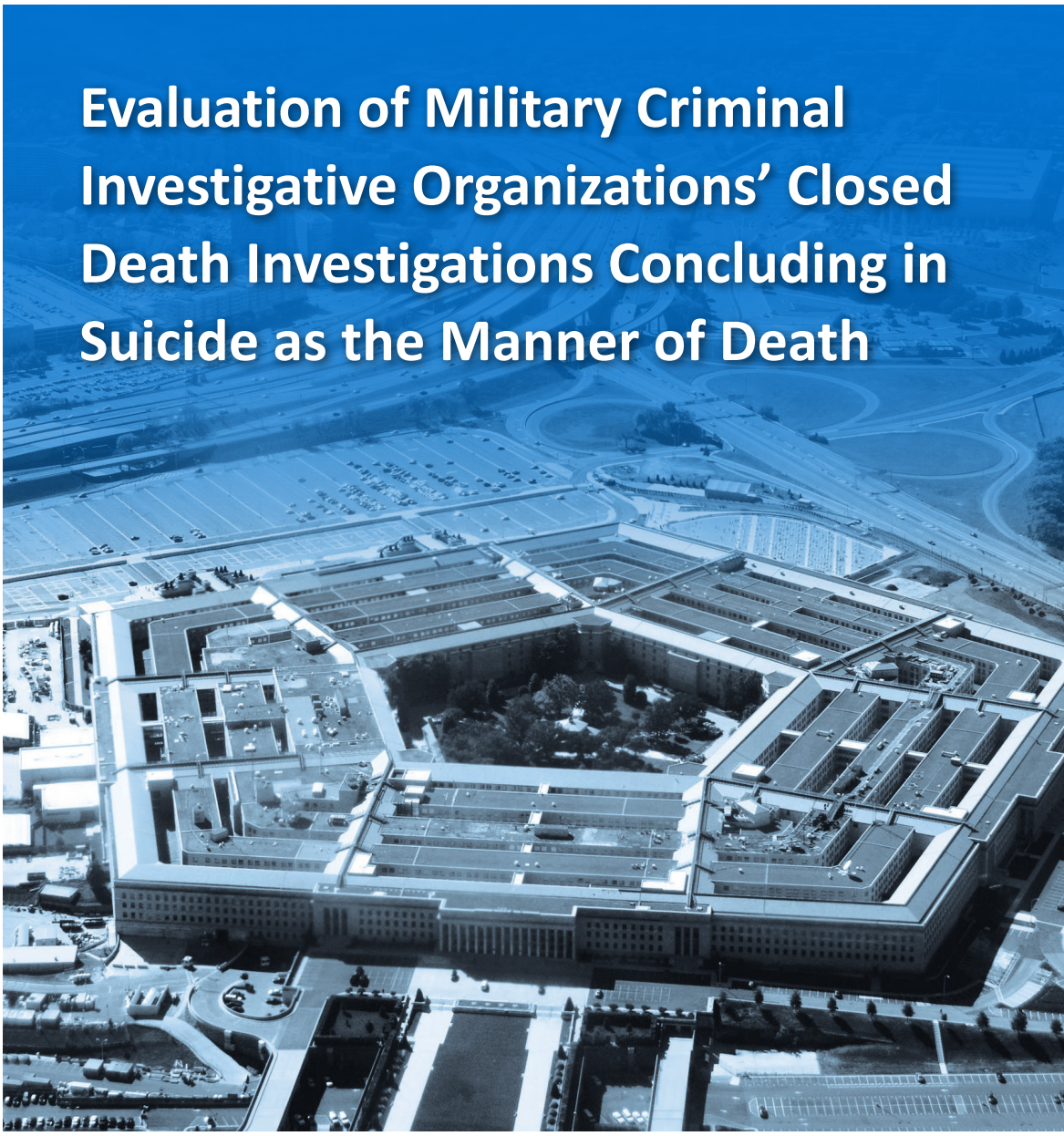
Report No. DODIG-2017-110

INSPECTOR GENERAL

U.S. Department of Defense

AUGUST 18, 2017

Evaluation of Military Criminal Investigative Organizations' Closed Death Investigations Concluding in Suicide as the Manner of Death



INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

INTEGRITY ★ EFFICIENCY ★ ACCOUNTABILITY ★ EXCELLENCE

Mission

Our mission is to provide independent, relevant, and timely oversight of the Department of Defense that supports the warfighter; promotes accountability, integrity, and efficiency; advises the Secretary of Defense and Congress; and informs the public.

Vision

Our vision is to be a model oversight organization in the Federal Government by leading change, speaking truth, and promoting excellence—a diverse organization, working together as one professional team, recognized as leaders in our field.

For more information about whistleblower protection, please see the inside back cover.

Results in Brief

Evaluation of Military Criminal Investigative Organizations' Closed Death Investigations Concluding in Suicide as the Manner of Death

August 18, 2017

Objective

We evaluated 188 Military Criminal Investigative Organization (MCIO) death investigations concluding in suicide as the manner of death opened on or after January 1, 2014, and closed on or before December 31, 2015, to determine whether the investigations were completed in accordance with DoD, Military Service, and MCIO policy. Our evaluation included MCIO work and assistance on 146 (77.7 percent) of the 188 cases that were investigated either solely or primarily by Federal, State or Local law enforcement agencies that had jurisdiction to investigate the service members' deaths.

Findings

We found that none of the 188 cases we evaluated had significant deficiencies, which are one or more deficiencies, or a series of minor deficiencies, demonstrating a material failure to conform to critical elements of DoD, Military Service, or MCIO policies and procedures. A significant deficiency indicates a breakdown in practices, programs, or policies having an adverse impact on, or having a likelihood of materially affecting, the integrity of the investigation, or adversely affecting the outcome of an investigation.

In addition, 55 (29.3 percent) of the 188 cases we evaluated had minor deficiencies, which are investigative tasks or steps the MCIO did not perform, or

Findings (cont'd)

performed not in conformity with DoD, Military Service, or MCIO policies and procedures. Minor deficiencies are deficiencies that are not likely to adversely affect either the investigative process or the outcome of an investigation. Examples of minor deficiencies are not determining the decedent's handedness, not interviewing the decedent's supervisors, not properly photographing a death scene, not including measurements in a death scene sketch, not triangulating death scene evidence, or not obtaining the 911 recordings.

We further analyzed the 55 (29.3 percent) of 188 cases which had minor deficiencies by examining the data points we developed to evaluate each case. The number of data points is dependent upon how the decedent committed suicide and the responsible agencies' investigative steps. Out of 14,990 data points we reviewed, the MCIOs had 125 minor deficiencies, which resulted in an average error rate of 0.83 percent for the 188 cases.

Our analysis of the minor deficiencies revealed one systemic concern. We found that in 20 (31.3 percent) of the 64 Naval Criminal Investigative Service (NCIS) cases we evaluated, the case files did not contain copies of death certificates as required by NCIS policy.

