



DEPARTMENT OF THE NAVY
CHIEF OF NAVAL OPERATIONS
2000 NAVY PENTAGON
WASHINGTON DC 20350-2000

5830
N00
7 Jul 20

From: Chief of Naval Operations
To: Secretary of the Navy

Subj: INVESTIGATION INTO FATAL SHOOTING INCIDENT ON PEARL HARBOR
NAVAL SHIPYARD OF 4 DECEMBER 2019

Encl: (1) Vice Chief of Naval Operations, ltr of 28 May 20

1. I concur with enclosure (1) as written and as endorsed by the Vice Chief of Naval Operations.

2. My point of contact for this matter is CAPT (b) (6) JAGC, USN, who may be reached at (b) (6) or e-mail: (b) (6) @navy.mil.


M. M. GILDAY



DEPARTMENT OF THE NAVY
VICE CHIEF OF NAVAL OPERATIONS
2000 NAVY PENTAGON
WASHINGTON DC 20350-2000

5830
Ser N09D/20U100831
28 May 20

FINAL ENDORSEMENT on RADM Scott Jones, USN ltr of 12 Mar 20
RADM John Meier, USN ltr of 21 Feb 20

From: Vice Chief of Naval Operations
To: File

Subj: INVESTIGATIONS INTO FATAL SHOOTING INCIDENTS ON PEARL HARBOR
NAVAL SHIPYARD OF 4 DECEMBER 2019 AND NAVAL AIR STATION
PENSACOLA OF 6 DECEMBER 2019

Encl: (1) RADM Scott Jones, USN, ltr of 12 Mar 20
(2) RADM John Meier, USN, ltr of 21 Feb 20
(3) Investigation side-by-side of 21 May 20

1. I have reviewed enclosure (1) and approve the findings of fact, opinions and recommendations of the investigating officer as modified by the first endorser, with the following additional modifications:

Recommendation 4.1.1: delete "OPNAVINST 5510.13C" and replace with "OPNAVINST 5530.13C."

2. I have reviewed enclosure (2) and approve the findings of fact, opinions and recommendations of the investigating officer as modified by the first endorser, with the following additional modifications:

Paragraph 4 on page 216 of the Report will be redacted in its entirety.

3. The number of recommendations provided in enclosure (3) and the expansive effort necessary to ensure full-implementation of each demand a whole of Navy approach.

4. Therefore, I direct the Office of the Chief of Naval Operations (OPNAV) Staff Security Coordination Board (SCB) to serve as the Echelon-I lead for reviewing and implementing these recommendations. No earlier than 1 July, the SCB will provide the following for discussion at a Navy Corporate Forum (NCF) or other similar leadership forum chaired by the Vice Chief of Naval Operations:

- a. A working group charter, detailing responsible organizations and participants.
- b. A plan of action and milestones, including a recommended battle rhythm.

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5. This effort shall also include a review of the Washington Navy Yard shooting investigation to assess the status of each recommendation and determine which are complete, which are no longer applicable, and which should be added into enclosure (3).

6. The safety and livelihood of our Sailors is dependent on this effort. My expectation is recommendations are enacted within a year. Please direct any questions or concerns to CAPT

(b) (6) IAGC, who may be reached at (b) (6) or email:
(b) (6) @navy.mil.


R. P. BURKE

Copy to:

COMUSFLTFORCOM NORFOLK VA
COMPACFLT PEARL HARBOR HI
BUMED FALLS CHURCH VA
OGC WASHINGTON DC
NAVY JAG WASHINGTON DC
NETC PENSACOLA FL
CNIC WASHINGTON DC
COMNAVSEASYS COM WASHINGTON DC
COMNAVSAFECEN NORFOLK VA
CHNAVPER WASHINGTON DC
DIRNAVCRIMINVSERV QUANTICO VA



DEPARTMENT OF THE NAVY
COMMANDER
UNITED STATES PACIFIC FLEET
250 MAKALAPA DRIVE
PEARL HARBOR HI 96860-3131

IN REPLY REFER TO:

5830

Ser N00/0545

24 Apr 20

FIRST ENDORSEMENT on RADM Scott Jones ltr of 12 Mar 20

From: Commander, U.S. Pacific Fleet
To: Vice Chief of Naval Operations

Subj: INVESTIGATION INTO THE FATAL SHOOTING INCIDENT ON PEARL HARBOR
NAVAL SHIPYARD ON 4 DECEMBER 2019

Ref: (a) VCNO ltr 5800 Ser N09/1U100565 of 19 Dec 19

1. Forwarded, approving the findings of fact, opinions, and recommendations of the investigating officer, as modified below.
2. The Naval Criminal Investigative Service's (NCIS) criminal investigation is still ongoing. As of the date of this endorsement, I do not anticipate findings in the criminal investigation that are inconsistent with the findings in the command investigation. However, should the NCIS investigation develop new or unforeseen information that is relevant to this command investigation, I will direct an additional fact-finding inquiry to ensure those insights are appropriately considered and captured. This investigation was specifically focused on noncompliance and deficiencies with applicable programs, policies, and procedures that could be considered factors related to the event, specifically: Machinist Mate Auxiliary Fireman Gabriel A. Romero's (hereinafter Romero) background; the command climate onboard USS COLUMBIA; force protection and emergency response management; insider threat and active shooter training, drills, lockdown, and emergency notifications; post-incident response; significant impacts to Pearl Harbor Naval Shipyard personnel and their workplace safety concerns; and armed watchstander qualifications and fitness to stand armed watch.
3. I concur with the report's primary theme which drove the associated recommendations across the chapters: Romero was solely responsible for this incident. After reviewing this investigation, I reached the conclusion that even if all of Romero's mental health, personal issues, and grievances had been known and taken into consideration, no one could have reasonably predicted that he would engage in this ultimate act of murder and suicide. This lack of predictability in mass shooting incidents, despite information that often does emerge after the fact as "warning signs," has confounded experts across the globe.
4. That being said, it is not enough to stop at that assessment. One of the primary objectives of this investigation was to identify actions that could be taken to reduce the risk associated with any Sailor's mounting mental health and personal stressors, and identify measures that can be taken to lessen the probability that tragedies like this one will reoccur. Within this investigation, I considered certain factors for their potential impact in the chain of events leading up to the

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procedures. I identified the following primary themes in the report that focus on potential contributing factors:

- The investigation did not establish any motive for the shooting and there is no perfect formula that could have predicted these events. However, compliance with arms, ammunition, and explosives (AA&E) rescreening standards should have identified risk factors to prompt a rescreening of Romero to be an armed watchstander.
- The Submarine Force Embedded Mental Health Program (eMHP) is valuable in providing mental health support to Sailors and assisting in the readiness of the submarine force. However, I am concerned that the Submarine eMHP Clinic failed to strike the balance between supporting the submarine community readiness and providing necessary mental health resources to submarine Sailors, to include diagnosing Sailors when necessary so they can receive further treatment.
- The Submarine Force eMHP program in this case also fell short in its objective of ensuring the resilience and well-being of Sailors by placing undue emphasis on patient confidentiality. It failed to strike an appropriate balance to consider the chain of command's inputs to better evaluate the context of the Sailor's mental health challenges and to recognize the chain of command's responsibility in ensuring that high-risk Sailors are identified and provided support, particularly where the Sailor may have access to weapons.
- As a result of active shooter incidents across the DoD, there has been greater emphasis on developing more robust insider threat programs and training. However, I still have concerns with increased information sharing and incorporating prevention principles and human factor assessments into programs, policies, and procedures.
- The failure to identify Romero as an insider threat led to doubts about the necessity of armed watchstander requirements in low force protection posture environments and where layered security already exists. The importance of protecting our critical national defense assets must not be understated. However, I am also acutely aware of how this tragedy shook the sense of safety and security of our Navy community, especially our valued shipyard workforce. We must work to restore confidence in the Navy's ability to protect its most valuable assets – its people – from threats, both external and insider. I determined that this warrants a broader, common-sense look, not only at how we screen armed watchstanders, but when we require their presence in various force protection environments.

4. **Chapters 1 and 2 (Introduction and Sequence of Events).** I concur with Chapters 1 and 2 as written.

5. **Chapter 3 (Embedded Mental Health).** I concur with the findings, opinions, and recommendations of Chapter 3 as modified below, and specifically highlight the following:

- **Finding 3.1.** The eMHP provider under-diagnosed and did not properly manage Romero's mental health condition and failed to provide an adequate level of care. Romero was first seen by a mental health professional at the Tripler Army Medical Center Emergency Room in March 2019, and received a referral to eMHP. However, Romero was not seen again by a mental health professional until September 2019. With eight visits to eMHP between then and December 2019, only one was with a licensed provider. The remaining visits were with the behavioral health technician, an unlicensed Enlisted Sailor. Manning shortages at eMHP

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contributed to the lack of proper oversight over an unlicensed technician providing mental health care to submarine Sailors.

In addition to the lack of oversight, eMHP relies heavily on diagnostic descriptors, arguably to allow for the execution of the “Resiliency Approach” by providing coping skills while also reducing unplanned losses in the submarine community. However, this approach also raises concerns about situations where a Sailor should be referred for mental health treatment. While manning and readiness is a consideration for the submarine community, these should not be primary factors when evaluating a Sailor for a mental health diagnosis which may require treatment. Although the mental health professionals in Romero’s care seem to have had the best of intentions, this incident highlights shortfalls in the Submarine Forces Pacific (SUBPAC) eMHP program’s ability to support both the submarine force and the individuals under its care.

- **Recommendation 3.1.1.** I recommend that VCNO direct the Command Surgeon, U.S. Fleet Forces Command, as the Privileging Authority, in coordination with Commander, Submarine Forces (COMSUBFOR), to conduct a quality assurance investigation into the clinical practice of the Force Psychologist with particular attention to any pattern of under-diagnosis and the behavioral health technician’s scope of practice without direct supervision.
- **Recommendation 3.1.2.** I recommend that VCNO direct the Department of the Navy’s Bureau of Medicine and Surgery (BUMED), in coordination with Type Commanders, to conduct a comprehensive review of the eMHP to determine whether there is a broader pattern of under-diagnosis and to clarify the proper role and scope of practice of behavior health technicians. The review should include manning, patient-provider ratios, facilities, and reporting tripwires to commands.
- **Recommendation 3.1.3.** I recommend that VCNO direct BUMED, in coordination with COMSUBFOR, evaluate MANMED policy regarding Disqualifying Mental Health Conditions for Submarine Duty.
- **Recommendation 3.1.4.** I direct COMSUBPAC to install outpatient electronic record terminals in eMHP clinics and request official clinic designation from Tripler Army Medical Center in order to receive electronic referrals. Report completion of this task no later than 30 November 2020, with interim progress reports in 30-day intervals until complete.
- **ADD Recommendation 3.1.5.** I recommend VCNO direct COMUSFLTFORCOM, in coordination with BUMED, to implement a process for the effective sharing records and transmitting referrals between military treatment facilities and eMHP clinics.
- **Finding 3.2.** The absence of a unifying plan among the chain of command, patient, and provider was contrary to the COMSUBFOR and COMSUBPAC Instruction 6490.1 (Submarine Force eMHP). The Commanding Officer must understand the warfighting readiness of his unit and crew. The Medical Department Representative (MDR) for USS COLUMBIA, who is both responsible for the submarine’s medical program and Romero’s primary care provider, was completely unaware of Romero’s eMHP Clinic visits prior to the shooting. This lack of communication was a barrier to intrusive leadership and creates a serious vulnerability in military readiness which is unacceptable. The stovepipe approach to treatment limited the coordination and information-sharing that is a vital cornerstone of the Submarine Force eMHP’s Resiliency Approach. The servicemember’s right to confidentiality must be balanced against evaluating what information is necessary to relay to the chain of

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command. This not only ensures our Sailors are receiving the best care, but also garners crucial support from the chain of command necessary for a successful resiliency approach. The overly-conservative stance on patient confidentiality served neither the patient nor the command well in this situation.

- **Recommendation 3.2.1.** I recommend that VCNO direct COMUSFLTFORCOM to require COMSUBFOR, in coordination with BUMED, to align Submarine Forces eMHP practice to present a unified plan among the chain of command, patient, and provider in accordance with the existing instruction. Use informed consent (waiver of confidentiality) with patients to improve care, and as necessary, disclose information through existing exceptions to DoD policy on confidentiality.
- **Recommendation 3.2.2.** I recommend that VCNO direct BUMED Psychological Health Advisory Board to issue guidance to mental health providers concerning the proper use of informed consent outside of enumerated exceptions in DoDI 6490.08 to improve care, ensure that high-risk personnel are identified and appropriately monitored, and improve the relationship between commander and provider. I further recommend that DoDI 6490.08 be amended to expressly address informed consent to improve patient care.
- **Recommendation 3.2.3.** I recommend that VCNO direct BUMED, in coordination with Type Commanders, include manning levels in a comprehensive review of eMHP.

6. **Chapter 4 (Arms, Ammunition & Explosives Program (AA&E)).** I concur with the findings, opinions, and recommendations in Chapter 4 as modified below.

- **Finding 4.1.** USS COLUMBIA did not comply with OPNAVINST 5510.13C (Physical Security for Conventional AA&E). (b) (5)

Romero was rescreened as a watchstander in September 2019. USS COLUMBIA failed to abide by the principle that commands “must be selective in assigning personnel to duties involving control of or unescorted access to AA&E.” Despite numerous factors indicating potential unsuitability and mounting evidence that Romero was decidedly not “mature, stable, and have shown a willingness and capability to perform assigned tasks dependably,” the command did not rescreen as required in the instruction.

I recognize that following Romero’s failed attempts to earn his submarine qualifications, the only watches he was qualified to stand were non-technical armed watches. However, armed watch should not be treated as a menial task for deficient performers. The policy to rescreen a servicemember “when circumstances indicate” is a part of the AA&E program cannot be overlooked.

- **Recommendation 4.1.1.** I recommend that VCNO direct OPNAV N4 to consider a revision to OPNAVINST 5510.13C to incorporate prevention principles, human factor assessments, and tripwires for rescreening, to include tripwires involving mental health treatment when present with other factors such as continuing poor performance, disciplinary actions, or personal (family or relationship) issues.
- **Recommendation 4.1.2.** I direct COMSUBPAC to ensure that commands under its cognizance comply with record retention requirements for OPNAV Form 5530/1. Report completion of this task no later than 15 May 2020.
- **ADD Recommendation 4.1.3.** I direct COMSUBPAC to conduct further investigation into the USS COLUMBIA’s armed watchstanding screening process to determine

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responsibility for noncompliance and accountability actions as appropriate. Report completion and results no later than 30 June 2020.

- **ADD Recommendation 4.1.4.** I further direct COMSUBPAC to ensure that weapons officers receive formal training on AA&E policy and procedures before assuming responsibility for implementing small arms programs. Report completion no later than 15 May 2020 for units in port. For units currently deployed, provide an estimated date of completion and interim reports at 30-day intervals until all training is complete.
- **Finding 4.2.** Romero assumed security duties as the Topside Roving Patrol without getting the required security brief. The security and safety brief consists of face-to-face interactions with duty section leadership, as well as an alcohol screening and pass-down for the day. The missed briefs not only demonstrated a lack of procedural compliance, but presented a missed opportunity for duty section leadership to assess Romero's demeanor and fitness for duty immediately prior to issuing him a firearm.
 - **Recommendation 4.2.1.** I direct COMSUBPAC to ensure duty section procedures require armed watchstanders complete safety and security briefs before assuming the watch. Report completion no later than 15 May 2020.
 - **Recommendation 4.2.2.** I direct Commanders, U.S. SEVENTH Fleet and U.S. THIRD Fleet to require all units under their OPCON to ensure that duty section procedures include a requirement that armed watchstanders complete safety and security briefs before assuming the watch. Report completion no later than 15 May 2020.

7. **Chapter 5 (USS COLUMBIA Command Climate).** I concur with the findings, opinions, and recommendations for Chapter 5 as modified below.

- **Finding 5.1.** The command climate on board USS COLUMBIA in 2019 was low despite some recent indications of improvement. Of note, in the command's Defense Organizational Climate Survey (DEOCS) in 2019, over 35% of survey participants knew of someone who had thought of suicide. More specifically, one participant provided an anonymous comment regarding job-related stress that should have raised significant alarm bells, stating that "I pray that on the driver [sic] I get in a car accident and die" and that "Often times I considering [sic] putting my pistol in my mouth and ending it all or just throwing myself into the dry dock basin." Despite this red flag raised in the DEOCS, the chain of command did not take proactive measures to address it. The command attempted to identify the source of the anonymous comment from among its list of identified high-risk Sailors, but then gave up. The comment was never linked to Romero, and the source of the comment has not been identified since. The Command Resiliency Team (CRT) played down the comment as that of a single Sailor and not reflective of a widespread crew issue. The XO opted not to conduct suicide prevention training, rationalizing that such training had just been completed the month prior to the survey.

