United States General Accounting Office

GAO

Report to the Honorable
Vic Fazio, House of Representatives

August 1992

MARINE CORPS TRAINING

Circumstances Surrounding the Death of a Marine and Resulting Actions

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National Security and
International Affairs Division

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August 4, 1992

The Honorable Vic Fazio
House of Representatives

Dear Mr. Fazio:

In response to your request, we reviewed the death of Lance Corporal (LCPL) Matthew W. Fitch, U.S. Marine Corps. You provided us with a letter dated July 25, 1991, from the Department of the Navy to Representative Les Aspin stating that LCPL Fitch's death was an accident resulting from a culmination of failures at all levels of command to follow established procedures. The letter also stated that

> . . . those Marines involved in the circumstances surrounding Lance Corporal Fitch's death have been held accountable for their actions. Moreover, safety procedures have been examined closely to preclude recurrence of this type of tragedy.

This report provides information on the events leading up to LCPL Fitch's death, the subsequent investigations, and actions taken by the Marine Corps as a result of this incident. The names of the Marines involved are protected by the Privacy Act, and we refer to them only by their positions.

Results in Brief

LCPL Fitch drowned while engaging in a training exercise in Panama on October 18, 1989. A Judge Advocate General Manual (JAGMAN) investigative report, as modified by higher level review officials, recommended that disciplinary actions be taken against four Marines for their involvement in Fitch's death. While the first lieutenant in charge of Fitch's detail received an adverse fitness report and was transferred, none of these Marines were charged with an offense or received any disciplinary action as recommended by the JAGMAN investigation and implied by the letter to Representative Aspin. The Marine Corps Ground Safety Office reviewed the case files and determined that no specific recommendations for safety improvements were warranted.

Background

On October 17, 1989, First Lieutenant (name deleted), executive officer of B Company, 2nd Light Armored Infantry Battalion (2nd LAI Bn), placed a passenger van in the TA-55 Training Area of the Empire Range Complex in the Gamboa section of Panama to serve as a live fire target vehicle. The target vehicle was intended for use in a patrol training exercise scheduled

for the next day, October 18, 1989. The exercise was to involve crossing the nearby Mandingo River and firing on the target vehicle.

On the morning of October 18, the B Company Commander canceled the patrol training exercise scheduled for that day because he believed that proper preparations had not been made. One of the reasons he cited for the cancellation was that a leader's reconnaissance[1] had not been conducted. The exercise was rescheduled for October 21, 1989.

Circumstances Surrounding the Death

On the same morning the training exercise was canceled, the U.S. Army Garrison Range Control Office and the Marine Forces Panama S-3 Office directed that the target vehicle placed in the TA-55 Training Area on October 17 be removed. A seven-man detail from Headquarters Platoon, B Company, 2nd LAI Bn, departed Rodman Naval Base between 12:30 and 1:30 p.m. on October 18 in a light armored vehicle to remove the target vehicle. LCPL Fitch was a member of the detail. The senior member of the detail was the first lieutenant serving as executive officer of B Company. All seven members of the detail were aware that three members of the detail would conduct a leader's reconnaissance at the river crossing to properly prepare for the rescheduled patrol training exercise.

The first lieutenant and his detail went to the French Cut sector (also known as the Cocoli sector) of the Panama Canal Operating Area to find a site where they could later sink and dispose of the target vehicle they intended to remove from the TA-55 Training Area. The first lieutenant entered the water at the French Cut to determine if it was deep enough to conceal the target vehicle. He then authorized the members of his detail to take turns jumping and diving off the 35- to 40-foot high embankment above the waters of the French Cut. According to the first lieutenant's later statements to Marine Corps investigating officers, he believed this to be a safe exercise that would serve "to reinforce the in-water confidence of good swimmers."

After this, the detail proceeded to the site of the target vehicle that was to be removed from the training area. As preparations were being made to remove the vehicle, the detail split into two groups: one four-man group to remove the vehicle and one three-man group to conduct the leader's reconnaissance. The leader's reconnaissance group was led by a corporal

[1]Unit leaders are expected to conduct a reconnaissance prior to a training or combat mission in order to become familiar with the area and to check plans and routes.

and included another lance corporal in addition to LCPL Fitch. The group departed the target vehicle site at approximately 2:50 p.m. on foot and proceeded to the French Bridge, which crosses the Mandingo River. After some maneuvering, the group returned to the French Bridge. The corporal then told the lance corporals that he was going to swim across the river to the west bank in order to see if it could be done using the French Bridge as cover and concealment. After some discussion, it was decided that all three Marines would swim the river.

The corporal led the attempted swim across the river, with Fitch going next, followed by the other lance corporal. At the point the group entered the river, it was about 246 feet wide and about 25 feet deep, with only a slight current. The three Marines were wearing their uniforms, combat boots, field gear, weapons, and fully loaded ammunition pouches. None of them had standard inflatable life vests.