In sum, overall, we found no cases with significant deficiencies and found that the number of cases with no deficiencies exceeded 70 percent.

Recommendation

We recommend that the Director, Naval Criminal Investigative Service, implement measures to improve compliance with the death certificate collection requirement.

Results in Brief

Evaluation of Military Criminal Investigative Organizations' Closed Death Investigations Concluding in Suicide as the Manner of Death

Management Comments and Our Response

The Executive Assistant Director, NCIS, concurred with our recommendation to implement measures to improve compliance with the death certificate collection requirement. NCIS stated the requirement to obtain death certificates is internal to NCIS, and as cited in this report, in all cases where a death certificate was not obtained by NCIS the death was investigated solely or primarily by law enforcement agencies other than NCIS. NCIS further stated that obtaining a death certificate in every investigation, specifically those that NCIS was not the lead investigative agency, is not always possible. Therefore, a policy change will be made requiring death certificates to be obtained only when NCIS is the lead investigative agency. The policy implementation date is tentatively scheduled for October 2017. The Executive Assistant Director, NCIS' comments addressed all specifics of the recommendation. We consider this recommendation to be resolved, but still open. We will close this recommendation once we receive and review a copy of the revised NCIS policy related the collection of death certificates for suicide investigations and verify the changes meet the intent of our recommendation. No further comments are required. We request NCIS provide a copy of the revised policy by the end of October 2017.

Recommendations Table

Management	Recommendations Unresolved	Recommendations Resolved	Recommendations Closed
The Director, Naval Criminal Investigative Service	None	1	None

Note: The following categories are used to describe agency management's comments to individual recommendations.

- **Unresolved** – Management has not agreed to implement the recommendation or has not proposed actions that will address the recommendation.
- **Resolved** – Management agreed to implement the recommendation or has proposed actions that will address the underlying finding that generated the recommendation.
- **Closed** – OIG verified that the agreed upon corrective actions were implemented.


INSPECTOR GENERAL
INTEGRITY
EFFICIENCY
DEPARTMENT OF DEFENSE

INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

August 18, 2017

MEMORANDUM FOR COMMANDER, U.S. ARMY CRIMINAL INVESTIGATION COMMAND
DIRECTOR, NAVAL CRIMINAL INVESTIGATIVE SERVICE
COMMANDER, AIR FORCE OFFICE OF SPECIAL INVESTIGATIONS

SUBJECT: Evaluation of Military Criminal Investigative Organizations' Closed Death Investigations Concluding in Suicide as the Manner of Death (Report No. DODIG-2017-110)

This report is provided for review. We evaluated 188 Military Criminal Investigative Organization (MCIO) death investigations concluding in suicide as the manner of death opened on or after January 1, 2014, and closed on or before December 31, 2015, to determine whether the investigations were completed in accordance with DoD, Military Service, and MCIO guidance. Our evaluation included MCIO work and assistance on 146 (77.7 percent) of the 188 cases that were investigated either solely or primarily by Federal, State, or Local law enforcement agencies that had jurisdiction to investigate the service members' deaths. We conducted this evaluation in accordance with the "Quality Standards for Inspection and Evaluation," published in 2012 by the Council of the Inspectors General on Integrity and Efficiency.

We found that none of the 188 cases evaluated had significant deficiencies, and that 55 (29.3 percent) of the 188 cases we evaluated had minor deficiencies. Our analysis of the minor deficiencies revealed one systemic concern. We found that in 20 (31.3 percent) of the 64 Naval Criminal Investigative Service (NCIS) cases we evaluated, the case files did not contain copies of death certificates as required by NCIS policy. Our analysis of the remaining minor deficiencies did not reveal evidence of patterns, trends, or systemic concerns.

We considered management comments on a draft of this report when preparing the final report. Comments from the Executive Assistant Director, Naval Criminal Investigative Service conformed to the requirements of DoD Directive 7650.3; therefore, we do not require additional comments.

We appreciate the courtesies extended to the staff during the evaluation. For more information on this report, please direct questions to Mr. John Dippel at (703) 604-9294 (DSN 664-9294).

Randolph R. Stone
Deputy Inspector General
Policy and Oversight

Contents

Introduction

Objective

We determined whether Military Criminal Investigative Organization (MCIO) death investigations concluding in suicide as the manner of death were completed in accordance with DoD, Military Service, and MCIO guidance. Our evaluation included MCIO work and assistance on cases that were investigated either solely or primarily by law enforcement agencies, other than the MCIOs, that had jurisdiction to investigate the service members' deaths. See Appendix A for our scope and methodology and prior coverage. See Appendix B for the demographic data of the cases.

Background

We initiated this project to meet the DoD Inspector General's (IG's) statutory obligations in accordance with the Inspector General Act of 1978 for policy, oversight, and performance evaluation "with respect to all DoD activities relating to criminal investigation . . . programs." This authority is embodied in DoD Directive 5106.01, "Inspector General of the Department of Defense (IG DoD)," April 20, 2012, (Incorporating Change 1, Effective August 19, 2014), and DoD Instruction (DoDI) 5505.03, "Initiation of Investigations by Defense Criminal Investigative Organizations," March 24, 2011, (Incorporating Change 1, December 22, 2015).

Finding

MCIO Closed Death Investigations Concluding in Suicide as the Manner of Death Had No Significant Deficiencies; However, Minor Deficiencies Existed

We found that none of the 188 MCIO cases we evaluated had significant deficiencies, which are one or more deficiencies, or a series of minor deficiencies, resulting from a material failure to conform to critical elements of DoD, Military Service, or MCIO policies and procedures. A significant deficiency indicates a breakdown in practices, programs, or policies having an adverse impact on, or had a likelihood of materially affecting, the integrity of the investigation, or adversely affecting the outcome of an investigation. In addition, we found that 133 (70.7 percent) of the 188 cases we evaluated had no deficiencies.

We also evaluated cases for minor deficiencies, which are investigative tasks or steps the MCIO did not perform, or performed not in conformity with DoD, Military Service, or MCIO policies and procedures. Minor deficiencies are deficiencies that are not likely to adversely affect either the investigative process or the outcome of an investigation. We found that 55 (29.3 percent) of the 188 cases we evaluated had only minor deficiencies. Some of the cases had more than one deficiency.

We evaluated each case against a set of policy-based data points to determine the level of compliance with pertinent policies. (See MCIO Error Rates for more information.) We found 125 (0.83 percent) errors (minor deficiencies) out of approximately 14,990 data points that we evaluated. See Tables 3 and 4 for the individual MCIO error rates.

Our analysis of the minor deficiencies revealed one systemic concern. We found that in 20 (31.3 percent) of the 64 Naval Criminal Investigative Service (NCIS) cases we evaluated, the case files did not contain copies of death certificates as required by NCIS policy, NCIS-3, Chapter 30.[1]

Overall, there were no cases with significant deficiencies and the number of cases with no deficiencies exceeded 70 percent.