The actions of USS COLUMBIA leadership were not intrusive or proactive. The leadership did not engage the chain of command to ensure the safety of the entire crew in light of that troubling comment. Leadership cannot assume a cavalier or complacent attitude toward anonymous complaints and assume they are not valid simply because the unit is in a challenging shipyard environment. The exercise of intrusive leadership, using all of its leadership tools, to include the CRT and eMHP, could have been more effective in assessing its Sailors' challenges.

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- **Recommendation 5.1.1.** I direct COMSUBPAC to evaluate the command climate of USS COLUMBIA and the effectiveness of the command triad, as well as CSS-7 oversight of subordinate units' command climate assessments. Take action as deemed appropriate. Report completion no later than 15 June 2020.
- **Recommendation 5.1.2.** I recommend that VCNO direct OPNAV N17, in coordination with Type Commanders, to identify approaches to improving crew morale and command climate for units in an industrial environment.
- **ADD Recommendation 5.1.3.** I direct COMSUBPAC to require USS COLUMBIA command triad to engage with the entire USS COLUMBIA crew to ensure their safety in light of the anonymous DEOCS comment and survey responses regarding suicidal thoughts. Report completion no later than 15 May 2020.
- **Finding 5.2.** Lack of coordination and communication between the command and the medical department representative (MDR) resulted in a general lack of awareness regarding Romero's mental health situation. This lack of information sharing contributed to a failure in oversight and poor decision making within the chain of command.
 - **Recommendation 5.2.1.** I recommend that VCNO direct COMUSFLTFORCOM to require that COMSUBFOR, in aligning eMHP practice to increase information sharing with the chain of command, take action to increase communication and collaboration across the submarine force concerning mental health.
 - **ADD Recommendation 5.2.2.** I direct COMSUBPAC to determine whether the MDR failed to properly execute his duties when he conducted Romero's PHA/MHA without reviewing Romero's medical record, and if so, take any accountability action as appropriate. Report completion no later than 15 June 2020.
- **Finding 5.3.** Command Resiliency Teams (CRT) and the Expanded Operational Stress Control Program (E-OSC) should take a more active role in promoting healthy command climates and Sailor well-being. There is potential benefit to expanding the resources available to these programs and to incorporate primary prevention principles and human factors, while also tailoring them to respective communities and their commands structure. This may lead to enhanced support for Sailors, contributing to their overall well-being, and preparing them for the mission.
 - **Recommendations 5.3.1.** I recommend that VCNO direct OPNAV N17, in coordination with Echelon 2 Commanders, to revise the E-OSC training plan to incorporate leadership resources in addition to CCSs and CMEO Managers.
 - **Recommendation 5.3.2.** I recommend that VCNO direct OPNAV N17 to update the CRT instruction and CRT guide to incorporate guidance on primary prevention principles and human factors.
 - **Recommendation 5.3.3.** I recommend that VCNO direct OPNAV N17 to develop CRT training for command leadership and Sailor development schools that is tailorable to platforms and across command environments.

8. **Chapter 6 (Personnel Security Program (PSP) and Insider Threat Program (ITP)).** I concur with the findings, opinions, and recommendations in Chapter 6 as modified below.

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- **Finding 6.1.** Security officials complied with PSP policies during Romero’s recruitment, training, and initial adjudication for his clearance. There was nothing in Romero’s background to indicate that he would become an insider threat.
 - **Recommendation 6.1.1.** I recommend that VCNO refer Romero’s initial clearance adjudication to DoD CAF for audit and to determine whether revising adjudicative guidelines and clearance procedures is warranted.
 - **Recommendation 6.1.2.** I recommend that VCNO direct Naval Education and Training Command, in coordination with BUMED, identify areas of improvement to mental health screening procedures at Recruit Training Command and accession training in light of the findings of this investigation.

- **Finding 6.2.** Romero’s behavior did not necessarily rise to the level of reportable behavior pursuant to SECNAV M-5510.30. However, this incident should be considered as a case study for process improvements, especially now that the DON’s Insider Threat Hub is operational.
 - **Recommendation 6.2.1.** I recommend that VCNO refer this incident to DoD CAF as a case study to evaluate Continuous Evaluation Program reporting thresholds. In so doing, I recommend that DoD CAF further define the catch-all category (“any other behaviors which appear to be abnormal and indicate impaired judgment, reliability, or maturity”), or provide illustrative examples through amplifying guidance and training to aid unit-level decision-making.

- **Finding 6.3.** Romero obviously constituted an insider threat even though he had no known history of violent behavior or of threatening violent behavior. The questionable behaviors he did exhibit are now being looked at through a lens for someone who committed a heinous crime. I strongly agree with Opinion 6.3.1 that no one could have reasonably predicted that Romero would shoot three civilian personnel and himself. However, I do not fully concur with Opinion 6.3.4. While a few of Romero’s shipmates provided some anecdotal examples of his concerning behavior, his chain of command already had direct knowledge of the risk indicators based on their positions of responsibility over Romero. For instance, Romero’s Chief was aware of his eMHP counseling, recognized that he was shutting down more than usual, and the Chief’s Mess and XO saw first-hand how emotional he was at DRB and XOI. His chain of command knew that he did not pass his advancement exam. They knew that he had been sent back after a curtailed TAD period on USS CHICAGO due to failure to progress in his qualifications. While reporting questionable behavior is always a prudent course of action, the chain of command had more than enough information to be concerned with providing support for the obviously troubled Romero. Opinion 6.3.4 is hereby modified to state “If shipmates had reported Romero’s questionable behavior and the chain of command had been more involved, then the aggregate of these risk factors may have prompted the command to rescreen Romero for armed watchstanding.”
 - **Recommendation 6.3.1.** I recommend that VCNO refer this incident to the DON Insider Threat Hub, in coordination Echelon 2 Commanders, to use as a case study in developing fleet reporting procedures as the DON Insider Threat Hub works toward full operational capability.

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- **Recommendation 6.3.2.** I recommend that VCNO refer this incident, including the identified insider threat indicators, to NCIS for incorporation into future DON Insider Threat Training.
- **Recommendation 6.3.3.** I recommend that VCNO refer this incident to DON Insider Threat Hub to consider use of the E-OSC program and CRTs when implementing PAR-like capabilities at the installation and organization level.

9. **Chapter 7 (Force Protection).** I concur with the findings, opinions and recommendations in Chapter 7 as modified below.

- **Finding 7.1.** The PHNSY Anti-Terrorism (AT) plan does not include Active Shooter PPRs. Despite watchstanders and Joint Base Pearl Harbor Hickam (JBPHH) Naval Security Forces (NSF) carrying weapons, PHNSY lacks a sufficient AT plan. PPRs and security de-confliction procedures for the Controlled Industrial Area (CIA) would reduce risk while improving the effectiveness of responses to an active shooter incident.
 - **Recommendation 7.1.1.** I recommend that VCNO direct COMNAVSEASYS COM to require PHNSY, in coordination with Type Commanders and JBPHH NSF, to develop active shooter PPRs and security de-confliction procedures for the CIA.
 - **Recommendation 7.1.2.** I recommend that VCNO direct COMNAVSEASYS COM to require PHNSY, in coordination with Type Commanders and JBPHH NSF, to conduct routine coordinated training within the CIA that includes active shooter responses and security de-confliction procedures.
 - **Recommendation 7.1.3.** I recommend that VCNO direct Echelon 2 Commanders to require that all subordinate commands have active shooter PPRs and security de-confliction procedures in their AT plans, and that the tenant AT plans be submitted to the respective installation for nesting under the base AT plan.
- **Finding 7.2.** There was a lack of coordinated training amongst PHNSY, JBPHH NSF, and afloat units in the CIA. Both PHNSY and USS COLUMBIA were noncompliant with COMSUBPACINST 4790.2B (Standard Work Practices for Performance of Repairs, Alterations and Maintenance on Pacific Fleet Submarines), and the training requirement.¹ Coordinated training might have prevented confusion about security responsibilities. Tighter coordination and communication are essential to improve response capabilities.
 - **Recommendation 7.2.1.** I direct that Commander, Navy Region Hawaii (CNRH) implement a routine coordinated training plan for tenant commands, including PHNSY and afloat units, to participate in local FP exercises. Provide a completed plan no later than 15 June 2020.
 - **Recommendation 7.2.2.** I recommend that VCNO direct COMNAVSEASYS COM to coordinate with Type Commanders to assess whether its shipyards are completing coordinated training with afloat units.
 - **Recommendation 7.2.3.** I direct COMSUBPAC, in coordination with PHNSY and Puget Sound Naval Shipyard, to issue necessary local guidance on Standard Work Practice requirements in light of the cancelation of COMSUBPACINST 4790.2B. Report completion no later than 15 June 2020.

¹ This instruction was canceled in December 2019.

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- **Recommendation 7.2.4.** I recommend that VCNO direct Echelon 2 Commanders to renew the Naval Shipyard Installation MOA and add a section delineating training responsibilities.
- **Finding 7.3.** PHNSY does not conduct required Antiterrorism Working Group (ATWG), Threat Working Group (TWG), or Antiterrorism Executive Council (ATEC) meetings. PHNSY is required to come into compliance with the PACFLT requirement for ATWGs, TWGs, and ATECs immediately.
 - **Recommendation 7.3.1.** I recommend that VCNO direct COMNAVSEASYSKOM to ensure that PHNSY conducts Antiterrorism Working Group (ATWG), Threat Working Group (TWG), and Antiterrorism Executive Council (ATEC) meetings as required.
 - **Recommendation 7.3.2.** I recommend that VCNO direct COMNAVSEASYSKOM to verify that all shipyards are conducting ATWG, TWG, and ATEC meetings as required by OPNAVINST F3300.53C and applicable Fleet Commander guidance.
- **Finding 7.4.** PHNSY did not conduct required Random Antiterrorism Measure (RAM) inspections. Conducting required inspections increases preparedness and responsiveness. Failing to follow requirements leads to complacency, which leads to vulnerability in force protection. This is unacceptable.
 - **Recommendation 7.4.1.** I direct CNRH to implement measures to support PHNSY in developing a RAM inspection program within the CIA. Report completion no later than 15 June 2020.
 - **Recommendation 7.4.2.** I recommend that VCNO direct COMNAVSEASYSKOM to verify that all shipyards under their responsibility have RAM inspection programs that include NSF support within the CIA.
- **Finding 7.5.** USS COLUMBIA's Topside Roving Patrol conducts armed watchstander responsibilities as delineated in Submarine Organization and Regulations Manual. The Topside Roving Patrol reports to the Petty Officer of the Deck, who is also armed. In dry dock, access to the submarine is controlled by two outer layers of security: the outermost layer is the armed security at entry control point (ECP) onto JBPHH; the next layer is armed ECP to the CIA, also controlled by JBPHH NSF; and finally, the Petty Officer of the Deck controls access onto the submarine. In addition to that, the Topside Roving Patrol on USS COLUMBIA conducts a continuous security patrol on the exclusion area in the vicinity of the submarine.
 - **Recommendation 7.5.1.** I recommend that VCNO direct Echelon 2 Commanders, in conjunction with NAVSEA 08 and Type Commanders, to review and assess armed watchstanding requirements for afloat units, with particular attention to units with nuclear reactors, to determine the appropriate level of security watch that is required across varying levels of force protection conditions.
 - **Recommendation 7.5.2.** I recommend that VCNO direct Echelon 2 Commanders to refer any armed watchstanding requirements developed in Recommendation 7.5.1 to the Type Commanders to promulgate guidance clearly delineating AT duties and responsibilities of armed watches across different environments, including the CIA, pier, and dry dock areas.

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10. **Chapter 8 (Incident Response and Emergency Management).** I concur with the findings, opinions, and recommendations in Chapter 8 as modified below.

- **Finding 8.1.** I commend the actions of all the emergency response personnel and organizations who promptly responded to the scene of the incident. JBPHH NSF responded to the incident within one minute. NCIS and HPD also responded to the scene without report or request for support. The proactive response by all the law enforcement organizations involved was impressive and would have prevented further loss of lives had a more robust response been required. One area identified for improvement was coordination and communication by JBPHH NSF. While NSF and other law enforcement organizations have integrated radio capability, JBPHH NSF did not communicate with outside law enforcement. Such coordination would be key to an effective response for any incidents requiring a coordinated response in the future.
 - **Recommendation 8.1.1.** I direct CNRH to review current mutual aid agreements with HPD and develop training scenarios to test interagency communication plans. Conclude a mutual aid agreement with HPD that addresses specific communication, coordination, and training procedures for general law enforcement response to incidents of mutual concern and incorporate those procedures into a training plan. Report completion no later than 30 September 2020.
 - **Recommendation 8.1.2.** I recommend that VCNO direct Commander, Naval Installations Command (CNIC) to assess the adequacy of mutual aid agreements of all installation communication plans with local law enforcements. Fort Hood and Washington Navy Yard investigations noted similar coordination issues.
- **Finding 8.2.** Navy TTPs and local JBPHH PPRs do not specifically address certain actions, such as use of physical restraints, personnel evacuation, or building clearance procedures in the context of an active shooter incident. This leads to a lack of uniformity in response and can contribute to confusion in an already chaotic and emotional situation. The need for more comprehensive TTPs and PPRs requires further evaluation.
 - **Recommendation 8.2.1.** I direct CNRH to ensure that JBPHH NSF conduct local training on building clearance, physical restraint, and evacuation procedures for active shooter incidents. Report completion no later than 30 June 2020.
 - **Recommendation 8.2.2.** I recommend that VCNO direct OPNAV N4, in coordination with USFLTFORCOM and Naval Warfare Development Command, to improve NTPPs consistent with partner law enforcement TTPs in the context of active shooter incidents.
 - **Recommendation 8.2.3.** I recommend that VCNO direct CNIC to require Region and Installation Commanders to train on building clearance, physical restraint, and evacuation procedures for active shooter incidents.
- **Finding 8.3.** JBPHH NSF and supporting law enforcement agencies could not access all locked spaces to clear building and secure the shooting scene. The lack of access procedures can lead to safety and security vulnerabilities and an increased risk to personnel and first responders. Access procedures require further examination.
 - **Recommendations 8.3.1 and 8.3.2 are combined.** I recommend VCNO direct Echelon 2 Commanders to ensure that all subordinate commands to revise access procedures in their physical security plan for first responders to have access to locked buildings and restricted

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areas in active shooter and other emergency situations. This plan should include debriefing any first responders who enter restricted areas.

- **Finding 8.4.** Federal Fire Department (FFD) Advanced Life Support units responded within the required seven minutes upon receiving the report of an active shooter, which is within the standard response time. Improvements to response procedures might be developed from lessons learned from this incident, including the need to designate entry and egress gates.
 - **Recommendation 8.4.1.** I recommend that VCNO direct CNIC to incorporate FFD lessons learned from this incident, including specifying entry and egress gates for off-base emergency response, into coordinated training with local law enforcement and emergency medical providers.
- **Finding 8.5.** USS COLUMBIA's Petty Officer of the Deck (POOD) responded as trained to the active shooter incident. However, USS COLUMBIA's standard casualty procedure did not account for an active shooter on the pier with personnel responding from the berthing barge. There was also some confusion when the POOD announced, "shots fired," as some of the crew thought they needed to respond to an actual fire. This miscommunication could have led to additional casualties.
 - **Recommendation 8.5.1.** I recommend that VCNO direct Echelon 2 Commanders require Type Commanders, in coordination with CNIC, add guidance to address an active shooter to casualty response procedures.
- **Finding 8.6.** The CNRH Regional Dispatch Center and JBPHH Emergency Operations Center did not send the initial mass notification lockdown messages within 2 minutes of incident notification and verification as required. The Mass Warning Notification (MWN) System must reach a target audience of 90 percent or more with specific protective action recommendations and 100 percent of assigned Emergency Management Resources. Within one hour, MWN systems should reach 100 percent of the protected population. Timelines were not met and the AtHoc and Giant Voice systems failed to reach 100 percent of the protected population. This is unacceptable. Critical information and protective action recommendations failed to reach many personnel on the installation. The MWN system can save lives when used correctly. However, failure to execute this system properly leaves our protected population vulnerable.
 - **Recommendation 8.6.1.** I direct CNRH and JBPHH to conduct an immediate review of the incident response and MWNs. Implement routine training on MWN to the continuing training program for bases and the region. Report completion no later than 30 June 2020.
 - **Recommendations 8.6.2.** I recommend that VCNO direct CNIC, in coordination with Naval Information Warfare Center (NIWC), to improve technical capabilities in MWN systems and SOPs to reduce the risk of human error.
 - **Recommendation 8.6.3.** I recommend that VCNO direct COMNAVSEASYS COM, in coordination with CNIC, to develop and implement visual and voice mass notification systems for shipyard environments.
 - **Recommendation 8.6.4.** I recommend that VCNO direct CNIC to develop distinctive tone-based signal or other means to alert personnel of lockdown procedures more effectively.