About one-half to two-thirds of the way across the Mandingo River, LCPL Fitch began having trouble remaining afloat. The other lance corporal attempted to assist Fitch while simultaneously calling out for help to the corporal, who was almost at the west bank of the river and was exhausted as a result of his swim. The other lance corporal became exhausted from his struggle to assist Fitch, ceased his effort to assist him, and continued his swim to the west bank of the river. He later stated that he had thought he might drown in the river due to his own exhaustion.

The corporal proceeded to the middle of the French Bridge and, after unsuccessful attempts to locate Fitch in the water, called out for help. The first lieutenant and his group responded to the calls for help at about 3:05 p.m. and proceeded to the middle of the French Bridge; however, they were also unable to find LCPL Fitch.

At about 5:30 p.m., almost 2 hours after the attempted swim across the Mandingo River, LCPL Fitch's body was found submerged in the immediate vicinity of the attempted swim site by a search detail consisting of U.S. Navy personnel from Special Warfare Unit 8. The cause of death was cited as fresh water drowning.

The first lieutenant in charge of the detail was subsequently given an adverse fitness report and transferred to the Marine Corps Recruit Depot at Parris Island, South Carolina. Three other Marines connected with the incident—the captain who was Fitch's company commander, the second lieutenant who was Fitch's platoon commander, and the corporal in charge

of the three-man leader's reconnaissance—returned with the 2nd LAI Bn to Camp Lejeune, North Carolina, the home base of the 2nd Marine Division.

Investigations of LCPL Fitch's Death

A JAGMAN investigation was conducted shortly after the death of LCPL Fitch by an officer appointed by the Commander, Marine Forces Panama. The investigative report, however, was disapproved on endorsement by the Commanding General of the 6th Marine Expeditionary Brigade (6th MEB), who cited inconsistencies and additional questions that needed to be resolved. The Commanding General of the 6th MEB then appointed a new investigating officer, who conducted his investigation after Fitch's unit, the 2nd LAI Bn, had returned to Camp Lejeune. Witnesses' statements from the first JAGMAN investigation were retained and turned over to the second investigating officer. We were told that no other record of a first investigation is usually retained in cases where a commander directs a second investigation.

The second JAGMAN investigation was convened on December 28, 1989, 71 days after LCPL Fitch's death. The investigative report is dated January 29, 1990. The report was reviewed and endorsed by three echelons—the Commanding General of the 6th MEB; the Commanding General of the Fleet Marine Force, Atlantic; and the Commandant of the Marine Corps.

The first recommendation of this investigative report read as follows:

> That First Lieutenant [name deleted] be the subject of an Article 32 Investigation that inquires into the allegation that he was derelict in the performance of his duties as the senior officer of the seven man detail that departed Rodman Naval Base on the afternoon of 18 October 1989; the basis of such dereliction being that Lieutenant [name deleted] negligently failed to inquire of Corporal [name deleted] what the intentions were of the three man leader's reconnaissance.

The Commanding General of the 6th MEB forwarded the investigative report to the Commanding General of the Parris Island Recruit Depot for action regarding this recommendation.

The second recommendation read as follows:

> That Captain [name deleted] be the subject of administrative or disciplinary action, the basis of which being: his failure, as a unit commander, to be reasonably aware of the operational activities taking place within his command; his failure, as a unit commander, to be aware of the significant decisions being made by the subordinate leaders within his command; and his failure, as a unit commander, to inquire of his subordinate leaders if

proper supervision was being provided to the corporal who had advised him of a pending leader's reconnaissance.

The Commanding General of the 6th MEB modified this recommendation by deleting the words "administrative or" from the first sentence of the recommendation.

The investigative report basically exonerated the second lieutenant and the corporal and included recommendations that neither of them be charged. The Commanding General of the 6th MEB did not agree with these recommendations and revised them to recommend that the second lieutenant and corporal be the subject of disciplinary action. He forwarded a copy of the investigative report for action to the Commanding General of the 2nd Marine Division at Camp Lejeune.

In endorsing the investigative report, the Commandant of the Marine Corps requested the Commanding General of the Recruit Depot at Parris Island to advise him of what action had or would be taken concerning the first recommendation. He also requested the Commanding General of the 2nd Marine Division at Camp Lejeune to advise him of what action had or would be taken concerning the other recommendations, as modified by the Commanding General of the 6th MEB.