[1] NCIS-3, Chapter 30, 30-27.15. April 2008. "In cases of off-base deaths under the primary investigative jurisdiction of another agency, NCIS 'details and disposition' reporting to command should include, at a minimum, a copy of the death certificate, the preliminary and final autopsy reports if it is a medical examiner or coroner case, and a summary of the agency's investigation documented in an IA."

Results of Death Investigations Evaluations

We evaluated a randomly selected statistical sample amounting to 188 of 346 MCIO closed death investigations concluding in suicide as the manner of death.[2] The numerical breakdown of the 188 MCIO cases is as follows:

- 73 were from U.S. Army Criminal Investigation Command (USACIDC);
- 64 were from NCIS; and
- 51 were from Air Force Office of Special Investigations (AFOSI).

The scope of our evaluation included cases that were opened on or after January 1, 2014, and closed on or before December 31, 2015.

A total of 146 (77.7 percent) of the 188 cases we evaluated were investigated either solely or primarily by Federal, State, and Local law enforcement agencies with jurisdiction to investigate service members' deaths.[3] Table 1 depicts a breakdown of the number of cases led by Federal (4), State (1), or Local (141) law enforcement agencies having investigative jurisdiction of service members' deaths, compared to the number of cases led by an MCIO.

Table 1. The Number of Cases Led by Federal, State, or Local Law Enforcement Compared to MCIO Led Cases

Category	Total	USACIDC	NCIS	AFOSI
Federal, State, or Local Law Enforcement was the Lead Agency	**146**	**60**	**50**	**36**
Federal lead agency	**4**	2	1	1
State lead agency	**1**	0	1	0
Local lead agency	**141**	58	48	35
MCIO was the Lead Agency	**42**	**13**	**14**	**15**
Joint investigation	**10**	1	2	7
MCIO exclusive investigation	**32**	12	12	8
Total Investigations	**188**	**73**	**64**	**51**

We found that of the 188 cases we evaluated, 133 (70.7 percent) had no deficiencies and 55 (29.3 percent) had minor deficiencies that are not likely to affect either the investigative process or adversely impact the investigative outcome. For example, we found that in 20 (31.3 percent) of the 64 NCIS cases we evaluated, the case

[2] We used a 90-percent confidence level and a 7-percent precision rate.

[3] Military Departments do not always have investigative jurisdiction or investigative responsibility and do not have control over the other Federal, State, Local, or Foreign law enforcement agencies conducting death investigations. In accordance with DoDI 5505.10, Enclosure 2, 3.b, "the MCIO will liaison with the law enforcement organization that is conducting the [death] investigation."

files did not contain copies of death certificates as required by NCIS policy. We found that in all instances when the case file did not contain a copy of the death certificate, the death was investigated solely or primarily by law enforcement agencies other than NCIS. Our analysis of the remaining minor deficiencies did not reveal evidence of any other patterns, trends, or systemic concerns.

In addition, in 28 (14.9 percent) of the 188 cases we evaluated, we identified and commented on exceptional performance by the case agents, supervisors, or both. Examples of the noteworthy performance we found include:

- USACIDC—"Outstanding effort overall from initial response to closure, especially in trying to explain the 'why' [decedent committed suicide]. A neighborhood canvass identified a witness whose testimony corroborated a significant witnesses' testimony about what had happened just prior to the death." Digital and testimonial evidence identified life stressors (sexuality & financial) and past events (child sexual assault & prior suicide attempt) that more than likely contributed to the death;
- NCIS—"Great coordination between NCIS, AFOSI, and local law enforcement. NCIS provided good support to AFOSI lead investigation in scene examination and initial contact with ex-fiancé and mother when they ensured the well-being of them after finding a female's photograph in decedent's vehicle. [Agents] did an outstanding job throughout the entire investigation. Highly professional product";
- AFOSI—"Excellent investigation; well documented and professional follow-up subsequent to the scene being released by local authorities to AFOSI. Excellent crime scene documentation and use of specialized techniques."

Cases with Significant Deficiencies

None of the 188 cases we evaluated had significant deficiencies. A case had a "significant deficiency" if one or more deficiencies, or a series of minor deficiencies, demonstrating a material failure to conform to critical elements of DoD, Military Service, or MCIO policies and procedures. A significant deficiency indicates a breakdown in practices, programs, or policies having an adverse impact on, or having a likelihood of materially affecting, the integrity of the investigation, or adversely affecting the outcome of an investigation. If we had identified one or more significant deficiencies in an investigation, we would have returned the investigation to the appropriate MCIO with an explanation of the deficiencies along with applicable guidance and policies related to the deficiencies.

Examples of significant deficiencies, steps which could change the outcome of the investigation, include the following:

- key evidence was not collected from the death scene or the decedent;
- death scene examinations were not completed, not completed thoroughly, or not completed before the loss of crucial evidence; and
- critical interviews or reinterviews were not thorough or not conducted.

Cases with Minor Deficiencies

Of the 188 cases we evaluated, 55 (29.3 percent) had minor deficiencies. A "minor deficiency" is an investigative task or step the MCIO did not perform, or performed not in conformity with DoD, Military Service, or MCIO policies and procedures. Minor deficiencies are deficiencies that are not likely to adversely affect either the investigative process or the outcome of an investigation.

Examples of the minor deficiencies, steps which would not change the outcome of the investigation, include the following:

- USACIDC
    - agents did not determine the decedent's handedness;
    - agents did not interview the decedent's supervisors;
- NCIS
    - agents did not properly photograph a death scene;
    - agents did not include measurements in a death scene sketch;
- AFOSI
    - agents did not triangulate death scene evidence; and
    - agents did not obtain the 911 recordings.

Our analysis of the minor deficiencies in the USACIDC and AFOSI cases did not reveal evidence of patterns, trends, or systemic concerns. In 20 (36.4 percent) of the 55 cases with minor deficiencies (31.3 percent of the 64 NCIS cases) we evaluated, the case files did not contain copies of death certificates as required by NCIS policy. We found that in all instances when the case file did not contain a copy of the death certificate, the death was investigated solely or primarily by law enforcement agencies, other than NCIS, with jurisdiction to investigate service members' deaths.

Table 2 depicts a breakdown by MCIO of the number of cases with no deficiencies, significant deficiencies, and minor deficiencies.

Table 2. Cases with No Deficiencies, Significant Deficiencies, and Minor Deficiencies

Case Deficiencies	Total	USACIDC	NCIS	AFOSI
None	**133**	69	42	22
Significant	**0**	0	0	0
Minor	**55**	4	22	29
Total	**188**	**73**	**64**	**51**

MCIO Error Rates

We developed an evaluation protocol based on pertinent DoD, Military Service, and MCIO policies. The evaluation protocol addressed the investigative steps that are needed to complete a thorough death investigation (See Appendix A for details regarding the protocol). The number of data points for each case depended upon whether the investigation was led by either an MCIO or a Federal, State, or Local law enforcement agency, as well as the way in which the decedents committed suicide.[4] The evaluation protocol for an investigation led by an MCIO includes approximately 200 data points (varies slightly by MCIO as well as the way in which the decedents committed suicide). The number of data points for an MCIO investigation led by Federal, State, or Local law enforcement agency ranged from 25 to 90 data points depending upon each MCIO's policy requirements.