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- **Finding 8.7.** The Navy's AtHoc system is not interoperable with the Air Force AtHoc system, which is six generations and software updates ahead of the Navy.
 - **Recommendations 8.7.1.** I recommend that VCNO direct NIWC to complete the AtHoc Connect upgrade to enable Navy and Air Force interoperability and ensure the system performs as required during installation exercises where AtHoc messages are sent installation-wide.
 - **Recommendation 8.7.2.** I recommend that VCNO direct OPNAV N2/N6 to share the results of this investigation report related to interoperability of Navy and Air Force systems with the appropriate Air Force code.
 - **ADD Recommendation 8.7.3.** I recommend that VCNO direct OPNAV N4 to prioritize modernization and sustainment funding for MWN systems.
- **Finding 8.8.** The lockdown that followed the shooting prevented required personnel from accessing the JBPHH Emergency Operations Center (EOC) during the incident. Because JBPHH EOC personnel are not first responders, they are subject to lockdown procedures.
 - **Recommendation 8.8.1.** I direct CNRH to require JBPHH to revise EOC activation procedures to account for base lockdowns and to conduct an unannounced drill to validate that the EOC can attain necessary manning levels within required time limits during a base lockdown. Report completion no later than 31 July 2020.
 - **Recommendation 8.8.2.** I recommend that VCNO direct CNIC to require all region and installation commanders to review and revise ROC and EOC standard operating procedures to account for base lockdown impacts on EOC activation.
- **Finding 8.9.** The industrial shipyard environment presents circumstances not addressed in COMNAVSEASYSKOM and CNIC active shooter training. Because of the shipyard's unique challenges, active shooter training should be adapted for type of environment and other outdoor scenarios.
 - **Recommendation 8.9.1.** I recommend that VCNO direct COMNAVSEASYSKOM, in coordination with CNIC, develop active shooter exercises for naval shipyards that cover outdoor active shooter scenarios suited to local conditions and lockdown procedures.
 - **Recommendation 8.9.2.** I recommend that VCNO direct CNIC and COMNAVSEASYSKOM to revise active shooter training to include additional scenarios and lessons learned identified in this incident.

11. **Chapter 9 (Post-Incident Response).** I concur with the findings, opinions, and recommendations in Chapter 9 as modified below.

- **Finding 9.1.** Civilian Benefits Center (CBC) personnel provided timely support to the victim's families after the incident. Casualty Assistance Calls Officers (CACO) are also required to coordinate actions with CBCs in the event of a civilian death, but there is no procedure for such coordination. I directed CACO support be provided to victims' families but the lack of CBC policy to delineate coordination procedures caused confusion and delay in providing more effective casualty support to families. The Fort Hood and Washington Navy Yard shooting investigations identified gaps in policy between military and civilian personnel casualty matters, yet they remain. Rather than push for CACOs to be inserted into the CBC

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procedure, more resources should be made available to ensure that CBC personnel can deliver the level of support that CACOs provide for military casualties.

- **Recommendation 9.1.1.** I recommend that VCNO refer this finding to DON Office of Civilian Human Resources (OCHR) to review CBC policy and manning to ensure delivery timely and comprehensive support to victims' families when providing casualty support for DON civilian deaths.
- **Finding 9.2.** Next of kin (NOK) information was not available in the official civilian personnel records system and contributed to a delay in casualty support. While DON policy does not require NOK information for official personnel files for civilian employees, policies require further review to determine best practices.
 - **Recommendations 9.2.1.** I recommend that VCNO refer this finding to DON OCHR to develop and implement policy requiring DON civilian employees to provide NOK information for official personnel records and to verify such information annually.
 - **Recommendation 9.2.2.** I recommend that VCNO refer this finding to DON OCHR for coordination with DoD and the Office of Personnel Management to evaluate the multiple personnel tracking systems such as DCPDS, TWMS, and NFAAS to determine whether consolidation into a single system or sharing of information across these systems is appropriate and/or feasible.
- **Finding 9.3.** The Navy provided timely and effective support to victims, families, and other civilian employees regarding death and injury compensation claims.
 - **Recommendation 9.3.1.** I direct that PACFLT HRO provide lessons learned and materials prepared in response to this incident to DON OCHR for compilation and sharing with the DON human resources community. Report completion no later than 30 June 2020.
- **Finding 9.4.** While counseling support programs provided effective counseling to civilians, active duty personnel and families, some support programs had to increase services to offset a lack of Civilian Employee Assistance Program (CEAP) resources. The lack of coordination and communication affected delivery of counseling support. CEAP did not have sufficient counseling support immediately after the shooting and additional CEAP augments did not arrive until the week of 16 December 2019. Additionally, due to a lack of coordination, HROs and JBPHH did not provide timely and accurate information about counseling support services.
 - **Recommendation 9.4.1.** I recommend that VCNO refer this finding to DON OCHR to review CEAP contracts to ensure adequate counseling support, including crisis management and the ability to surge additional support following major incidents such as active shooter or mass casualties.
 - **Recommendation 9.4.2.** I recommend that VCNO direct CNIC to develop policy that designates an official to lead coordination of counseling support services throughout Navy regions following major incidents.
 - **Recommendation 9.4.3.** I direct that CNRH ensure that the JBPHH EFAC Director complies with requirements to establish and implement staffing, training, and recall plans in accordance with EFAC guidance. Report completion no later than 30 June 2020.

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- **Finding 9.5.** PHNSY workforce has significant workplace safety concerns stemming from this incident, primarily focused on the level of preparedness to respond to future events and perceived lack of communication. Policies were put in place to review the PHNSY CO's workforce communications pertaining to the shooting investigation in order to protect law enforcement sensitive information. However, an unintended consequence of these policies may have been that communication with the workforce was stifled post-incident. I place a great deal of importance on transparency toward our workforce and their sense of safety and confidence in our ability to address their needs in an emergency.
 - **Recommendation 9.5.1.** I recommend that VCNO direct COMNAVSEASYS COM to support PHNSY in developing a communication plan with the shipyard workforce to inform them of the progress of this investigation and its mandate to review and improve programs, policies, and procedures as a result of this incident. I will support and coordinate in this effort.
 - **Recommendation 9.5.2.** I recommend that VCNO direct CNIC to form a multi-disciplinary team to include impacted installation and tenant command leaders and subject matter experts in human resources, law enforcement, clinical counseling, medical services, religious support, legal, public affairs, and external agencies as appropriate to implement recovery procedures and protocols regarding effective communications to impacted workforce after major incidents.
 - **Recommendation 9.5.3.** (b) (5) [REDACTED]
[REDACTED] I recommend that VCNO direct NIWC to further explore whether AtHoc can be tailored to allow individual commands to send notifications to their personnel via the AtHoc system.
- **Finding 9.6.** Unclear guidance was issued by PHNSY to the shipyard workforce regarding whether or not to report to work the day after the incident. The PHNSY emergency management plan should clearly designate essential personnel in the event of closures following major incidents. This will help diminish any confusion amongst the workforce.
 - **Recommendation 9.6.1 and 9.6.2 are combined.** I recommend that VCNO direct Echelon 2 Commanders to ensure that all subordinate commands update their emergency management plan to clearly designate essential personnel for closures that are not weather related, to include closure as a result of a major incident or mass casualty.
- **Finding 9.7.** Navy Family and Accountability and Assessment System (NFAAS) was not activated to account for personnel following the incident despite being the required mechanism for personnel accountability.
 - **Recommendation 9.7.1.** I recommend that VCNO direct CNIC to review procedures and conduct training on recall and post-incident accountability for personnel and families, and in coordination with OPNAV N1, assess what the right solution should be for this type of personnel accountability, whether it be TWMS, NFAAS, or a different solution.
- **Finding 9.8.** Public affairs external communications were in accordance with Navy instructions, and were timely, accurate, and appropriate. While CNRH PAO did not have an

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be for this type of personnel accountability, whether it be TWMS, NFAAS, or a different solution.

- **Finding 9.8.** Public affairs external communications were in accordance with Navy instructions, and were timely, accurate, and appropriate. While CNRH PAO did not have an active shooter response SOP prior to this incident, they are in the process of creating one as a result of this incident.
 - **Recommendation 9.8.1.** I recommend that VCNO refer this investigation to CHINFO to coordinate with CNIC in developing a public affairs policy for active shooter and other major security incidents that incorporate shorter response timelines, share best practices, and lessons learned from previous incidents. A best practice is to include periodic drills and/or tabletop exercises to test procedures and ensure individual understanding and proficiency.

12. **Chapter 10 (Opinions and Recommendations).** Chapter 10 provides the primary opinions and recommendations from the investigation. These opinions and recommendations are addressed in the various preceding paragraphs. Additionally, individuals were specifically identified for further review and/or investigation into their potential responsibility and accountability. I direct COMSUBPAC to review the investigations and the modifications contained in this endorsement to determine appropriate actions. Report completion and results for this review no later than 30 June 2020.

13. This command investigation was extremely broad in nature and resulted in wide-ranging recommendations; therefore, in order to maintain accountability on progress, PACFLT will take the lead on tracking the recommendations, including recommendations forwarded to Echelon I for review and consideration.


P. C. AQUILINO

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COMMAND INVESTIGATION REPORT

PEARL HARBOR NAVAL SHIPYARD SHOOTING OF DECEMBER 4, 2019

March 12, 2020

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Executive Summary

Machinist Mate Auxiliary Fireman Gabriel A. Romero, a 22-year-old active-duty Sailor assigned to the Fast Attack Submarine USS COLUMBIA (SSN 771), reported at 1404 on December 4, 2019, for duty as the Topside Roving Patrol. USS COLUMBIA was in Dry Dock 2 inside the Controlled Industrial Area (CIA) at Pearl Harbor Naval Shipyard (PHNSY) on Joint Base Pearl Harbor-Hickam (JBPHH). The Sailor who Romero relieved described the watch turnover, and Romero, as ordinary. Standing just outside the Casualty Control (CASCON) shack on the port side of Dry Dock 2, the two exchanged the standard words “I am ready to relieve you” and “I am ready to be relieved.” Romero took possession of the M-4 rifle with 90 rounds of ammunition and M-9 pistol with 45 rounds of ammunition and made required entries in the duty logbook. Before Romero began his first roving patrol, he said “I’ll be back” to the Petty Officer of the Deck, the second of two armed topside watchstanders on USS COLUMBIA, and proceeded to walk from the CASCON shack around Dry Dock 2 from port to starboard. Around the same time, three PHNSY civilian employees who had been working on USS COLUMBIA earlier in the day left their workstations in a trailer between Dry Docks 2 and 3. They began walking along the starboard side of Dry Dock 2. Romero turned around on the starboard side of Dry Dock 2 before he had circulated the entire dry dock and approached the three civilian employees from behind. The Petty Officer of the Deck observed Romero chamber a round, raise his M-4 rifle, and begin firing at the civilians. The three civilians fell to the ground 15-20 feet in front of Romero at the head of Dry Dock 2. While the victims lay on the ground, and before first responders were on the scene, Romero used his M-9 pistol to shoot himself. Two of the victims succumbed to their injuries and were declared deceased at local hospitals. The third victim was transported to a local hospital and later released. Romero died at the scene. The shooting only lasted a few seconds from beginning to end.

JBPHH Navy Security Forces (NSF) arrived at the scene within 1 minute and Federal Fire Department (FFD) emergency medical services arrived within 6 minutes. Post-incident response in terms of casualty assistance and counseling support was effective with areas for improvement in coordination and communication.

On December 19, 2019, the Vice Chief of Naval Operations (VCNO) directed Commander, U.S. Pacific Fleet (COMPACFLT) to convene this administrative investigation into the facts and circumstances surrounding the fatal shooting incident. On December 20, 2019, COMPACFLT appointed Rear Admiral Scott D. Jones as the Investigating Officer to conduct an in-depth investigation into Romero's background; the command climate aboard USS COLUMBIA; force protection and emergency response management; insider threat and active shooter training, drills, lockdown, and emergency notifications; post-incident response; significant impacts to PHNSY personnel and their workplace safety concerns; and armed watchstander qualifications and fitness to stand armed watch. Rear Admiral Jones assembled a multidisciplinary investigation team comprised of subject matter experts in mental health, force protection, shipyard operations, command climate, casualty assistance, human resources, law, public affairs, and submarine operations. The investigation team completed its work on March 12, 2020, after COMPACFLT granted an extension from the February 20, 2020 due date. This report documents the team's findings, opinions, and recommendations.

Findings

The cause of this incident is that Romero used a service-issued M-4 rifle to shoot three civilian shipyard employees, killing two of them and seriously injuring the other before shooting himself with a service-issued M-9 pistol. He constituted an insider threat. The investigation team determined that Romero had long-developing problems that in aggregate should have raised concerns about his mental condition, and his maturity, stability, and dependability. If these risk factors would have been shared among medical providers and the USS COLUMBIA chain of command before December 4, 2019, the Navy may have interrupted the chain of events that led to this tragedy.

The findings in this report are grouped into two general categories depending on their potential to prevent the PHNSY shooting incident on December 4, 2019: (1) **Potential contributing factors** are those factors that may have interrupted the chain of events that led to the PHNSY shooting incident; and (2) **Noncontributing factors** are those factors that had no direct impact on the chain of events that led to the shooting incident but should be addressed to improve readiness and safety.

Potential Contributing Factors

- A Submarine Embedded Mental Health Program (eMHP) provider under-diagnosed and did not properly manage Romero’s mental health condition during eight visits to the eMHP Clinic in Pearl Harbor between September and November 2019. The eMHP provider only diagnosed “Phase of Life Problems” and “Unspecified Problem Related to Unspecified Psychosocial Circumstances” when Romero showed signs of an undiagnosed mental disorder that likely would have disqualified him from submarine duty. Seven of Romero’s eight visits to the eMHP Clinic were with the behavioral health technician, not the eMHP provider.
- Contrary to the Submarine Force eMHP instruction, the eMHP Clinic did not present a unified plan among the chain of command, patient, and provider regarding Romero’s mental health treatment. The eMHP Clinic staff’s broad interpretation of Department of Defense (DoD) policy on confidentiality imposed a barrier on information sharing and collaboration with the chain of command. Information on Romero’s treatment may have led USS COLUMBIA’s chain of command to question his fitness for duty and rescreen him for armed watch.
- Romero completed required arms screening in September 2018 and qualified to stand the Topside Rover Patrol watch in December 2018. He completed required annual rescreening in September 2019, but OPNAV Instruction 5530.13C also requires rescreening “when circumstances indicate review would be prudent.” He was not rescreened on that basis despite risk factors known to the Navy including his mental health; his concern over his (b) (6) health issues; two single motor vehicle accidents (motorcycle and car) within a year; general isolation from his shipmates; delinquent qualifications; repeated counseling; a disciplinary review board (DRB); a failure to advance to E-4; and an executive officer inquiry (XOI) the day before the shooting. OPNAV Instruction 5530.13C and current training do not provide amplifying guidance on when circumstances require rescreening.
- USS COLUMBIA’s chain of command and medical department representative (MDR) did not share information regarding Romero’s disciplinary issues, medical and mental condition, and family situation effectively. With information sharing

and collaboration on Romero's long-developing problems, the chain of command may have taken more intrusive actions to direct additional mental health evaluation or remove Romero from armed watchstanding.

- Romero demonstrated potential risk indicators to shipmates that were not significant enough to prompt reports through any established insider threat reporting procedures or to law enforcement, but they should have been reported to supervisors. These indicators included Romero complaining to a shipmate that he was tired of work and people calling him stupid, punching a locker in anger, and yelling at a shipmate when he suggested Romero seek counseling to deal with stress. If shipmates would have reported these indicators to supervisors, the chain of command may have aggregated them with other known risk factors to recognize that circumstances warranted his rescreening for armed watchstanding.