No Disciplinary Actions Taken

After reviewing the case of the first lieutenant, the Staff Judge Advocate's (SJA) office at Parris Island decided not to take any disciplinary action against him. The depot SJA told us the SJA staff had examined the investigative file and had concluded there was no basis on which to pursue charges of dereliction of duty against the first lieutenant in connection with LCPL Fitch's death. The SJA and his staff concluded that any possible dereliction of duty charges would have to be confined to the first lieutenant's failure to (1) obtain permission to enter the area where the death occurred and (2) ensure that his detail was capable of radio contact with Marine Forces Panama Headquarters. The SJA officials concluded that these factors were not directly related to LCPL Fitch's death and were not serious offenses. Rather, they believed these incidents exhibited bad judgment, which is usually remedied by administrative action rather than a court-martial.

Officials in the chain of command at the depot agreed with the SJA's assessment and declined to take further action against the first lieutenant. The depot never advised the Commandant of the Marine Corps in writing of the disposition of this case. Notification was reportedly done by phone,

which we were told is a common practice in the Marine Corps. Marine Corps Headquarters officials we interviewed in the fall of 1991, however, had no idea why the depot had not followed the recommendation of the investigating officer and endorsers to initiate disciplinary action against the first lieutenant.

Similarly, no actions were taken by the 2nd Marine Division against the three Marines who returned to Camp Lejeune. The SJA of the 2nd Marine Division briefed the commanding officer of the 2nd LAI Bn about his options in responding to the recommendations for adverse actions against the three Marines. The SJA told us he did not make any specific recommendations to the commander of the 2nd LAI Bn, but he did offer him the opinion that if any criminal culpability existed in the Fitch case, it would attach to the first lieutenant involved. He believed that the captain, the second lieutenant, and the corporal were only peripherally involved in the events surrounding Fitch's drowning. Lacking any direction from the 2nd Marine Division to do so, the commander of the 2nd LAI Bn did not take disciplinary action against any of the three Marines.

Safety Review of the Fitch Case

The Marine Corps Ground Safety Office reviewed the Fitch investigative files and determined that no specific recommendations were warranted. Marine Corps officials we spoke with said that safety policies and procedures were in place when the Fitch drowning occurred, but they were not followed. For example, in a briefing before the training exercise, a river crossing was put forth as a potential part of the exercise, and safety precautions, such as using a long rope and inflatable life vests, were discussed. However, as noted earlier, such safety devices were not used by the group that attempted the river crossing.

The Safety Office routed the investigation to the Marine Corps Medical Officer and the Marine Corps Combat Development Command (the Marine Corps' training command) for comment. In response, the Medical Officer elaborated on the protocols used in the initiation and cessation of cardiopulmonary resuscitation to a drowning patient. The training command saw no need for specific actions but commented that failure to adhere to established safety training restrictions and the lack of proper supervision during training exercises can lead to preventable and unfortunate tragedies.

As a result of the Fitch incident and other mishaps resulting in fatalities, the Commandant of the Marine Corps, in August 1990, sent a message to all Marine commands stating the following:

I have told all of you before that all Marines, two echelons up and two echelons down must thoroughly understand the mission, scheme of maneuver, safety restrictions, and overall conduct of the exercise, operation or activity. You are never off duty when safety is involved and I expect everyone to understand that whenever two or more Marines gather—one is in charge.

Scope and Methodology

To obtain information on the events leading to LCPL Fitch's death, we reviewed available documentation and correspondence, in particular, the JAGMAN report dated January 29, 1990. We also interviewed officials at Marine Corps Headquarters, Arlington, Virginia; the Marine Corps Recruit Depot, Parris Island, South Carolina; the Fleet Marine Force, Atlantic, Norfolk, Virginia; and the 2nd Marine Division, 6th MEB, and 2nd LAI Bn, Camp Lejeune, North Carolina.

To determine what actions the Marine Corps took in response to the recommendations of the JAGMAN investigating officer, we examined the personnel records of the personnel involved and interviewed officials in the office of the Judge Advocate General of the Marine Corps, the Marine Corps Recruit Depot at Parris Island, and the 2nd Marine Division at Camp Lejeune. We also interviewed officials and reviewed documents at the Marine Corps Ground Safety Office in Arlington, Virginia.

We conducted our review from August 1991 to May 1992 in accordance with generally accepted government auditing standards. We did not independently assess the actions of the Marines involved or go beyond the investigations and other administrative actions that took place. As agreed, we did not obtain official agency comments. However, we discussed the results of our work with Marine Corps officials and have incorporated their comments where appropriate.

Unless you announce its contents earlier, we plan no further distribution of this report until 15 days from its issue date. At that time, we will send copies to the Secretary of Defense and the Commandant of the Marine Corps. Copies will be made available to others on request.

Please contact me on (202) 275-3990 if you or your staff have any questions. The major contributors to this report were William E. Beusse, Assistant Director, and James H. Woods, Evaluator-in-Charge.

Sincerely yours,

Paul L. Jones
Director, Defense Force Management Issues

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