Within the 55 (29.3 percent) of 188 cases which had minor deficiencies, the MCIOs had a total of 125 data points with minor deficiencies out of approximately 14,990 data points. The resulting approximate average error rate for the MCIOs was 0.83 percent. We define the error rate as the percent of the approximate data points for a given MCIO and type of investigation which had minor deficiencies.

Table 3 depicts a breakdown by MCIO of how the total number of minor deficiencies relates to the approximate number of data points per case when the MCIO was not the lead agency. The data points are approximated because the number of data points depends upon individual MCIO investigative requirements and how the decedent committed suicide. To determine the overall and individual MCIO error rates for the investigations in which the MCIO was not the lead (55 cases) we multiplied the approximate number of data points (35 USACIDC, 25 NCIS, and 90 AFOSI) we used to evaluate the investigation and then divided by the total approximated data points.

[4] The MCIO was considered the lead investigative agency if they had jurisdiction over the decedent and the location of the death and if any other law enforcement agency involved agreed the MCIO should be the lead agency. The MCIO was not considered the lead investigative agency when another law enforcement agency had jurisdiction over the decedent and/or the location of the death.

Table 3. MCIO Minor Deficiency Error Rates when MCIO was Not the Lead Agency

Category	Total	USACIDC	NCIS	AFOSI
Number of Minor Deficiencies	**56**	**1**	**21**	**34**
Number of cases when MCIO was not the lead	**146**	60	50	36
Approximate data points per case	**N/A**	35	25	90
Total Approximated Data Points	**6,590**	**2,100**	**1,250**	**3,240**
MCIO Error Rate	**0.85%**	**0.05%**	**1.68%**	**1.05%**

Table 4 depicts a breakdown by MCIO of how the total number of minor deficiencies relates to the approximate number of data points per case when the MCIO was the lead agency. The data points are approximated because the number of data points depended upon each MCIO's policy requirements and the way in which the decedents committed suicide. To determine the overall and individual MCIO error rates for the 42 cases in which the MCIO was the lead agency, we multiplied the approximate number of data points (200 data points) we used to evaluate each case divided by the total approximated data points.

Table 4. MCIO Minor Deficiency Error Rates when MCIO was the Lead Agency

Category	Total	USACIDC	NCIS	AFOSI
Number of Minor Deficiencies	**69**	**9**	**3**	**57**
Number of cases when MCIO was the lead	**42**	13	14	15
Approximate data points used per case	**N/A**	200	200	200
Total Approximated Data Points	**8,400**	**2,600**	**2,800**	**3,000**
MCIO Error Rate	**0.82%**	**0.35%**	**0.11%**	**1.90%**

Conclusions

None of the 188 cases we evaluated had significant deficiencies, which are deficiencies that demonstrate a breakdown in practices, programs, or policies having an adverse impact on, or having a likelihood of materially affecting, the integrity of the investigation, or adversely affecting the outcome of an investigation. In addition, 133 (70.7 percent) of the 188 cases we evaluated had no deficiencies.

We also found and made comments on exceptional performance by the case agents, supervisors, or both. Their performance was noteworthy in 28 (14.9 percent) of the 188 cases.

We found 55 (29.3 percent) of the 188 cases we evaluated had minor deficiencies, which are deficiencies that are not likely to adversely affect either the investigative process or the outcome of an investigation. The average error rate for cases with minor deficiencies was 0.80 percent, meaning that from a total of 14,990 data points that we evaluated we found only 120 errors, i.e., minor deficiencies.

In 20 (31.3 percent) of the 64 NCIS cases we evaluated, the case files did not contain copies of death certificates as required by NCIS policy. Other than the 20 NCIS death certificate deficiencies, our analysis of the MCIO minor deficiencies for both MCIO led cases and cases led by other law enforcement agencies did not reveal evidence of patterns, trends, or systemic concerns.

A total of 146 (77.7 percent) of the 188 cases we evaluated were investigated solely or primarily by law enforcement agencies, other than MCIOs. In these cases the other law enforcement agency and the MCIO had jurisdiction over the decedent. A scenario in which this may happen is during a death investigation, later to be determined a suicide, an active duty service member is found dead in an off-military installation park. The MCIO has a nexus as the decedent is active duty and the Local law enforcement has jurisdiction because the death occurred in their area of responsibility.

Overall, none of the cases reviewed had significant deficiencies and the number of cases with no deficiencies exceeded 70 percent.

Recommendations, Management Comments, and Our Response

Recommendation 1

We recommend that the Director, Naval Criminal Investigative Service, implement measures to improve compliance with the death certificate collection requirement.

Director, Naval Criminal Investigative Service, Comments

The Executive Assistant Director, NCIS, concurred with our recommendation to implement measures to improve compliance with the death certificate collection requirement. NCIS stated the requirement to obtain death certificates is internal to NCIS, and as cited in this report, in all cases where a death certificate was not obtained by NCIS the death was investigated solely or primarily by law enforcement agencies other than NCIS. NCIS further stated that obtaining a death certificate in every investigation, specifically those that NCIS was not the lead investigative agency, is not always possible. Therefore, a policy change, tentatively scheduled for October 2017, will require death certificates to be obtained only when NCIS is the lead investigative agency.

Our Response

The Executive Assistant Director, NCIS' comments addressed all specifics of the recommendation. We consider this recommendation to be resolved, but still open. We will close this recommendation once we receive and review a copy of the revised NCIS policy related the collection of death certificates for suicide investigations and verify the changes meet the intent of our recommendation. We request NCIS provide a copy of the revised policy by the end of October 2017.

Appendix A

Scope and Methodology

We evaluated 188 MCIO death investigations concluding in suicide as the manner of death opened on or after January 1, 2014, and closed on or before December 31, 2015, to determine whether the investigations were completed in accordance with DoD, Military Service, and MCIO policy. Our evaluation included such cases that were investigated either solely or primarily by law enforcement agencies, other than the MCIOs, with jurisdiction to investigate service members' deaths.

We completed the evaluation between November 14, 2016, and January 23, 2017. We conducted this evaluation in accordance with the "Quality Standards for Inspection and Evaluation," published in 2012, by the Council of the Inspectors General on Integrity and Efficiency. Those standards require that we plan and perform the evaluation to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings, conclusions, and recommendations based on our evaluation objectives. We believe that the evidence obtained during the evaluation provides a reasonable basis for our conclusions.