Noncontributing Factors

- Security officials complied with Personnel Security Program policies in the initial adjudication of Romero's security clearance and in the continuous evaluation program during his assignment on USS COLUMBIA. Further clarifying definitions on general catch-all categories concerning judgment, reliability, trustworthiness, and maturity as well as amplifying guidance through training would aid unit-level decision-making in continuous evaluation program reporting.
- JBPHH NSF responded in 1 minute to the shooting scene, well within the prescribed timeline of 15 minutes, but did not promptly establish radio communications with other responding law enforcement organizations. The Naval Criminal Investigative Service (NCIS) and the Honolulu Police Department (HPD) responded quickly without a report or request for support from NSF.
- Commander, Navy Region Hawaii (CNRH) and HPD have a mutual aid agreement on Special Weapons and Tactics (SWAT) and related support. HPD and JBPHH do not have other written communication or coordination procedures for law enforcement responses to incidents of mutual concern.

- Navy tactics, techniques, and procedures (NTTP) and local JBPHH pre-planned responses (PPRs) do not specifically address physical restraints, evacuation of personnel, or building clearance procedures in the context of an active shooter incident. Two NSF personnel initially used flex cuffs and duct tape to temporarily control personnel during building clearance. NSF and supporting law enforcement agencies also conducted building clearance procedures differently.
- The PHNSY Security Program lacks an active shooter PPR, and security training has not occurred among shipyard, base security, and afloat units in the shipyard's CIA. The lack of coordinated training increased risk to first responders.
- The CNRH Regional Dispatch Center (RDC) sent an Automatic Target Hand-Off Correlator (AtHoc) lockdown alert message to shipyard personnel within 6 minutes of the PHNSY Emergency Management Officer's direction to send the lockdown message and 11 minutes after JBPHH NSF arrived on scene. This was not within the prescribed 2 minute timeline. The JBPHH Emergency Operations Center (EOC) did not send out a mass warning notification to the surrounding area on the AtHoc alert system because of human error.
- JBPHH EOC announced lockdown procedures on the Giant Voice exterior speaker system 17 minutes after JBPHH NSF arrived on scene. This was not within the prescribed 2 minute timeline. The voice announcements on the Giant Voice system were not easily understood.
- DoD and Navy policy lack adequate guidance concerning coordination between Casualty Assistance Calls Officers (CACOs) and Civilian Benefits Center (CBC) personnel when CACOs are assigned to assist in civilian casualty support.
- Department of the Navy (DON) Office of Civilian Human Resources (OCHR) policy does not adequately delineate roles and responsibilities concerning delivery and coordination of post-traumatic event counseling support.

- The PHNSY workforce has significant concerns for workplace safety resulting from this incident. These concerns primarily relate to the level of preparedness in the future and to lack of communication.

Opinions

Based on the findings, four main opinions inform the recommendations in this report:

Opinion 1: The evidence does not establish with certainty why Romero chose to shoot three civilians and kill himself, but it does show that he had several stressors in his life in the months leading up to the shooting that, when taken together, likely led him to choose violence. No effective formula exists to predict violent behavior with any level of accuracy. Amplifying guidance and training in arms, ammunition, and explosives (AA&E) rescreening standards may have prompted Romero's rescreening based on the risk factors known to the Navy before the December 4, 2019 shooting incident.

Opinion 2: The Submarine eMHP is a valuable program that enhances the readiness of the submarine force through early intervention and prevention. However, a review of Romero's care and eMHP Clinic diagnostic data indicate a potential pattern of under-diagnosis to maintain patients on submarine duty.

Opinion 3: The DoD policy on confidentiality is central to removing the stigma of seeking mental health treatment and building trust between medical providers and patients. However, the chain of command is also central to ensuring the resilience and well-being of Sailors, unit mission readiness, and warfighting effectiveness. A better balance must be achieved between confidentiality and sharing information to improve care, and ensure that high-risk personnel are identified and appropriately monitored, especially where Sailors are given access to means that can kill or cause serious injury.

Opinion 4: DoD and DON insider threat programs and training have developed in recent years in part as a result of lessons learned from the tragic shootings at Fort Hood and the Washington Navy Yard. This incident demonstrates more work is required in some areas. These areas include increased information sharing, and incorporating prevention

principles and human factor assessments into programs, policies, and procedures, such as arms, ammunition, and explosives (AA&E) screening and Sailor resilience programs.

Recommendations

Potential Contributing factors. The primary recommendations concerning potential contributing factors in this incident include the following:

- Bureau of Medicine and Surgery (BUMED), in coordination with Type Commanders, conduct a comprehensive review of the eMHP to determine if there is a pattern of under-diagnosis and to clarify the proper role and scope of practice of behavioral health technicians. The review should also include manning, patient/provider ratios, facilities, and reporting tripwires to commands.
- Commander Submarine Forces, in coordination with BUMED, align eMHP practice to comply with the existing instruction to present a unified plan among the chain of command, patient, and provider. Use informed consent with patients to share information and improve care, and as necessary, disclose information to commanders through existing exceptions to DoD policy on confidentiality—specifically, the harm to mission, special personnel, or other special circumstances exceptions.
- OPNAV N4 revise AA&E policy, procedures, and training requirements on screening and rescreening to clarify vague standards, and incorporate prevention principles, human factor assessments, and tripwires. Mental health treatment without a diagnosis should not be a tripwire by itself but should be considered a tripwire for rescreening if present with other factors, such as continuing poor performance, disciplinary actions, or family issues that raise concerns about maturity, stability, or dependability.
- In combination with aligning eMHP practice to increase information sharing with the chain of command, Commander Submarine Forces take action as appropriate to increase communication and collaboration across the submarine force concerning mental health.

- OPNAV N17 expedite and fully resource changes to the Expanded Operational Stress Control (E-OSC) Program, including incorporation of primary prevention principles and human factors into Command Resilience Team (CRT) efforts to promote healthy command climates and well-being.
- Director, Navy Staff (DNS), in coordination with DON Insider Threat Hub, use this incident as a case study when developing fleet reporting procedures to the DON Insider Threat Hub as it works toward full operational capability. Consider use of the E-OSC program and CRTs when implementing Prevention, Assistance and Response (PAR) or PAR-like capabilities at the installation and organization-level.

Noncontributing Factors. The primary recommendations concerning noncontributing factors in this incident include the following:

- DoD Consolidated Adjudications Facility (DoD CAF) use this incident as a case study to evaluate continuous evaluation reporting thresholds. Further define catch-all categories on judgment, trustworthiness, reliability, and maturity as well as provide illustrative examples through amplifying guidance and training to aid unit-level decision-making in continuous evaluation reporting.
- Naval Education and Training Command (NETC), in coordination with BUMED, review this report to identify potential improvements to mental health screening procedures in recruit training and accession training.
- CNRH enter into a comprehensive mutual aid agreement with HPD that addresses local communication, coordination, and training procedures. Commander, Naval Installations Command (CNIC) assess adequacy of mutual aid agreements with local law enforcement at other installations.
- OPNAV N4, in coordination with Commander, U.S. Fleet Forces Command (CUSFF) and Naval Warfare Development Command, revise NTTPs and training on building clearance, physical restraints, and evacuation procedures in active shooter incidents.

- Echelon 2 Commanders ensure that all subordinate commands have active shooter PPRs and security de-confliction procedures in Antiterrorism Plans.
- Commander Submarine Forces, in coordination with pertinent Echelon 2 Commanders, assess whether armed watchstanding requirements inside CIAs can be modified in some Force Protection conditions.
- CNIC improve technical capabilities of mass notification systems (AtHoc and Giant Voice) and revise operating procedures to reduce the probability of human error.
- DON OCHR, in coordination with OPNAV N1, revise CBC policy to incorporate coordination procedures between CACOs and CBC personnel when CACOs provide casualty support after civilian deaths.
- CNIC develop policy that designates an official (e.g., Region Director, Total Force Manpower Management (N1)) to take lead on coordinating counseling support services throughout Navy regions following major incidents.
- CNIC lead a multi-disciplinary team to include subject matter experts in command leadership, human resources, law enforcement, counseling support, religious support, law, and public affairs to develop policy guidance and best practices regarding effective communications to impacted workforce after major incidents.
- PHNSY, in coordination with Commander, Naval Sea Systems Command (COMNAVSEASYS COM), increase communication with the shipyard workforce concerning the steps being taken to review programs, policies, and procedures, and to improve readiness and safety as a result of this incident.

Accountability

Recommend COMPACFLT forward this report to responsible commands for further investigation and appropriate action as set forth in Chapter 10.

Chapter 1 - Introduction

Machinist Mate Auxiliary Fireman (MMAFN) Gabriel A. Romero, a 22-year-old active-duty Sailor assigned to the Fast Attack Submarine USS COLUMBIA (SSN 771), reported at 1404 on December 4, 2019, for duty as the Topside Roving Patrol.¹ USS COLUMBIA was in Dry Dock 2 inside the Controlled Industrial Area (CIA) at Pearl Harbor Naval Shipyard (PHNSY) on Joint Base Pearl Harbor-Hickam (JBPHH).² The Sailor who Romero relieved described the Topside Roving Patrol watch turnover, and Romero, as ordinary.³ Standing just outside the Casualty Control (CASCON) shack on the port side of Dry Dock 2, the two exchanged the standard words “I am ready to relieve you” and “I am ready to be relieved.”⁴ Romero took possession of the M-4 rifle with 90 rounds of ammunition and M-9 pistol with 45 rounds of ammunition and made required entries in the duty logbook.⁵

Before Romero began his first roving patrol, he said “I’ll be back” to the Petty Officer of the Deck, the second of two armed topside watchstanders on USS COLUMBIA, and proceeded to walk from the CASCON shack around Dry Dock 2 from port to starboard.⁶ Around the same time, three PHNSY civilian employees who had been working on USS COLUMBIA earlier in the day left their workstations in a trailer between Dry Docks 2 and 3.⁷ They walked along the starboard side of Dry Dock 2.⁸ Romero turned around on the starboard side of Dry Dock 2 before he had circulated the entire dry dock, and he approached the civilian employees from behind.⁹ The Petty Officer of the Deck observed Romero chamber a round, raise his M-4 rifle, and begin firing at the civilians.¹⁰ The three civilians fell to the ground 15-20 feet in front of Romero at the head of Dry Dock 2.¹¹ While the victims lay on the ground, and before first responders were on the scene, Romero used his M-9 pistol to shoot himself.¹² Two of the victims succumbed to their injuries and were declared deceased at local hospitals.¹³ A third victim was transported to a local hospital and later released.¹⁴ Romero died at the scene.¹⁵ The shooting only lasted a few seconds from beginning to end.¹⁶

Scope of Investigation

On December 19, 2019, the Vice Chief of Naval Operations (VCNO) directed Commander, U.S. Pacific Fleet (COMPACFLT) to convene an investigation into the facts and circumstances surrounding the PHNSY shooting incident.¹⁷ The VCNO directed Commander, U.S. Fleet Forces Command (CUSFF) to convene a separate investigation into the facts and circumstances surrounding the fatal shooting on December 6, 2019, at Naval Air Station (NAS) Pensacola.¹⁸ The VCNO directed each of these investigations to segregate recommendations into those issues within Navy control and outside Navy control, provide detailed recommendations for action where appropriate on areas within Navy control, and identify the lead agency with cognizance over the issue identified on any areas outside Navy control.¹⁹ On December 20, 2019, COMPACFLT appointed Rear Admiral (RADM) Scott D. Jones, USN, to conduct an in-depth investigation into the facts and circumstances surrounding the PHNSY shooting incident.²⁰ Rear Admiral (RDML) Robert M. Gaucher, USN, was appointed as chief of staff for the investigation.²¹ Per COMPACFLT's direction, this investigation addresses the following:²²

- Background on MMAFN Gabriel A. Romero to include his military service record, performance history, disciplinary record, as well as his criminal, medical and mental health records, and any other indicators that he posed an insider threat, to include whether such issues were known, or reasonably knowable, by the chain of command.
- Command climate on USS COLUMBIA, along with any other factors that contributed to that environment.
- The execution of and compliance with programs, policies, and procedures pertaining to force protection and emergency response management by command personnel, Navy Security Forces, local law enforcement, and first responders.
- The execution of and compliance with programs, policies, and procedures pertaining to insider threat and active shooter training, drills, lockdown, and emergency notifications.

- The execution of post-incident response related to emergency medical care; support to victims, survivors, and their families; mission continuity; and communication.
- Significant impacts to personnel and their concerns for workplace safety resulting from this incident to include recommendations for changes, if any, in programs, policies, procedures or manning levels to improve physical security and confidence in workplace security.
- The execution of and compliance with programs, policies, and procedures pertaining to watchstander qualifications and fitness to stand an armed watch, as well as supervision, vetting, and issuance of weapons.

In accordance with the convening order, this investigation also identifies and addresses relevant deficiencies in applicable programs, policies, and procedures to ensure the safety and well-being of uniformed and civilian personnel.

Methodology

RADM Jones assembled and led an investigation team of 22 Department of the Navy (DON) military and civilian subject matter experts in mental health, force protection, shipyard operations, command climate, casualty assistance, human resources, law, public affairs and submarine operations.²³ The investigation team conducted site visits, program reviews, and interviews. The cooperation of several commands and organizations were instrumental to the investigation team being able to conduct a thorough inquiry and develop independent findings, opinions, and recommendations. These commands and organizations included, but were not limited to, the Department of Defense Central Adjudication Facility; DON Insider Threat Hub; OPNAV; U.S. Fleet Forces Command; U.S. Pacific Fleet; Submarine Force, U.S. Pacific Fleet; Submarine Squadron SEVEN; Naval Submarine Support Command Pearl Harbor; USS COLUMBIA; Navy Region Hawaii; JBPHH; Naval Sea Systems Command; PHNSY; Naval Education and Training Command; Bureau of Medicine and Surgery; Tripler Army Medical Center; the Naval Criminal Investigative Service; and the Honolulu Police Department.

The investigation team used a multidisciplinary approach to investigate the facts and circumstances surrounding the shooting incident. The team was grouped into four

smaller teams based on subject matter expertise. The Medical Team focused on reviewing Romero's medical history and medical treatment, and identifying any indicators that he would harm others or himself. The Command Climate Team focused on the command environment and related factors on USS COLUMBIA. The Force Protection, Incident Response, and Emergency Management Team focused on armed watchstander qualification and training, force protection measures, pre-planned responses, and emergency management. The Shipyard Team focused on workplace safety concerns at PHNSY and civilian support programs, policies, and procedures. The investigation team completed its work on March 12, 2020, after COMPACFLT granted an extension from the February 20, 2020 due date. This report documents the team's findings, opinions, and recommendations.

Report Organization

This report is organized into chapters that provide findings, opinions, and recommendations concerning the subjects listed in the convening order. Chapter 2 provides a sequence of events, starting from Romero's pre-service history through post-incident response. Chapter 3 examines the Submarine Embedded Mental Health Program (eMHP). Chapter 4 examines the Arms, Ammunition, and Explosives (AA&E) program on USS COLUMBIA. Chapter 5 examines USS COLUMBIA's command climate and related factors. Chapter 6 examines the Personnel Security Program (PSP) and DON Insider Threat Program (ITP) as applied to Romero. Chapter 7 examines force protection for JBPHH, PHNSY, and USS COLUMBIA. Chapter 8 examines incident response and emergency management. Chapter 9 examines post-incident response regarding casualty assistance, employee support services, and PHNSY workplace safety concerns. Chapter 10 provides overarching opinions and recommendations. The appendices contain a compilation of the specific findings, opinions, and recommendations (Appendix A); an investigation team roster (Appendix B); a detailed timeline (Appendix C); and supporting documentary evidence (Appendix D).

The findings, opinions, and recommendations of the investigation are in Chapters 3 through 10 of this report. The findings are grouped into two general categories – **potential contributing factors** and **noncontributing factors**. Potential contributing factors are those factors that may have interrupted the chain of events that led to the

PHNSY shooting incident. Noncontributing factors are those that had no direct impact on the chain of events that led to the shooting incident but should be addressed to improve readiness and safety. Consistent with the convening order, the findings are also grouped into **compliance** and **deficiency** categories depending on whether they address compliance with or deficiencies in current programs, policies, or procedures. The recommendations are within Navy control to implement except where noted.

Background

Joint Base Pearl Harbor-Hickam (JBPHH)

JBPHH is located on the island of Oahu in Hawaii (see Figure 1.1). JBPHH, the larger of two Navy Region Hawaii installations, hosts over 175 tenant commands, over two dozen ships and submarines, and six fixed-wing aviation squadrons.²⁴ The total population of Navy and Air Force active-duty personnel, civilians, and family members exceeds 65,000.²⁵ JBPHH is home to a large number of nuclear-powered fast attack submarines and is one of four U.S. Navy submarine homeports in the Pacific Ocean.

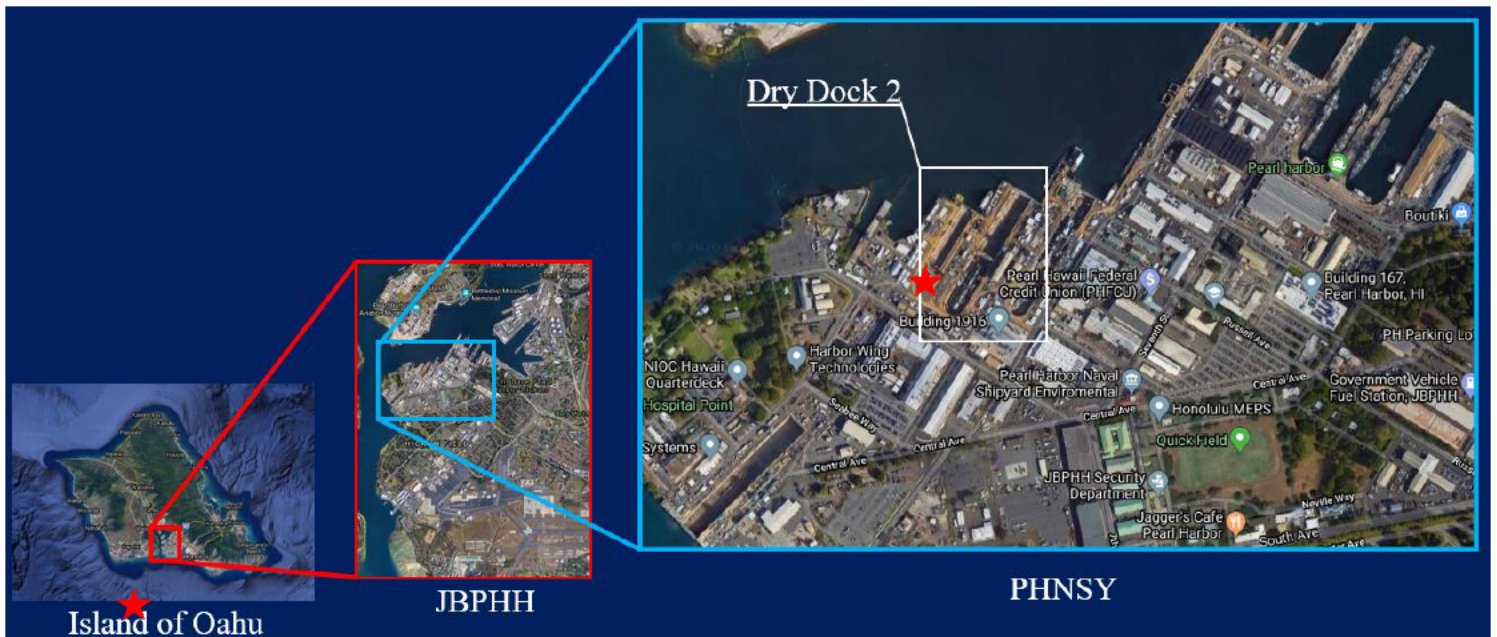
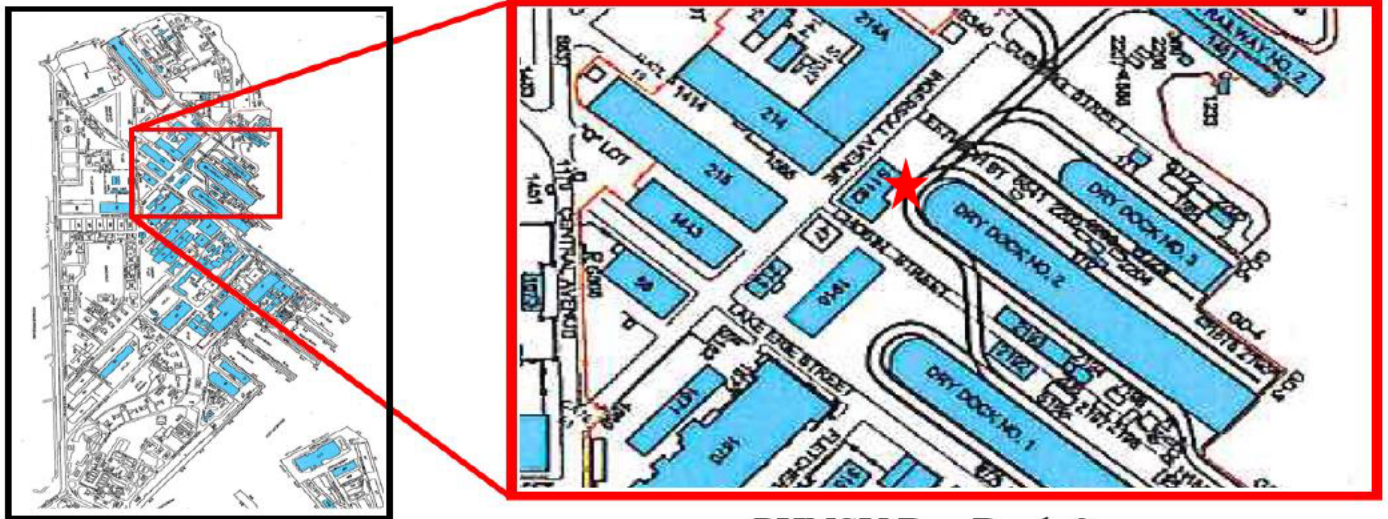


Figure 1.1 JBPHH, PHNSY, Dry Dock 2 (location of shooting incident).²⁶

Pearl Harbor Naval Shipyard and Intermediate Maintenance Facility (PHNSY & IMF)

PHNSY & IMF, the nation's largest fleet repair and maintenance facility between the west coast of the United States and Asia, is located on JBPHH (see Figure 1.1).²⁷ PHNSY employs over 6,000 DON civilian employees and active-duty Navy personnel. PHNSY has four dry-docking areas that allow for naval surface ships and submarines to undergo intensive maintenance availabilities, alterations, and major upgrades. PHNSY contains a CIA.²⁸ The CIA is required, pursuant to the Atomic Energy Act of 1954 (as amended), to ensure that only personnel with a valid U.S. Government security clearance and need-to-know are given access to work on U.S. Navy nuclear-powered submarines.²⁹ The CIA requires special access and uses Shipyard Access Control Badges (SACBs) at all entry control points.³⁰ SACBs, which are primarily an information security (INFOSEC) measure, are issued to employees after confirmation of their valid U.S. Government security clearances.³¹ All personnel are required to display SACBs while in the CIA.³² The shooting that is the subject of this investigation occurred within the CIA at the head of Dry Dock 2 (see Figure 1.2).



PHNSY Building Map
Figure 1.2 PHNSY.

PHNSY Dry Dock 2
★ Shooting Incident at the head of Dry Dock 2.

USS COLUMBIA (SSN 771)

USS COLUMBIA is a Los Angeles class nuclear-powered fast attack submarine homeported in Pearl Harbor as one of eight submarines in Submarine Squadron SEVEN.

The crew is comprised of approximately 150 officers and enlisted personnel.³³ USS COLUMBIA was built at Electric Boat in Groton, Connecticut, and commissioned in 1995.³⁴ The submarine returned from a Western Pacific deployment in July 2018, its tenth overall deployment and second deployment in 3 years, and entered Dry Dock 2 at PHNSY in October 2018 for a Chief of Naval Operations (CNO) major maintenance availability scheduled for completion in January 2021 (see Figures 1.3 and 1.4).³⁵



Figure 1.3: USS COLUMBIA entering Dry Dock 2 at PHNSY.³⁶



Figure 1.4: USS COLUMBIA in Dry Dock 2.³⁷

Pertinent Chains of Command and TACON for FP

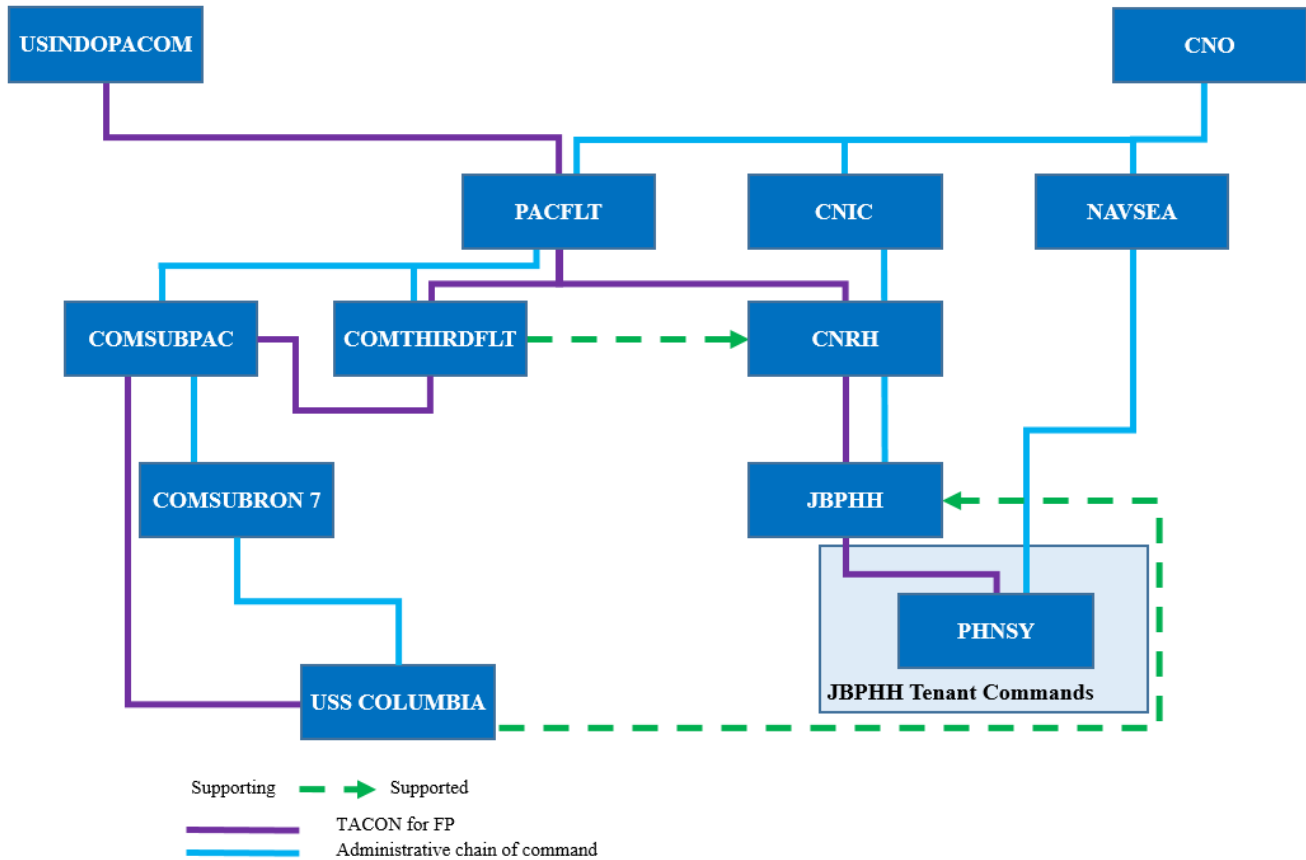


Figure 1.5 TACON for FP

Description of the Insider Threat Program

In October 2011, Executive Order 13587 directed ITPs to be established across the Executive Branch as a result of unauthorized disclosures of classified information that damaged national security.³⁸ The DON established the DON ITP in 2013.³⁹ The Fiscal Year 2017 National Defense Authorization Act (NDAA) expanded the insider threat definition to include a threat presented by a person who has or once had authorized access and who “commits a destructive act, which may include physical harm to another in the workplace.”⁴⁰

DON policy, as set forth in SECNAV Instruction 5510.37A, is “to establish an integrated set of policies and procedures to deter, detect, and mitigate insider threats before damage is done to national security, personnel, resources, or capabilities.”⁴¹ The DON Insider Threat Hub achieved initial operating capability in October 2019 to serve as an

integrating capability to monitor and audit information for insider threat detection and mitigation that is derived from the following areas: Antiterrorism/Force Protection (AT/FP) risk management; Counterintelligence; civilian and military personnel management; Cybersecurity (CS); Law Enforcement (LE); Security; Inspector General (IG); the monitoring of user activity on classified DON information networks; Prevention, Assistance, and Response (PAR) capabilities and framework; and continuous evaluation and other sources to improve existing insider threat detection and mitigation efforts.⁴²

SECNAV Instruction 5510.37A, which entered into effect on October 28, 2019, assigns responsibilities concerning, among other things, information sharing, training, and reporting and response requirements, including implementation of PAR or PAR-like capabilities.⁴³ The PAR framework—which was established in February 2017 as part of the final implementation actions on recommendations after the tragic 2009 Fort Hood shooting—requires information sharing between installation and organizational commanders and Department of Defense (DoD) component Insider Threat Hubs on personnel at risk of potentially violent behavior.⁴⁴ The PAR framework does not create new capabilities but instead requires DoD components to use and synchronize existing support functions to help personnel at risk of potentially violent behavior.⁴⁵

¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 32, Enclosure B.

² SI with ETR2 (b)(6) of 22 Jan 20.

³ SI with MMA3 (b)(6) of 13 Jan 20.

⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 5 ¶ 2.

⁵ *Id.*; NCIS Report of Investigation of 2 Jan 20, Exhibit 32, Enclosure B; NCIS Report of Investigation of 2 Jan 20, Exhibit 3 ¶ 6.

⁶ SI with ETR2 (b)(6) of 22 Jan 20; NCIS Report of Investigation of 2 Jan 20, Exhibit 5 ¶ 2.

⁷ NCIS Report of Investigation of 2 Jan 20, Exhibit 20 ¶ 4.

⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 61 ¶ 2.

⁹ SI with ETR2 (b)(6) of 22 Jan 20 ¶ 3; NCIS Report of Investigation of 2 Jan 20, Exhibit 13 ¶ 2; NCIS Report of Investigation of 2 Jan 20, Exhibit 21 ¶ 2.

¹⁰ SI with ETR2 (b)(6) of 22 Jan 20 ¶ 3. Based on shell casings and weapon magazines recovered at the scene, Romero fired eight (8) rounds with his M-4 rifle and three (3) rounds with his M-9 pistol. NCIS Report of Investigation of 2 Jan 20, Exhibit 54 ¶ 26.

¹¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 16 ¶ 3.

¹² SI with ETR2 (b)(6) of 22 Jan 20.

¹³ NCIS Report of Investigation of 2 Jan 20, Exhibit 54 ¶ 1.

¹⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 61 ¶ 1.

¹⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 54 ¶ 20.

¹⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 74 ¶ 2; NCIS Report of Investigation of 2 Jan 20, Exhibit 75 ¶ 2; NCIS Report of Investigation of 2 Jan 20, Exhibit 5 ¶ 4.

¹⁷ Vice Chief of Naval Operations Investigation Ltr of 19 Dec 19.