We evaluated the MCIOs' policy for investigating noncombat deaths to assess its alignment with parent Service and DoD policy, and the extent to which it addressed investigative activity expected in response to death investigation reports. We reviewed MCIO policy specifying tasks required for all death investigations and developed specific case evaluation protocols to ensure uniform evaluations of sample cases.

At the onset of the evaluation, we requested that each MCIO provide a list of the death investigations concluding in suicide as the manner of death that were opened on or after January 1, 2014, and closed on or before December 31, 2015.[5] The MCIOs provided lists that included: (1) the investigation case numbers; (2) dates the investigations were opened and closed; (3) the number of decedents; (4) names and identifying information of the decedents; (5) the MCIO office responsible for the case; and (6) prior offenses involving the decedent investigated by an MCIO or non-MCIO law enforcement organization.

We provided the MCIO case lists to the DoD Office of Inspector General (OIG) Quantitative Methods Division to determine a simple random sample of cases, stratified by MCIO, to evaluate based on a desired level of reliability. The

[5] The list included investigations worked jointly or were another law enforcement agency's investigation and was monitored and later reported on by an MCIO.

sample size was selected from the population using a 90-percent confidence level, 50-percent probability of occurrence, and a 7-percent precision level. The Quantitative Methods Division identified a sample of 188 investigations (by case number), stratified by MCIO, for evaluation. We provided the case list to each MCIO and requested that the cases be made available for evaluation at each of the MCIO's headquarters.

We developed a death case evaluation protocol based on DoD, Military Service, and the MCIO's investigative policies and procedures. The evaluation protocol addressed, in detail, the required investigative steps that are essential to completing a thorough death investigation ensuring compliance with applicable DoD, Military Service, and MCIO policy. Upon completion of the evaluation protocol, we provided the protocol to the MCIO's for review and comment prior to its finalization and implementation during the evaluation.

In conducting the evaluations we noted observations[6] and deficiencies found in the case files using the following definitions.

Significant Deficiency. An investigation was found to contain significant deficiencies if one or more deficiencies, or a series of minor deficiencies, resulted from a material failure to conform to critical elements of DoD, Military Service, or MCIO policies and procedures. A significant deficiency indicates a breakdown in practices, programs, or policies having adverse impact on, or had a likelihood of materially affecting, the integrity of the investigation or adversely affecting the outcome of an investigation.

Minor Deficiency. An investigative task or step the MCIO did not perform, or performed not in conformity with DoD, Military Service, or MCIO policies and procedures. Minor deficiencies are deficiencies that are not likely to adversely affect either the investigative process or the outcome of an investigation.

Observation. An observation is an aspect of an investigation that an evaluator deemed warranted added attention and documentation. Observations may also be administrative errors in a report or specific information the MCIOs requested we focus upon during our case evaluations.

Data Analysis and Deficiencies Analysis

At the conclusion of the case evaluation phase, we analyzed the data we collected and stored in the protocol database by developing queries to efficiently identify investigative tasks or steps that the MCIOs did not complete, did not document, or did not perform correctly. The queries displayed what tasks or steps were involved with each deficiency and the number of instances of each. Additional data analysis was facilitated by exporting query results into spreadsheets.

[6] We made no observations during this evaluation.

We evaluated a representative sample of all MCIO closed death investigations, concluding in suicide as the manner of death, and that provides the OIG with a unique vantage point that individual MCIOs do not. This vantage point affords us the opportunity to not only identify Department-wide patterns, trends, and best practices, but also provide the MCIOs with recommendations for improvement, when warranted.

Documenting Minor Deficiencies for Review by MCIOs

At the conclusion of the case evaluation process, we provided documentation of minor deficiencies to each MCIO with a request to validate our assessment of the deficiencies and provide comment. This data allowed the MCIOs to validate or refute each minor deficiency. We discussed the deficiencies we found with the MCIOs, we analyzed their responses to the minor deficiencies, and updated the protocol database to reflect the final outcome of the deficiency validation process. We provided the MCIOs with our conclusions regarding their validations of our case-by-case minor deficiency findings for their information and action.

Prior Coverage

The DoD OIG has issued four reports discussing topics related to suicide investigations in the last 7 years. The unrestricted DoD OIG reports can be accessed at http://www.dodig.mil/pubs/index.cfm.

DoD OIG

Report No. DODIG-2015-182, "Assessment of DoD Suicide Prevention Processes," September 30, 2015

> The DoD IG evaluated DoD processes used to develop suicide prevention policy and determine what process changes are required to improve suicide prevention and intervention policies. Observations included the DoD lacked a clearly defined structure and alignment of responsibilities for the Defense Suicide Prevention Program.

Report No. DODIG-2015-007, "Evaluation of Matters Related to the Death of Navy Seaman Kyle Antonacci," October 28, 2014

> DoD IG initiated this evaluation in response to a complaint to the Defense Hotline. The complaint questioned the integrity of the investigation into the death of Navy Seaman Kyle Antonacci. The DoD IG found the NCIS rape investigation was not conducted in full compliance with NCIS investigative standards.

Report No. DODIG-2015-016, "Department of Defense Suicide Event Report (DoDSER) Data Quality Assessment," November 14, 2014

The assessment focused on decreasing the number of "don't know" responses on suicide death submissions. The assessment identified seven topics for DoDSER submission improvements and recommended the DoD improve the processes for collecting and submitting DoDSER data.

Report No. IPO2010E002, "Review of Matters Related to the Death of Hospitalman (HN) Christopher Purcell, U.S. Navy," October 27, 2010

DoD IG initiated this evaluation in response to a request from Representative Mark Steven Kirk (R – IL) on behalf of the parents of HN Christopher Purcell following his suicide on January 27, 2008. NCIS conducted their investigation in accordance with the DoD, Department of Navy, and NCIS standards.

Appendix B

Demographic and Other Case Details

This appendix contains information related to our case analysis as well as data pertaining to age ranges, gender, pay grades, where the deaths occurred, crimes in which the decedent of an investigation we evaluated was a subject or victim of a previous criminal offense, and modes of death. The data are provided for information only and for possible future analysis if compared to data gleaned from comparable statistical evaluations.

We found deaths occurred both on and off military installations, in a variety of settings, such as private residences, barracks, dormitories, hotels, and outdoors.

Case Analysis

Table 5 depicts the decedent's pay grade.