¹⁸ *Id.*

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- ¹⁹ *Id.*
- ²⁰ COMPACFLT Convening Order of 20 Dec 19.
- ²¹ *Id.*
- ²² *Id.*
- ²³ Appendix B of this report.
- ²⁴ CNIC Fact Sheet: Joint Base Pearl Harbor-Hickam last updated 26 Feb 15.
- ²⁵ *Id.*
- ²⁶ Google Maps Imagery of 4 Feb 20.
- ²⁷ Naval Sea Systems Command, PHNSY & IMF Information Sheet.
<https://www.navsea.navy.mil/Home/Shipyards/PHNS-IMF/>
- ²⁸ PHNSY & IMF Map.
- ²⁹ NAVSEA M-5510.2 § 6(a).
- ³⁰ *Id.*
- ³¹ *Id.* at § 5(a).
- ³² *Id.*
- ³³ USN Submarine Fact File last updated 26 Feb 19.
https://www.navy.mil/navydata/fact_display.asp?cid=4100&ct=4&tid=100.
- ³⁴ COMSUBPAC “About USS Columbia.” <https://www.csp.navy.mil/columbia/About/>.
- ³⁵ USS COLUMBIA (SSN 771) FY 19 Extended Overhaul Information Sheet.
- ³⁶ Email from (b)(6) to CDR (b)(6) of 4 Feb 20.
- ³⁷ Email from (b)(6) to CDR (b)(6) of 3 Feb 20.
- ³⁸ Executive Order 13587 of 13 Oct 11.
- ³⁹ SECNAV 5510.37 of 8 Aug 13 (Canceled); SECNAV 5510.37A.
- ⁴⁰ National Defense Authorization Act for FY 2017, Subtitle F “Other Matters” § 951 ¶ (f)(b)(ii).
- ⁴¹ SECNAVINST 5510.37A ¶ 6.
- ⁴² *Id.* at ¶ 6(c); UNSECNAV Memo of 2 May 19.
- ⁴³ SECNAVINST 5510.37A.
- ⁴⁴ DEPSECDEF Memo of 2 Feb 17.
- ⁴⁵ *Id.*

Chapter 2 – Sequence of Events

Romero's Background

Machinist Mate Auxiliary Fireman (MMAFN) Gabriel A. Romero, age 22, was born on April 4, 1997, at Oakwood Hospital in Dearborn, Michigan.¹ After his (b) (6) at age three, he was raised primarily by his mother along with two older brothers and a younger sister.² He attended three high schools in four years, Douglas MacArthur High School, San Antonio, Texas; iSchool of Lewisville, Lewisville, Texas; and Woburn Memorial High School, Woburn, Massachusetts, where he graduated in 2015.³ Romero was challenged by academics but excelled at competitive hockey.⁴ After high school, he played hockey in Casper, Wyoming, in a hockey association that develops young players to play in college. When he became too old to play in the hockey association, he returned to San Antonio where he enrolled in community college.⁵ He continued to struggle with academics, and on November 17, 2017, he decided to enlist in the U.S. Navy.⁶

Pre-Service History

Romero had no documented mental or physical medical conditions before entering military service.⁷ Although never medically treated, his mother reported that Romero sustained recurring concussions without loss of consciousness while playing competitive hockey.⁸ A review of his recruitment and service record revealed no waivers for any criminal record, or drug, or alcohol abuse.⁹ He completed the Armed Services Vocational Aptitude Battery (ASVAB) with a score of 51, and he was processed into military service at the Military Entrance Processing Station (MEPS) in San Antonio, Texas.¹⁰ The minimum ASVAB score required for enlistment in the active-duty Navy for non-prior service applicants is 31.¹¹ Romero initially applied to be a Steel Worker (SW), but on December 4, 2017, he volunteered for submarine duty as a Machinist Mate (MM).¹² Romero had a full medical screening at MEPS and reported no preexisting mental issues, suicidal thoughts, or depression.¹³

Recruit Training History

Romero reported for recruit training at Naval Station Great Lakes, Great Lakes, Illinois, on December 11, 2017, and graduated on February 3, 2018.¹⁴ On February 3, 2018, he transferred to Naval Submarine School, Groton, Connecticut.¹⁵ He graduated from Machinist Mate Auxiliary “A” School on June 12, 2018.¹⁶ The training record did not reflect the class ranking.¹⁷ He received a follow-on duty assignment to the Fast Attack Submarine USS COLUMBIA (SSN 771), homeported in Pearl Harbor, Hawaii.¹⁸ On June 28, 2018, Romero reported to USS COLUMBIA at JBPHH as a Machinist Mate Auxiliary Fireman Recruit (MMAFR).¹⁹ He had no documented mental health counseling or suicidal behaviors before reporting.²⁰ Overseas and sea duty screening were not required for duty in Hawaii.²¹ Romero underwent a submarine duty physical and submarine duty screening; nothing abnormal was noted.²²

Service History

Romero was assigned to USS COLUMBIA’s auxiliary division. He lived on JBPHH in the barracks at Building 654, Paquet Hall, Room 361.²³ USS COLUMBIA entered Pearl Harbor Naval Shipyard (PHNSY), Dry Dock 2, in October 2018, for a Chief of Naval Operations (CNO) major maintenance availability.²⁴ Within the first six months on board, Romero qualified Barge Security Watch and two armed watch stations: Topside Roving Patrol and Petty Officer of the Deck.²⁵ After these initial qualifications, Romero quickly fell behind in his other qualifications, and the chain of command took administrative action to address exceeding the qualification deadline of 12 months, poor performance, and continued tardiness.²⁶ He received written counseling or extra military instruction on ten separate occasions in the months before the shooting, beginning in June 2019, and he had to attend after-work study periods for his qualification delinquency (see figure 2.1).²⁷ Since he was not qualified in submarine warfare or to stand technical watches, he was mostly assigned non-technical watches on the pier, including the Topside Roving Patrol and Barge Security Watch, which involve continuously roving the area around the submarine and the berthing barge near the dry dock.²⁸

One of the written counseling chits was related to poor watchstanding.²⁹ On September 11, 2019, Romero received a counseling chit for sitting down while on his tour as the

Barge Security Watch.³⁰ The chain of command required Romero to perform a watchstanding upgrade, which was a remedial process that included reviewing watchstanding principles, conducting interviews, and completing a “Barge Security Watch” qualification card.³¹

On November 4, 2019, Romero went on temporary duty for 10 days to the Fast Attack Submarine USS CHICAGO (SSN 721) to finish his remaining practical evolution factors to receive his helmsman qualification and ultimately earn his submarine warfare pin.³² While on the USS CHICAGO, Romero did not interact much with the other Sailors, demonstrated a low level of knowledge, and gave the impression that he did not want to be there.³³ The USS CHICAGO chief of the boat (COB) does not believe the crew of the USS CHICAGO would have discussed the previous suicide of an armed watchstander aboard USS CHICAGO in July 2019 with Romero.³⁴ The USS CHICAGO COB sent Romero back to USS COLUMBIA before his temporary duty was complete for him to build up more knowledge for his qualifications.³⁵

On November 21, 2019, USS COLUMBIA held a disciplinary review board (DRB) to review Romero’s repeated tardiness and qualification delinquency.³⁶ As Romero often did when counseled for poor performance, he began crying at the DRB.³⁷ The chief petty officers’ recommendation from the DRB was to send Romero’s case to executive officer inquiry (XOI).³⁸ On November 26, 2019, Romero was informed that he did not pass the Naval Advancement Exam and would not be promoted to E-4.³⁹

The executive officer (XO) conducted Romero’s XOI on December 3, 2019.⁴⁰ The charge under review was for violation of Article 92, Uniform Code of Military Justice. The specification read, “In that Machinist’s Mate (Auxiliary) Fireman Gabriel A. Romero, U.S. Navy, USS COLUMBIA, on active duty, who knew his duties on board USS COLUMBIA, on or about (5 June, 16 July, 18 July, 11 September, 11 October, 16 October, 29 October 2019), was derelict in the performance of those duties in that he has shown a pattern of misconduct which has resulted in member being late to Ship’s muster times, delinquent study muster times, watch relief times, and duty section muster times.”⁴¹ The XO asked Romero if his mother would be happy if she knew he was squandering the opportunity the Navy gave him.⁴² Romero became emotional and began to cry, expressing he wanted to stay in the Navy.⁴³ The XO did not refer the charge to the commanding officer (CO) for non-judicial punishment (NJP) but decided to issue

Romero formal written counseling or “Page 13.”⁴⁴ The Page 13, which had unsigned signature blocks for the XO and Romero, read in all capital letters above the XO’s signature block, “IF I AM LATE TO WORK AGAIN, I WILL BE HELD ACCOUNTABLE AT CO’S NJP.”⁴⁵ Romero did not sign the Page 13 when ship’s administrative personnel presented it to him after XOI on the same day.⁴⁶ Romero stated he would not sign the Page 13 because the XO had told him that he did not have to sign it until the end of the week, which Romero assumed was Friday.⁴⁷ The ship’s administrative personnel informed the COB, and the COB discussed it with the XO.⁴⁸ The XO intended to clarify it with Romero and deliver the Page 13 personally the next day, December 4, 2019.⁴⁹ The Page 13 was not signed or delivered before the shooting incident.⁵⁰

Service Mental Health History

As stated above, Romero had no prior history of mental health treatment before reporting to USS COLUMBIA.⁵¹ On March 4, 2019, Romero went to the Tripler Army Medical Center (TAMC) emergency room, reporting that he had difficulty focusing at a traffic court hearing earlier in the day.⁵² At TAMC, Romero denied any suicidal or homicidal ideations.⁵³ TAMC staff called a Tripler Police Department Officer to conduct a contraband search as a precautionary measure and contacted the command to provide support.⁵⁴ Romero’s division chief went to the emergency room where TAMC staff told him that Romero was not a risk to harm others or himself.⁵⁵ TAMC personnel noted in the electronic medical record that Romero had a possible Attention Deficit Disorder.⁵⁶ The TAMC attending physician referred him to the Naval Submarine Support Command (NSSC) Embedded Mental Health Program (eMHP) Clinic in Pearl Harbor for further evaluation and treatment.⁵⁷ This referral involved TAMC staff entering it into the electronic medical record and informing Romero.⁵⁸ The eMHP Clinic cannot receive outpatient referrals through the electronic medical record system, and the TAMC staff did not inform the division chief, the eMHP staff, or USS COLUMBIA’s medical department representative (MDR) by telephone, email, or other means. Romero only told his division chief that he was having difficulty sleeping and that he was worried about this (b) (6) health.⁵⁹ Romero did not go to the eMHP Clinic until September 2019 when his

division chief noticed Romero was upset about his (b) (6) declining health and would not express himself to his chief.⁶⁰

Romero went to the eMHP Clinic for eight voluntary visits over three months (see Figure 2.1).⁶¹ On September 23, 2019, Romero was assessed at the eMHP Clinic by a licensed provider, the Submarine Force, U.S. Pacific Fleet (SUBPAC) Force Psychologist.⁶² The Force Psychologist did not diagnose Romero with a mental disorder, but gave him a diagnostic impression of having a “Phase of Life Problem” and an “Unspecified Problem Related to Unspecified Psychosocial Circumstances.”⁶³ Because Romero was not diagnosed with a mental disorder, he remained qualified for submarine duty without any limitations.⁶⁴ The Force Psychologist recommended Romero continue individual therapy with the eMHP staff behavioral health technician, a non-licensed Navy enlisted (E-5) corpsman, to focus on issues related to his (b) (6), his biological (b) (6) failing health, and to teach Romero coping skills.⁶⁵ Romero met with the technician in five separate sessions without the licensed provider present on September 30, October 8, October 16, October 22, and October 30.⁶⁶ At the October 22 session, the technician and Romero agreed that they should discontinue care because all goals had been met.⁶⁷ However, Romero came back for the October 30 session because of what the technician characterized as a miscommunication, and the technician agreed to schedule him for additional peer support sessions.⁶⁸ The Force Psychologist’s supervision of the technician was always after appointments and typically consisted of informal documentation review and editing.⁶⁹ Romero attended peer support sessions on November 19 and November 26, 2019, and his next appointment was scheduled for December 5, 2019.⁷⁰ Romero never expressed suicidal ideations or threats of violence toward others during his eMHP Clinic visits.⁷¹

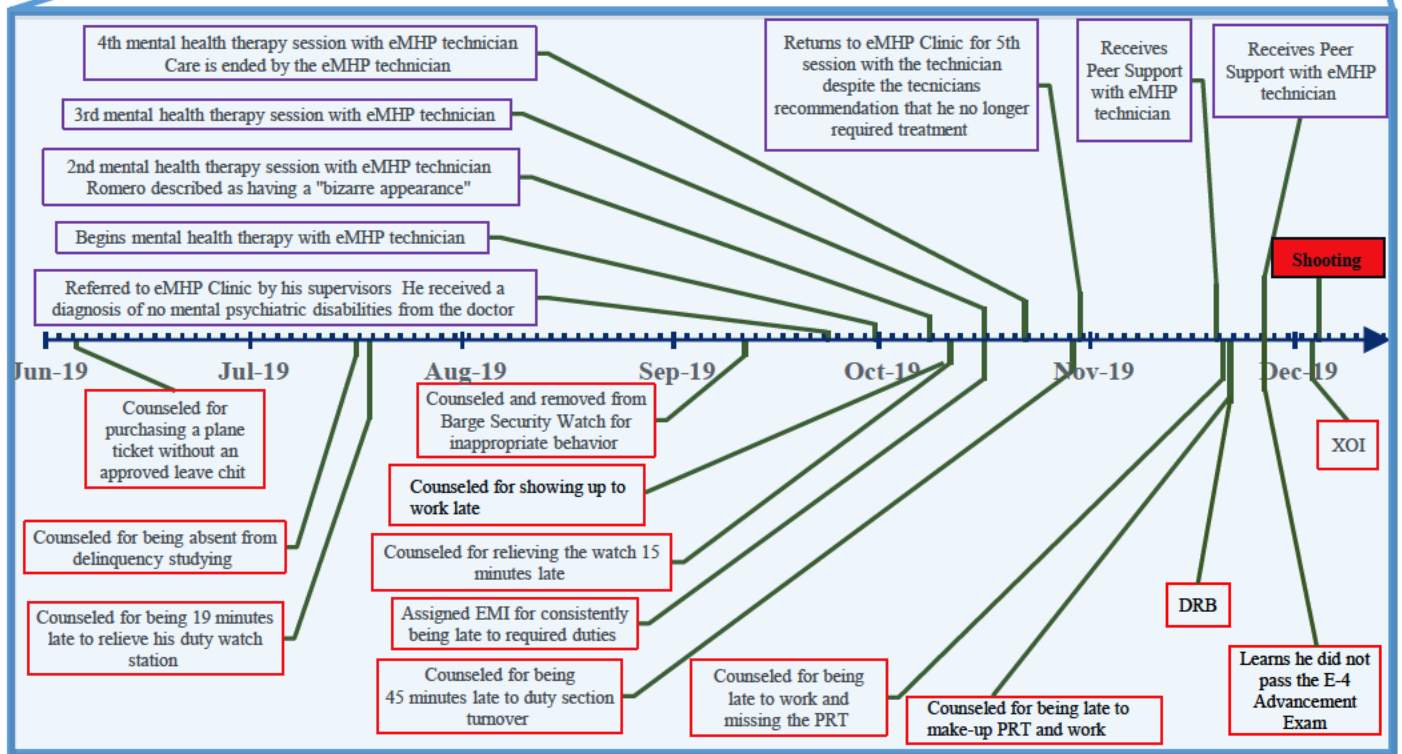
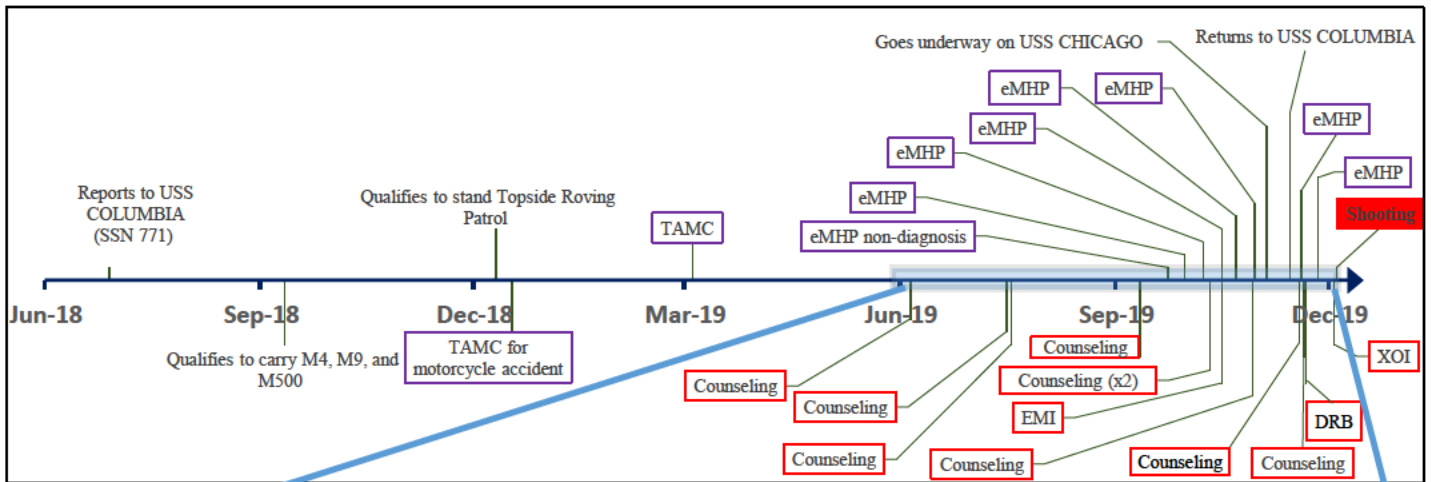


Figure 2.1 Timeline of Romero's Medical and Performance Issues.

Events of December 4, 2019

Actions Leading Up to Watch Relief

On Wednesday, December 4, 2019, a video surveillance system shows Romero returning to his barracks room at 0011, but the key log system records him entering at 0019.⁷² The video surveillance system is not synchronized with the key log system, displaying a 7 to 8 minute time difference.⁷³ Based on the video surveillance system, he left his barracks room at 0313 in civilian attire with a backpack and carrying his military boots to pick up his civilian girlfriend from work and spend time with her.⁷⁴ He returned to his barracks room from his girlfriend's residence at 0738 and left shortly after to go to Ford Island for scheduled small arms sustainment training from 0830 to 1100 in the virtual Firearms Training Simulator (FATS).⁷⁵ Romero called and texted with his girlfriend that morning.⁷⁶ He left no impression with her that anything was wrong.⁷⁷ The last call from Romero to his girlfriend was at 0951.⁷⁸

At the FATS trainer, Romero was described by the instructor, USS COLUMBIA's Torpedoman Chief, as slow and partially responsive.⁷⁹ Romero appeared uncomfortable, but this was not unique to him as this was the first time many of the USS COLUMBIA Sailors had used the simulator.⁸⁰ Romero and other USS COLUMBIA crewmembers practiced shooting virtual targets.⁸¹ They performed proficiency shootings with the M-4 rifle and the M-9 pistol.⁸² Upon completion of small arms training at the FATS trainer, Romero returned to his barracks room at 1312 (according to the video surveillance system) and 1319 (according to the key log system).⁸³ Romero then left his room and drove to PHNSY for duty at USS COLUMBIA, entering the shipyard gate at 1348.⁸⁴

Actions from Watch Relief through Shooting

Romero reported at 1404 for duty as the Topside Roving Patrol.⁸⁵ USS COLUMBIA was in Dry Dock 2 inside the Controlled Industrial Area (CIA) at PHNSY.⁸⁶ The Sailor who Romero relieved described the Topside Roving Patrol watch turnover, and Romero, as ordinary.⁸⁷ The two exchanged the standard words "I am ready to relieve you" and "I am ready to be relieved" just outside the Casualty Control (CASCON) shack on the port side of Dry Dock 2. Romero took possession of the M-4 rifle with 90 rounds of ammunition

and M-9 pistol with 45 rounds of ammunition and made required entries in the duty logbook.⁸⁸

Before Romero began his first roving patrol, he said “I’ll be back” to the Petty Officer of the Deck, the second of two armed watchstanders on USS COLUMBIA, and proceeded to walk from the CASCON shack around Dry Dock 2 from port to starboard.⁸⁹ Around the same time, three PHNSY civilian employees who had been working on USS COLUMBIA earlier in the day left their workstations in a trailer between Dry Docks 2 and 3.⁹⁰ They walked along the starboard side of Dry Dock 2.⁹¹ Romero turned around on the starboard side of Dry Dock 2 before he had circulated the entire dry dock, and he approached the civilian employees from behind.⁹² See Figure 2.2.

The Petty Officer of the Deck observed Romero chamber a round, raise his M-4 rifle, and begin firing at the civilians.⁹³ The three civilians fell to the ground 15-20 feet in front of Romero at the head of Dry Dock 2, near the bow of the submarine.⁹⁴ Two of the victims were fatally wounded.⁹⁵ The third victim suffered a gunshot wound to the pelvic area.⁹⁶

While Romero was firing, the Petty Officer of the Deck in the CASCON shack made radio calls immediately while drawing his weapon.⁹⁷ His first call was over the USS COLUMBIA’s ship announcement circuit, the 1MC, “Repel Boarders.”⁹⁸ He then called “shots fired, shots fired” over the force protection radio and announced on the Command Early Warning Net (CEWN), a base security radio network, that “there was an active shooter at the head of Dry Dock 2.”⁹⁹ The USS COLUMBIA Ship’s Duty Officer (SDO) then called on the ship’s force protection radio to ask what was happening.¹⁰⁰ The Petty Officer of the Deck replied, “Repel Boarders, shots fired, Romero is shooting shipyard workers.”¹⁰¹ While the three victims lay on the ground, and before first responders were on scene, Romero used his M-9 pistol to shoot himself.¹⁰² The shooting only lasted a few seconds from beginning to end.¹⁰³ The surviving victim was conscious enough to make a 911 phone call at 1426.¹⁰⁴ See Figures 2.2. and 2.3.

The first responder on scene was a civilian JBPHH Guard Officer, serving as the CIA Rover “India One.”¹⁰⁵ The guard was out of his patrol vehicle checking the door on Building 214, also known as Shop 67, located on Ingersoll Avenue.¹⁰⁶ While checking the door, a few unknown civilian shipyard employees told him they thought they heard shots fired.¹⁰⁷ The guard got into his patrol vehicle, drove back down Ingersoll Avenue, took a left onto Chosin Street and parked his vehicle about a quarter of the way down Dry

Dock 2 on Chosin Street (see Figure 1.2).¹⁰⁸ After he parked, an unidentified civilian shipyard employee informed him, “I think that guy shot those guys.”¹⁰⁹ The guard also observed about five uniformed members at the “guard shack” (the CASCON).¹¹⁰ He exited his vehicle and observed four people on the ground with one of them moving.¹¹¹ As he approached the scene at 1427, he called the CNRH Regional Dispatch Center (RDC) on his radio to report on the situation and the status of the victims.¹¹² He then was joined by the next responding JBPHH Navy Security Forces (NSF) officer, and they began clearing procedures to look for other active shooters.¹¹³

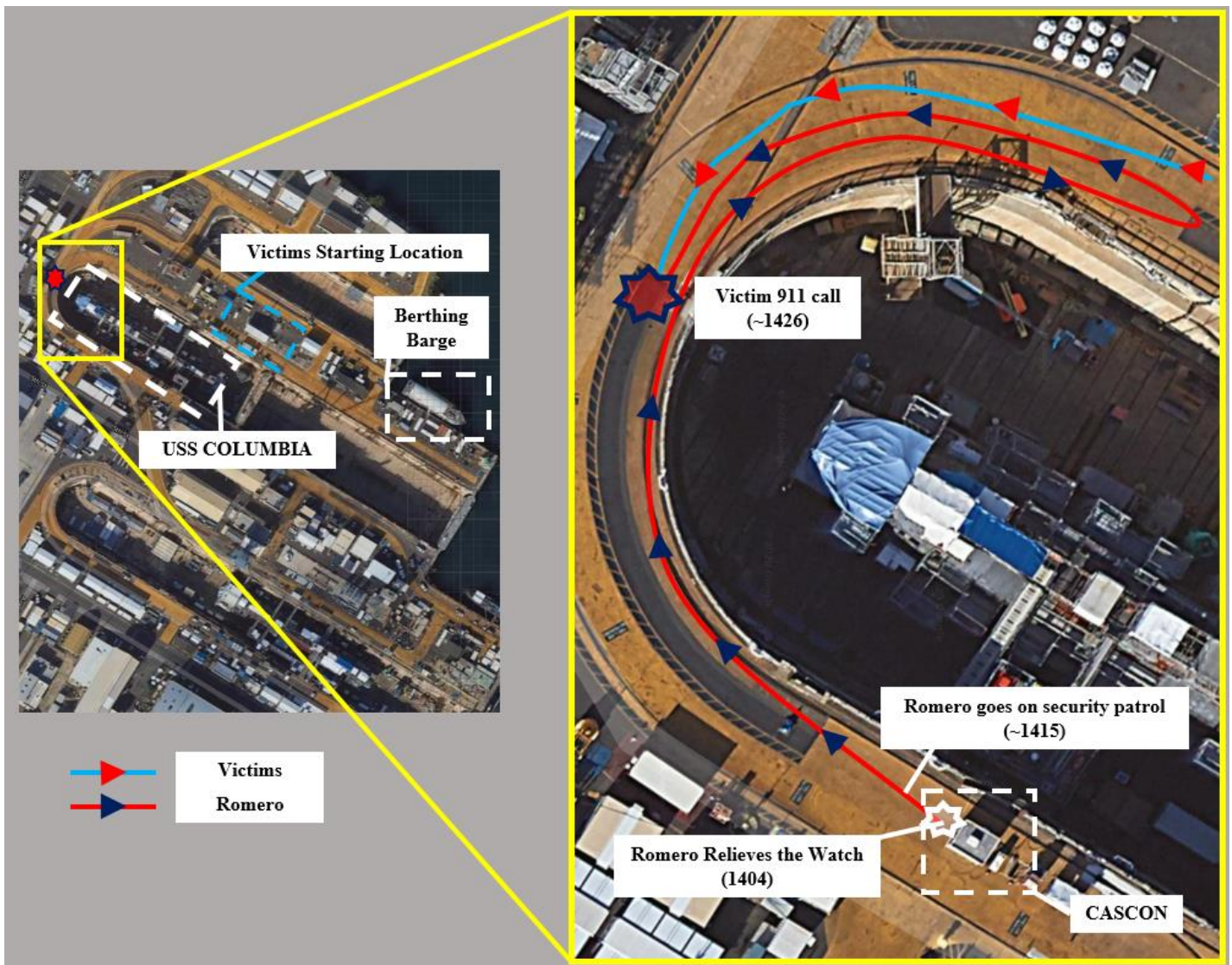


Figure 2.2 Actions from watch relief to shooting incident.
 (Routes depicted in this figure are approximations based on interviews and reports in evidence).



Figure 2.3 Crime scene.¹¹⁴

Immediate Post-Shooting Actions

At the time of the shooting, USS COLUMBIA’s duty chief was at General Military Training with many of the crew on the ship’s berthing barge, which was located at Gun Dock 4 at the end of Dry Dock 2, approximately 200 yards from the shooting scene.¹¹⁵ See Figure 2.2. As the Petty Officer of the Deck called away the incident on the Force Protection Radio, the duty chief and many of the crew heard the word “Fire” on the radio and started to leave the barge to respond to what they thought was a fire casualty.¹¹⁶ Several crewmembers were already on Dry Dock 2 and heading toward the damage control locker behind the CASCON on the port side of the dry dock before the Petty Officer of the Deck informed them that it actually was an active shooter event.¹¹⁷ After

the “Repel Boarders” announcement and learning it was an active shooter, some crewmembers went down to the USS COLUMBIA to arm the ship’s self-defense force while others took cover on the dry dock behind nearby structures.¹¹⁸

The CNRH RDC notified JBPHH NSF and Federal Fire Department (FFD) Hawaii after receiving the 911 phone call at 1426.¹¹⁹ JBPHH NSF was on the scene at 1427.¹²⁰ FFD arrived at 1432 and began rendering aid to the three victims.¹²¹ The surviving victim, (b) [REDACTED], was triaged on Fifth Street.¹²² He was found with a gunshot wound to his pelvis and lower abdomen area with a visible exit wound.¹²³ He was transported to a local hospital at 1452, and later released.¹²⁴ FFD triaged Mr. Roldan Agustin on the yellow concrete roadway just south of Dry Dock 2.¹²⁵ He was found with an anterior gunshot wound to the chest and determined to be asystole (cardiac arrest with no heartbeat).¹²⁶ He was transported to a local hospital at 1504, where he also succumbed to his injuries.¹²⁷ FFD also triaged Mr. Vincent Kapoi, Jr., on a yellow concrete roadway just south of Dry Dock 2.¹²⁸ He was found with a gunshot wound to the left anterior chest and determined to be pulseless, apneic (not breathing), and unresponsive.¹²⁹ He was transported to a local hospital at 1510, where he succumbed to his injuries.¹³⁰ A doctor from TAMC later pronounced Romero deceased at the scene at 1803 due to a traumatic gunshot wound to the head.¹³¹

At 1430, the JBPHH Chief Staff Officer ordered the JBPHH Emergency Operations Center (EOC) to be manned in response to the active shooter incident.¹³² Due to a later lockdown directive, the EOC was never fully manned despite the direction to do so.¹³³

At 1432, the PHNSY Emergency Management Officer (EMO) directed the RDC to send out an Automatic Target Hand-Off Correlator (AtHoc) lockdown alert message to the PHNSY distribution list.¹³⁴ RDC sent it at 1438 within 6 minutes of direction from the PHNSY EMO and 11 minutes after JBPHH NSF arrived on scene.¹³⁵ The JBPHH Commander (JBC) directed the JBPHH Deputy Emergency Management Officer (DEMO) to send an AtHoc lockdown alert message to the surrounding area, but that never occurred because the DEMO mistakenly believed a message he had seen earlier was from JBPHH to the JBPHH distribution list. That AtHoc message was actually from the U.S. Air Force 15th Air Wing command post on the Hickam side of JBPHH.¹³⁶ The U.S. Air Force 15th Wing command post continued to send timely updates to tenant commands every 15 minutes based on information received in the JBPHH EOC.¹³⁷

At 1433, the CNRH Regional Operations Center (ROC) informed the CNRH Public Affairs office of the active shooter incident.¹³⁸ CNRH Public Affairs started to coordinate information for public release and for eventual media queries.¹³⁹ This effort was later joined by the various military public affairs offices in the area and Washington D.C. The first public affairs external release (social media and press release) was issued at 1500 by CNRH and JBPHH, followed by periodic updates.¹⁴⁰

The Naval Criminal Investigative Service (NCIS) was notified of the active shooter incident by a phone call from an NCIS special agent who was attending a meeting with the JBC.¹⁴¹ The NCIS special agent called the NCIS administrative officer who then informed other NCIS personnel.¹⁴² At 1442, NCIS arrived at PHNSY Dry Dock 2.¹⁴³ They would later take the lead in the law enforcement investigation.¹⁴⁴ At 1443, RDC directed the JBPHH EOC to make an active shooter lockdown announcement on the base's Giant Voice system, and the JBPHH EOC made the announcement one minute later at 1444.¹⁴⁵ At 1520, external gates to JBPHH were secured.¹⁴⁶

The Honolulu Police Department (HPD) responded without a direct report or request for support after overhearing radio calls on an integrated channel.¹⁴⁷ HPD arrived approximately 18 minutes after the shooting and proceeded to the Incident Command Post (ICP). HPD would later dispatch 100 officers to include 40 personnel from the Special Weapons and Tactics (SWAT) team, 40 to 50 personnel from the Unit Crime Reduction Patrol and 15 detectives from Criminal Investigation Division (CID).¹⁴⁸ HPD provided support in clearing buildings and interviewing witnesses.¹⁴⁹ Law enforcement personnel, to include NCIS, the Federal Bureau of Investigation (FBI), Air Force Office of Special Investigations (AFOSI), Coast Guard Special Investigations (CGSI), United States Secret Service (USSS) and Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), conducted screening interviews of over 1,000 personnel in the CIA.¹⁵⁰

At 1557, JBPHH main gates reopened.¹⁵¹ At 1637, the RDC logs all clear except for PHNSY.¹⁵² At 2013, "All Clear" was announced on the Giant Voice system.¹⁵³

At 2125, building clearance was completed within the CIA.¹⁵⁴ After the scene was cleared and secured, with the lockdown no longer in effect, approximately 1,000 civilian employees were allowed to exit through the CIA main exit gate at Ingersoll Avenue.¹⁵⁵

Post-Incident Response

On December 4, 2019, Commander, U.S. Pacific Fleet (COMPACFLT) directed each victim's families be assigned military Casualty Assistance Calls Officers (CACOs).¹⁵⁶

On December 5 and December 6, 2019, Human Resources Civilian Benefits Specialists made contact with the victims' families to assist in benefits processing.¹⁵⁷

The PHNSY commander released all hands and employee notifications emails on December 4, 2019 and December 5, 2019.¹⁵⁸ On December 6, 2019, the PHNSY commander, along with Commander, Submarine Force, U.S. Pacific Fleet, conducted three all hands calls with the shipyard workforce.¹⁵⁹ On December 12, 2019, the PHNSY commander emailed the shipyard workforce an update on the investigation.¹⁶⁰

After the incident, regional and local manpower and human resources offices began to coordinate counseling services for impacted military personnel and civilians.¹⁶¹ The Special Psychiatric Rapid Intervention Team (SPRINT) arrived on island on December 8, 2019, and stayed through December 13, 2019.¹⁶² The team interacted with approximately 800 individuals, both active duty and civilian.¹⁶³ The COMPACFLT Director of Civilian Human Resources, COMPACFLT Human Resource Officer, CNRH Director of Total Force and Manpower Management, all made requests to the Department of the Navy (DON) Office of Civilian Human Resources (OCHR) for additional counselors.¹⁶⁴ The counselor contractor, Magellan Health, made additional Civilian Employee Assistance Program (CEAP) counselors available from December 16 through December 20, 2019.¹⁶⁵

There was minimum property damage and associated costs as a result of the incident. Some exterior bullet holes remain in temporary offices, conex boxes, and an electrical transfer box. However, all the components and facilities remain serviceable.¹⁶⁶

Appendix C to this report provides a comprehensive timeline of events.