Table 5. Military Decedent's Rank

Category	Total	Army	Navy	Air Force	Marine Corps
Junior Enlisted	**76**	**33**	**13**	**21**	**9**
E-1	5	4	0	1	0
E-2	4	2	0	2	0
E-3	29	11	6	6	6
E-4	38	16	7	12	3
NCO	**64**	**20**	**19**	**20**	**5**
E-5	37	12	9	12	4
E-6	27	8	10	8	1
Senior NCO	**14**	**6**	**2**	**6**	**0**
E-7	12	4	2	6	0
E-8	2	2	0	0	0
E-9	0	0	0	0	0
Total Enlisted	**154**	**59**	**34**	**47**	**14**
Warrant Grade	**1**	**1**	**0**	**NA**	**0**
W-1	0	0	0	NA	0
W-2	0	0	0	NA	0
W-3	1	1	0	NA	0
W-4	0	0	0	NA	0
W-5	0	0	0	NA	0

Table 5. Military Decedent's Rank (cont'd)

Category	Total	Army	Navy	Air Force	Marine Corps
Company Grade	**13**	**5**	**3**	**3**	**2**
O-1	1	1	0	0	0
O-2	7	2	3	1	1
O-3	5	2	0	2	1
Field Grade	**3**	**1**	**2**	**0**	**0**
O-4	2	1	1	0	0
O-5	0	0	0	0	0
O-6	1	0	1	0	0
Flag Officer	**0**	**0**	**0**	**0**	**0**
Total Officer	**17**	**7**	**5**	**3**	**2**
Military Service Academy Cadet	0	0	0	0	0
Military Decedent Total	**171**	**66**	**39**	**50**	**16**

Note: Two of the military decedents are listed in separate investigations by two MCIOs. For example, one MCIO opened an investigation into the death upon notification. During the investigation, the decedent was found to be a member of a different service so the first MCIO might then transfer the investigation to another MCIO. The total number of investigations evaluated for 171 military decedents is 173.

Table 6 depicts the numbers and percentages of military decedents in each pay grade. For comparison, the table also provides the DoD active duty military population numbers and percentages of the total population of DoD active duty military in each pay grade. The DoD active duty military numbers are averages of the 2014 and 2015 monthly statistics made available by the Defense Manpower Data Center.

Table 6. Military Decedent's Pay Grade Numbers Compared with DoD Active Duty Military Population

Category	Military Decedents in Evaluated Investigations		2014-2015 DoD Active Duty Military Population	
	Number	Percentage of Military Sample	Number	Percentage of Population
Junior Enlisted	**76**	**45.61%**	**569,940**	**42.77%**
E-1	**5**	2.92%	46,130	3.46%
E-2	**4**	2.34%	65,812	4.94%
E-3	**29**	16.96%	189,660	14.23%
E-4	**38**	22.22%	268,338	20.14%
NCO	**64**	**37.43%**	**387,136**	**29.05%**
E-5	**37**	21.64%	226,308	16.98%
E-6	**27**	15.79%	160,828	12.07%
Senior NCO	**14**	**8.19%**	**129,397**	**9.71%**
E-7	**12**	7.02%	92,255	6.92%
E-8	**2**	1.17%	26,998	2.03%
E-9	**0**	0.00%	10,144	0.76%
Total Enlisted	**154**	**90.06%**	**1,086,473**	**81.54%**
Warrant Grade	**1**	**0.58%**	**19,098**	**1.43%**
W-1	**0**	0.00%	7,748	0.58%
W-2	**0**	0.00%	5,376	0.40%
W-3	**1**	0.58%	2,868	0.22%
W-4	**0**	0.00%	828	0.06%
W-5	**0**	0.00%	2,278	0.17%
Company Grade	**13**	**7.60%**	**129,578**	**9.72%**
O-1	**1**	0.58%	22,984	1.72%
O-2	**7**	4.09%	30,549	2.29%
O-3	**5**	2.92%	76,044	5.71%
Field Grade	**3**	**1.75%**	**84,041**	**6.31%**
O-4	**2**	1.17%	44,586	3.35%
O-5	**0**	0.00%	27,951	2.10%
O-6	**1**	0.58%	11,503	0.86%
Flag Officer	**0**	**0.00%**	**903**	**0.07%**
Total Officer	**17**	**9.94%**	**233,619**	**17.53%**
Military Service Academy Cadet	**0**	0.00%	12,347	0.93%
Military Decedent Total	**171**	**100.00%**	**1,332,439**	**100.00%**

Note: Two of the military decedents are listed in separate investigations by two MCIOs. The total number of investigations evaluated for 171 military decedents is 173.

Table 7 depicts the branch of service to which the civilian decedent was affiliated.

Table 7. Civilian Decedent Service Affiliation

Category	Total	Army	Navy	Air Force	Marine Corps	No Affiliation
Child	**2**	2	0	0	0	0
Adult	**12**	4	4	1	1	2*
Civilian Decedent Total	**14**	**6**	**4**	**1**	**1**	**2**

* Decedents found on or near DoD property that is under exclusive Federal jurisdiction.

Table 8 depicts the age range of the decedent.

Table 8. Age Range of Decedents

Category	Total	Army	Navy	Air Force	Marine Corps	Civilian
0-18	**3**	0	0	0	0	3
19-24	**59**	25	8	16	10	0
25-30	**50**	16	12	16	3	3
31-36	**41**	10	14	10	3	4
37-42	**21**	10	4	6	0	1
43 and over	**11**	5	1	2	0	3
Decedent Total	**185**	**66**	**39**	**50**	**16**	**14**

Note: Three decedents are listed in separate investigations by two MCIOs. For example, one MCIO opened an investigation into the death upon notification. During the investigation, the decedent was found to be a member of a different Service so the first MCIO may have transferred the investigation to another MCIO. The total number of investigations evaluated for 185 decedents is 188.

Table 9 depicts the gender of the decedents.

Table 9. Decedent's Gender

Category	Total	Army	Navy	Air Force	Marine Corps	Civilian
Female	27	8	2	6	2	9
Male	158	58	37	44	14	5
Total	**185**	**66**	**39**	**50**	**16**	**14**

Note: Three decedents are listed in separate investigations by two MCIOs. The total number of investigations evaluated for 185 decedents is 188.

Table 10 depicts the location of death.

Table 10. Location of Death

Category	Total	USACIDC	NCIS	AFOSI
On Installation	**39**	**13**	**14**	**12**
Barracks/Dorm	**9**	3	3	3
Hotel/Motel	**2**	0	1	1
Office/Workplace	**4**	1	0	3
Private Vehicle	**2**	0	1	1
Residence/Home	**13**	6	4	3
Roadway	**1**	0	1	0
School	**1**	1	0	0
Ship/Vessel	**2**	0	2	0
Wooded or Open Area	**5**	2	2	1
Off Installation	**146**	**58**	**49**	**39**
Bar	**1**	0	0	1
Church	**1**	1	0	0
Hospital (Care Area)	**1**	1	0	0
Hotel/Motel	**8**	2	3	3
Park/Beach	**2**	1	1	0
Parking Lot	**7**	4	2	1
Prison/Brig	**1**	0	1	0
Private Vehicle	**2**	1	0	1
Residence/Home	**99**	41	34	24
Retail Store/Facility	**5**	2	2	1
Roadway	**7**	2	3	2
Wooded or Open Area	**12**	3	3	6
Location Total	**185**	**71**	**63**	**51**

Note: Three decedents are listed in separate investigations by two MCIOs. The total number of investigations evaluated for 185 decedents is 188.

Table 11 depicts other law enforcement involvement.

Table 11. Other Law Enforcement Involvement

Category	Total	USACIDC	NCIS	AFOSI
Level of Other Law Enforcement Agency Involved	**146**	**60**	**50**	**36**
Federal	**4**	2	1	1
State	**1**	0	1	0
Local	**141**	58	48	35
MCIO was the Lead	**42**	**13**	**14**	**15**
Joint investigation	**10**	1	2	7
MCIO exclusive investigation	**32**	12	12	8
Total Investigations	**188**	**73**	**64**	**51**

Table 12 depicts the modes of death investigated.

Table 12. Modes of Death Investigated

Category	Total	USACIDC	NCIS	AFOSI
Asphyxiation-chemical/gas[1]	**3**	1	1	1
Asphyxiation-environmental[2]	**4**	1	3	0
Asphyxiation-mechanical[3]	**44**	19	18	7
Blunt force	**7**	0	5	2
Drug and poison	**7**	2	2	3
Firearm	**121**	48	35	38
Sharp force	**1**	1	0	0
Self-immolation	**0**	0	0	0
Total	**187**	**72**	**64**	**51**

Note: The total number of deaths investigated was 185. In the deaths of two decedents, two modes of death were investigated. In one case, the investigation determined the decedent jumped from a high bridge into a river so both blunt force trauma and asphyxiation-environmental were examined. In the second case, the investigation determined the decedent cut and hung himself so both sharp force and asphyxiation-mechanical were examined.

[1] A chemical/gas asphyxiation death occurs when oxygen in the body is replaced by a chemical or gas. An example is death by carbon monoxide.

[2] An environmental asphyxiation death occurs when oxygen is replaced by something naturally present in the environment. An example is death by drowning.

[3] A mechanical asphyxiation death occurs when external pressure prevents breathing. An example is death by hanging.

We requested the MCIOs provide data identifying investigations in which the victim of the suicide was also either a subject or a victim in a preceding DoD law enforcement investigation. This data is arrayed in Tables 13 and 14. The data includes MCIO and other DoD criminal investigations and traffic offenses related to the decedents. We do not make inferences or conclusions regarding the decedent's suicidal motivations based upon these prior law enforcement contacts; this data is provided for possible DoD suicide prevention considerations and information only. The numbers in Tables 13 and 14 represent the numbers of offenses committed by or alleged to have been committed by subjects or against victims. In some instances, single investigations included multiple offenses committed by subjects or against victims.

Table 13 depicts other crimes, of which, the decedent of an investigation we evaluated was a subject, which were known of or investigated by military law enforcement. The following 118 offenses were committed or were suspected to have been committed by 56 of the decedents (27 Army, 13 Navy, 9 Air Force, and 7 Marine Corps). Additionally, two of the decedents (one Air Force and one Marine Corps) were listed in investigations that pertained to reports of suicidal ideations.

Table 13. Other Offenses with Decedent as a Subject

Category	Total	Army	Navy	Air Force	Marine Corps
Absent without leave	**7**	7	0	0	0
Aggravated assault	**7**	7	0	0	0
Alcohol/Drugs (including traffic related)	**27**	22	2	3	0
Arson	**1**	0	0	1	0
Assault	**3**	0	0	0	3
Assault/Neglect-child	**2**	0	1	1	0
Burglary/Unlawful entry	**2**	2	0	0	0
Destruction/Damaging property	**2**	1	0	1	0
Disorderly conduct	**1**	0	0	1	0
Failure to obey	**2**	2	0	0	0
False official statement	**2**	2	0	0	0
Family abuse	**7**	3	2	1	1
Fraud	**2**	2	0	0	0
Homicide/Manslaughter	**1**	0	0	1	0
Kidnapping	**1**	1	0	0	0

Table 13. Other Offenses with Decedent as a Subject (cont'd)

Category	Total	Army	Navy	Air Force	Marine Corps
Larceny	**10**	4	0	2	4
Resisting apprehension	**1**	1	0	0	0
Robbery	**1**	1	0	0	0
Sex crimes-adult*	**5**	4	0	1	0
Sex crimes-child*	**5**	2	1	1	1
Traffic offense	**29**	10	12	0	7
Total	**118**	**71**	**18**	**13**	**16**

* Sex crimes may include rape, sodomy, sexual assault, sexual abuse, sexual contact, child pornography, carnal knowledge, incest, and sexual harassment.

Table 14 depicts other crimes, of which, the decedent of an investigation we evaluated was a victim, which were known of or investigated by military law enforcement. The following 35 offenses were committed or were suspected to have been committed against 20 of the decedents (11 Army, 4 Navy, 2 Air Force, and 3 Marine Corps).

Table 14. Other Offenses with Decedent as a Victim

Category	Total	Army	Navy	Air Force	Marine Corps
Aggravated assault	**2**	2	0	0	0
Assault/Neglect-child	**1**	0	0	1	0
Burglary/Housebreaking	**2**	1	0	0	1
Cruelty of subordinates	**3**	3	0	0	0
Destruction/Damaging property	**1**	1	0	0	0
Family abuse	**4**	2	1	0	1
Larceny	**8**	3	2	0	3
Sex crimes-adult*	**7**	6	0	1	0
Sex crimes-child*	**2**	0	0	2	0
Traffic offense	**5**	4	1	0	0
Total	**35**	**22**	**4**	**4**	**5**

* Sex crimes may include rape, sodomy, sexual assault, sexual abuse, sexual contact, child pornography, carnal knowledge, incest, and sexual harassment.

Appendix C

Memorandum of Results

To: [redacted] Violent Crimes Division July 27, 2017

From: [redacted] QMD [redacted]

Through: [redacted], QMD [redacted]

Subject: Evaluation of Military Criminal Investigative Organization Death Investigations Which Concluded Suicide as the Manner of Death (Project No. D2016C010)

This memorandum documents the support that we provided for your evaluation. In it, we provide details of the methodology we employed in support of your objective. Also, we include the results we calculated based on the data you provided by executing this plan.

QUANTITATIVE PLAN

Objective: The objective is to determine whether MCIO death investigations which resulted in the manner of death as suicide were completed as required by guiding DoD, Military Service, and MCIO policies.

Population: The evaluation covers 347 investigations conducted by the three MCIOs [time period]. They break down as follows: Army CID, 151 cases, Navy NCIS, 117 cases, and Air Force OSI, 79 cases.

Measures: The project team assessed each sample case for compliance with administrative policy and investigative policy, as noted above.

Parameters: The evaluation team requested Quantitative Methods Division (QMD) provide statistical samples from each MCIO's case inventory. Per team direction, QMD developed each MCIO's sample size using a 90 percent confidence level and seven percent precision[1]. The sample sizes are as follows:

Table 1

Number of Cases and Number of Sample Cases

MCIO	All Cases	Sample Cases
AFOSI	79	51
CID	151	73
NCIS	117	64
Total	347	188

[1] QMD used an assumed occurrence rate of 50 percent which is the mathematically most conservative assumption; precision calculated from sample results may be tighter than seven percent.

Memorandum of Results (cont'd)

RESULTS AND INTERPRETATION

CID Results

Based on the sample results we have calculated four estimates: number of cases with no Defects, number of cases with administrative Defects, number of cases with investigative Defects, and number of cases with both administrative and investigative Defects. The results are as follows:[2]

Table 2
Number of Cases with No Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	87.9	94.5	98.1
Number	133	143	148

Table 3
Number of Cases with Administrative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	1.0	3.8	9.5
Number	2	6	14

Table 4
Number of Cases with Investigative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	1.0	3.8	9.5
Number	2	6	14

Table 5
Number of Cases with Investigative and Administrative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	0.1	1.3	5.9
Number	0	2	9

The results are interpreted as follows, for the cases with no defects – we estimate with 90 percent confidence that there are between 133 and 148 of the 151 cases that have no defects and that our best single estimate is that there are 143 cases with no defects.

[2] All four CID estimates are based the exact binomial calculation (using Stata 14). Percent estimates five percent and under as well as 95 percent and under have unequal upper and lower bounds, not the equal, symmetric ones seen for most percent estimates.

Memorandum of Results (cont'd)

AFOSI Results

Based on the sample results we have calculated four estimates: number of cases with no Defects, number of cases with administrative Defects, number of cases with investigative Defects, and number of cases with both administrative and investigative Defects. The results are as follows:

Table 6
Number of Cases with No Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	35.3	43.1	51.0
Number	28	34	40

Table 7
Number of Cases with Administrative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	20.3	27.5	34.6
Number	16	22	27

Table 8
Number of Cases with Investigative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	43.1	51.0	58.9
Number	34	40	47

Table 9
Number of Cases with Investigative and Administrative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	14.9	21.6	28.2
Number	12	17	22

The results are interpreted as follows, for the AFOSI cases with no defects – we estimate with 90 percent confidence that there are between 28 and 40 of the 79 cases that have no defects and that our best single estimate is that there are 34 cases with no defects.

NCIS Results

Based on the sample results we have calculated four estimates: number of cases with no Defects, number of cases with administrative Defects, number of cases with

Memorandum of Results (cont'd)

investigative Defects, and number of cases with both administrative and investigative Defects. The results are as follows[3]:

Table 10
Number of Cases with No Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	58.2	65.6	73.0
Number	68	77	85

Table 11
Number of Cases with Administrative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	25.5	32.8	40.1
Number	30	38	47

Table 12
Number of Cases with Investigative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	.6	3.1	9.5
Number	1	4	11

Table 13
Number of Cases with Investigative and Administrative Defects

	Lower Bound	Point Estimate	Upper Bound
Percent	0.1	1.6	7.2
Number	0	2	8

The results are interpreted as follows, for the NCIS cases with no defects – we estimate with 90 percent confidence that there are between 68 and 85 of the 151 cases that have no defects and that our best single estimate is that there are 77 cases with no defects.

Documentation, Presentation, and Defense of Results

This memorandum constitutes QMD's documentation of our quantitative support for your working papers. As needed, we will respond to questions or challenges concerning the quantitative plan, analysis or results.

[3] All the NCIS estimates for cases investigative defects and those with both defects (Tables 12 and 13) are based the exact binomial calculation (using Stata 14). Percent estimates five percent and under as well as 95 percent and under have unequal upper and lower bounds, not the equal, symmetric ones seen for most percent estimates.

Appendix D

Table Listing

Management Comments

Naval Criminal Investigative Service

DEPARTMENT OF THE NAVY
HEADQUARTERS
NAVAL CRIMINAL INVESTIGATIVE SERVICE
27130 TELEGRAPH ROAD
QUANTICO VA 22134-2253

July 17, 2017

MEMORANDUM FOR IG, DoD, ATTN: Assistant IG Investigative Policy and Oversight

FROM: [redacted] Executive Assistant Director, Criminal Investigations Directorate

SUBJECT: NCIS Response to Report No. DODIG-2017-TBD, *Evaluation of Military Criminal Investigative Organizations' Closed Death Investigations Concluding in Suicide as the Manner of Death*

1. This memorandum is the Naval Criminal Investigative Service (NCIS) response to the recommendation contained in draft report number DODIG-2017-TBD, pertaining to the *Evaluation of Military Criminal Investigative Organizations' Closed Death Investigations Concluding in Suicide as the Manner of Death.* The report requested NCIS management comment on one recommendation.

2. Recommendation to Director, NCIS, "…implement measures to improve compliance with the death certificate collection requirement."

   NCIS Response: Concur, with comment.

   As indicated in the aforementioned report, 20 NCIS investigative files of the 64 files reviewed did not contain death certificates. In all cases wherein a death certificate was not contained in the case file, "the death was investigated solely or primarily by law enforcement agencies other than NCIS". The requirement to include death certificates in all death investigations is an internal NCIS policy, not derived from higher level policy. Understanding it is not possible to obtain death certificates during the course of every investigation, specifically those in which NCIS is not the lead; a policy change will be made requiring death certificates be obtained only when NCIS is the lead investigative agency.

3. NCIS appreciates the opportunity to provide comment on draft report number DODIG-2017-TBD. Please contact me or Special Agent [redacted] Criminal Investigations and Operations, Deputy Assistant Director (Acting), at [redacted] with any questions regarding this memorandum.

[redacted]
Executive Assistant Director
NCIS Criminal Investigations Directorate

Acronyms and Abbreviations

AFOSI	Air Force Office of Special Investigations
DoDSER	Department of Defense Suicide Event Report
IG	Inspector General
MCIO	Military Criminal Investigative Organization
NCIS	Naval Criminal Investigative Service
OIG	Office of Inspector General
USACIDC	U.S. Army Criminal Investigation Command

Whistleblower Protection
U.S. Department of Defense

The Whistleblower Protection Ombudsman's role is to educate agency employees about prohibitions on retaliation and employees' rights and remedies available for reprisal. The DoD Hotline Director is the designated ombudsman. For more information, please visit the Whistleblower webpage at www.dodig.mil/programs/whistleblower.

For more information about DoD OIG reports or activities, please contact us:

Congressional Liaison
congressional@dodig.mil; 703.604.8324

Media Contact
public.affairs@dodig.mil; 703.604.8324

For Report Notifications
www.dodig.mil/pubs/email_update.cfm

Twitter
www.twitter.com/DoD_IG

DoD Hotline
www.dodig.mil/hotline

DEPARTMENT OF DEFENSE | OFFICE OF INSPECTOR GENERAL

4800 Mark Center Drive
Alexandria, Virginia 22350-1500
www.dodig.mil
Defense Hotline 1.800.424.9098