¹ DD Form 1966/1, of Romero, Gabriel Antonio.

² SI with (b)(6) of 18 Jan 20.

³ DD Form 1966/2, of Romero, Gabriel Antonio.

⁴ SI with (b)(6) of 18 Jan 20.

⁵ *Id.*

⁶ *Id.*; DD Form 1966/1 of Romero, Gabriel Antonio.

⁷ DD Form 2807-1 of Romero, Gabriel Antonio.

⁸ SI with (b)(6) of 18 Jan 20.

⁹ USMEPCOM PCN 680-3ADP, Processee/Enlistee Record of Romero, Gabriel Antonio.

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- ¹⁰ DD Form 1966/2 of Romero, Gabriel Antonio.
- ¹¹ Email from CMDM (b)(6) to LN1 (b)(6) of 25 March 20.
- ¹² Administrative Remarks NAVPERS 1070/613 of Romero, Gabriel Antonio of 4 Dec 17.
- ¹³ USMEPCOM PCN 680-3ADP, Processee/Enlistee Record of Romero, Gabriel Antonio.
- ¹⁴ Electronic Training Jacket of Romero, Gabriel Antonio.
- ¹⁵ USMEPCOM PCN 680-3ADP, Processee/Enlistee Record, of Romero, Gabriel Antonio.
- ¹⁶ Electronic Training Jacket of Romero, Gabriel Antonio; Basic Enlisted Submarine School Training Summary of Romero, Gabriel Antonio.
- ¹⁷ *Id.*
- ¹⁸ *Id.*
- ¹⁹ Career History of Romero, Gabriel Antonio; Electronic Training Jacket of Romero, Gabriel Antonio.
- ²⁰ DD Form 2807-1 of Romero, Gabriel Antonio.
- ²¹ MILPERSMAN 1300-304.
- ²² Basic Enlisted Submarine School Training Summary of Romero, Gabriel Antonio; Email from CAPT (b)(6) to CDR (b)(6) of 24 Jan 20.
- ²³ NCIS Report of Investigation of 2 Jan 20, Exhibit 39 ¶ 1.
- ²⁴ USS COLUMBIA FY19 Extended Overhaul Information Sheet.
- ²⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 34, Enclosure C.
- ²⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 32.
- ²⁷ NCIS Report of Investigation of 2 Jan 20, Exhibit 32, Enclosure A.
- ²⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 53.
- ²⁹ Record of Counselings of Romero, Gabriel Antonio page 6.
- ³⁰ *Id.*
- ³¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 32, Enclosure B.
- ³² SI with FTCM (b)(6) of 15 Jan 20.
- ³³ *Id.*
- ³⁴ SI with FTCM (b)(6) of 15 Jan 20; LODI ICO ETV3 (b)(6).
- ³⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 66; SI with FTCM (b)(6) of 15 Jan 20.
- ³⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 33.
- ³⁷ NCIS Report of Investigation of 2 Jan 20, Exhibit 34 ¶ 4; Exhibit 33 ¶ 7.
- ³⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 33 ¶ 3; NCIS Report of Investigation of 2 Jan 20, Exhibit 36 ¶ 2.
- ³⁹ NCIS Report of Investigation of 2 Jan 20, Exhibit 5 ¶ 5.
- ⁴⁰ SI with LCDR (b)(6) of 17 Jan 20; NAVPERS 1626/7 Report and Disposition of Offenses of 3 Dec 19.
- ⁴¹ NAVPERS 1626/7 Report and Disposition of Offenses of 3 Dec 19.
- ⁴² NCIS Report of Investigation of 2 Jan 20, Exhibit 36.
- ⁴³ *Id.*
- ⁴⁴ SI with LCDR (b)(6) of 17 Jan 20.
- ⁴⁵ NAVPERS 1626/7 Report and Disposition of Offenses of 3 Dec 19.
- ⁴⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 36 ¶ 4.
- ⁴⁷ NCIS Report of Investigation of 2 Jan 20, Exhibit 36; NCIS Report of Investigation of 2 Jan 20, Exhibit 32 ¶ 4.
- ⁴⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 36.
- ⁴⁹ *Id.*
- ⁵⁰ *Id.*
- ⁵¹ DD Form 2807-1 of Romero, Gabriel Antonio; Email from CAPT (b)(6) to CDR (b)(6) of 24 Jan 20.
- ⁵² TAMC Emergency Room Chronology of Care of 4 Mar 19.
- ⁵³ *Id.*
- ⁵⁴ SI with MMAC (b)(6) of 14 Jan 20.
- ⁵⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 33; SI with MMAC (b)(6) of 14 Jan 20.
- ⁵⁶ TAMC Emergency Room Chronology of Care of 4 Mar 2019.
- ⁵⁷ *Id.*
- ⁵⁸ *Id.*; NSSC Mental Health Clinic Encounter of 26 Nov 19.
- ⁵⁹ SI with MMAC (b)(6) of 14 Jan 20.
- ⁶⁰ NCIS Report of Investigation of 2 Jan 20, Exhibit 33 ¶ 5.

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- ⁶¹ NSSC Mental Health Clinic Encounters from 23 Sep 19 to 26 Nov 19.
- ⁶² SI with CDR (b)(6) of 15 Jan 20.
- ⁶³ *Id.*
- ⁶⁴ *Id.*
- ⁶⁵ *Id.*
- ⁶⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 65 ¶ 5-10; SI with HM2 (b)(6) of 15 Jan 20.
- ⁶⁷ NSSC Mental Health Clinic Encounter of 22 Oct 19.
- ⁶⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 65 ¶ 10.
- ⁶⁹ SI with HM2 (b)(6) of 15 Jan 20.
- ⁷⁰ NCIS Report of Investigation of 2 Jan 20, Exhibit 65 ¶ 12.
- ⁷¹ SI with HM2 (b)(6) of 15 Jan 20.
- ⁷² NCIS Report of Investigation of 2 Jan 20, Exhibit 39, Enclosure A; NCIS Report of Investigation of 2 Jan 20, Exhibit 40 ¶ 7.
- ⁷³ NCIS Report of Investigation of 2 Jan 20, Exhibit 40 ¶ 3.
- ⁷⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 31 ¶ 4; NCIS Report of Investigation of 2 Jan 20, Exhibit 40, ¶ 7.
- ⁷⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 40 ¶ 5; SI with TMC (b)(6) of 16 Jan 20.
- ⁷⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 31 ¶ 15; NCIS Report of Investigation of 2 Jan 20, Exhibit 43 ¶ 6.
- ⁷⁷ *Id.*; NCIS Report of Investigation of 2 Jan 20, Exhibit 52 ¶ 3.
- ⁷⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 31 ¶ 15.
- ⁷⁹ NCIS Report of Investigation of 2 Jan 20, Exhibit 34 ¶ 4.
- ⁸⁰ SI with TMC (b)(6) of 16 Jan 20.
- ⁸¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 34 ¶ 2.
- ⁸² *Id.*
- ⁸³ NCIS Report of Investigation of 2 Jan 20, Exhibit 39, Enclosure A; NCIS Report of Investigation of 2 Jan 20, Exhibit 40, Enclosure 3.
- ⁸⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 41.
- ⁸⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 53, Enclosure G.
- ⁸⁶ Photos of USS COLUMBIA (SSN 771).
- ⁸⁷ SI with ETR2 (b)(6) of 22 Jan 20.
- ⁸⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 53, Enclosure G.
- ⁸⁹ SI with (b)(6) of 22 Jan 20.
- ⁹⁰ NCIS Report of Investigation of 2 Jan 20, Exhibit 8 ¶ 3.
- ⁹¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 9 ¶ 2.
- ⁹² SI with (b)(6) of 22 Jan 20. Video surveillance and other available evidence does not establish whether Romero and the victims crossed paths before Romero turned around on Dry Dock 2 an approached them from behind.
- ⁹³ *Id.* Based on shell casings and weapon magazines recovered at the scene, Romero fired eight (8) rounds with his M-4 rifle and three (3) rounds with his M-9 pistol. NCIS Report of Investigation of 2 Jan 20, Exhibit 54 ¶ 26.
- ⁹⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 5 ¶ 3.
- ⁹⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 48-49.
- ⁹⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 28 ¶ 4.
- ⁹⁷ SI with ETR2 (b)(6) of 22 Jan 20.
- ⁹⁸ *Id.*
- ⁹⁹ *Id.*
- ¹⁰⁰ SI with MMAC (b)(6) of 14 Jan 20.
- ¹⁰¹ SI with MMAC (b)(6) of 14 Jan 20; SI with ETR2 (b)(6) of 22 Jan 20.
- ¹⁰² SI with ETR2 (b)(6) of 22 Jan 20.
- ¹⁰³ NCIS Report of Investigation of 2 Jan 20, Exhibit 5 ¶ 4.
- ¹⁰⁴ *Id.*; CNRH Incident History Log of 4 Dec 19.
- ¹⁰⁵ SI with Guard Officer (b)(6) of 22 Jan 20.
- ¹⁰⁶ *Id.*
- ¹⁰⁷ *Id.*
- ¹⁰⁸ *Id.*
- ¹⁰⁹ *Id.*

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- ¹¹⁰ SI with Guard Officer (b)(6) of 13 Jan 20.
- ¹¹¹ SI with Guard Officer (b)(6) of 22 Jan 20.
- ¹¹² *Id.*; CNRH Incident History Log of 4 Dec 19; PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19.
- ¹¹³ SI with Guard Officer (b)(6) of 13 Jan 20; SI with Guard Officer (b)(6) of 22 Jan 20.
- ¹¹⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 54, Enclosure A.
- ¹¹⁵ SI with MMAC (b)(6) of 14 Jan 20; PHNSY & IMF Map.
- ¹¹⁶ SI with LCDR (b)(6) of 13 Jan 20; SI with LTJG (b)(6) of 14 Jan 20; SI with MMAFN (b)(6) of 14 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20.
- ¹¹⁷ SI with MMA3 (b)(6) of 13 Jan 20; SI with LTJG (b)(6) of 14 Jan 20; SI with MMN2 (b)(6) of 13 Feb 20.
- ¹¹⁸ SI with MMA2 (b)(6); SI with MMAFN (b)(6) of 13 Jan 20; SI with LT (b)(6) of 14 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20.
- ¹¹⁹ PHNSY & IMF Security Incident Checklist; CNRH Incident History Log of 4 Dec 19.
- ¹²⁰ PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19.
- ¹²¹ *Id.*; Computer Aided Dispatch Report of 4 Dec 19.
- ¹²² NCIS Report of Investigation of 2 Jan 20, Exhibit 1 ¶ 2.
- ¹²³ NCIS Report of Investigation of 2 Jan 20, Exhibit 60, Enclosure A; NCIS Report of Investigation of 2 Jan 20, Exhibit 28.
- ¹²⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 60, Enclosure A, page 5.
- ¹²⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 1 ¶ 3.
- ¹²⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 60, Enclosure A, page 10-11.
- ¹²⁷ *Id.* at page 10.
- ¹²⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 1 ¶ 3.
- ¹²⁹ NCIS Report of Investigation of 2 Jan 20, Exhibit 60, Enclosure A, page 14.
- ¹³⁰ *Id.* at page 13.
- ¹³¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 54 ¶ 20.
- ¹³² PHNSY & IMF Security Incident Checklist; CNRH Incident History Log of 4 Dec 19.
- ¹³³ SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 21 Jan 20.
- ¹³⁴ PHNSY & IMF ECC Timeline, Chronological Record of Events.
- ¹³⁵ *Id.*; CNRH Incident History Log of 4 Dec 19; DoDI 6055.17, § 5.5 ¶ a(1-3); JBPHHINST 3440.17D Emergency Management Plan, Annex 21; SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 21 Jan 20.
- ¹³⁶ SI with (b)(6) of 21 Jan 20; Annex A: Joint Base Emergency Operations Center of Sep 18 ¶ 2(c).
- ¹³⁷ CNRH Lessons Learned.
- ¹³⁸ CNRH PAO Lessons Learned; SI with (b)(6) of 13 Jan 20.
- ¹³⁹ SI with CDR (b)(6) OF 17 Jan 20; CNRH PAO Lessons Learned.
- ¹⁴⁰ CNRH PAO Lessons Learned; CNRH PAO External Communications.
- ¹⁴¹ SI with SSA (b)(6), NCIS of 12 Feb 20.
- ¹⁴² *Id.*
- ¹⁴³ NCIS Report of Investigation of 2 Jan 20, Exhibit 54 ¶ 1.
- ¹⁴⁴ *Id.*; SI with SSA (b)(6), NCIS of 12 Feb 20.
- ¹⁴⁵ CNRH Incident History Log of 4 Dec 19; Incident Action Plan of 4 Dec 19 to 5 Dec 19.
- ¹⁴⁶ Incident Action Plan of 4 Dec 19 to 5 Dec 19.
- ¹⁴⁷ SI with CAPT (b)(6), HPD of 21 Jan 20.
- ¹⁴⁸ *Id.*
- ¹⁴⁹ *Id.*
- ¹⁵⁰ SI with SSA (b)(6), NCIS of 12 Feb 20.
- ¹⁵¹ CNRH Incident History Log of 4 Dec 19.
- ¹⁵² *Id.*
- ¹⁵³ *Id.*
- ¹⁵⁴ PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19.
- ¹⁵⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 58 ¶ 2.
- ¹⁵⁶ SI with (b)(6) of 15 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 10 Jan 20.

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- ¹⁵⁷ SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 16 Jan 20.
- ¹⁵⁸ Email from CAPT (b)(6) to All Hands of 4 Dec 19; Email from (b)(6) to All Hands of 4 Dec 19; Email from CAPT (b)(6) to All Hands of 5 Dec 19.
- ¹⁵⁹ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 13 Jan 20.
- ¹⁶⁰ Email from CAPT (b)(6) to All Hands of 12 Dec 19.
- ¹⁶¹ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 17 Jan 20.
- ¹⁶² After Action Report ICO SPRINT of 7 Jan 20.
- ¹⁶³ Email from CDR (b)(6) to (b)(6) of 5 Feb 20.
- ¹⁶⁴ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 10 Jan 20.
- ¹⁶⁵ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 17 Jan 20.
- ¹⁶⁶ Email from (b)(6) to (b)(6) of 22 Jan 20.

Chapter 3 – Embedded Mental Health Program

This chapter examines Romero’s treatment at the Naval Submarine Support Command (NSSC) Embedded Mental Health Program (eMHP) Clinic in Pearl Harbor. The investigation team’s practicing forensic psychiatrist did not evaluate Romero before his death, but the forensic psychiatrist’s expert assessment informs this chapter of the report.¹

Several warfare communities have embraced the eMHP in recent years. The eMHP model is designed to increase access to treatment, tailor treatment to unique warfare community needs, and decrease the stigma of seeking mental health treatment.² The program delivers clinical care, counseling, coaching, command liaison, outreach, education, and training.³ Between 2013 and 2016, the submarine community conducted an eMHP pilot program, and it became a program of record in 2016.⁴

The Submarine eMHP enhances readiness through an early intervention and preventive approach.⁵ The submarine community embraced the eMHP, at least in part as a means to decrease “unplanned losses,” a term that includes Sailors who are disqualified from submarine duty, often as a consequence of a mental disorder.⁶

Regulatory Background

DoDD 5124.02 (Under Secretary of Defense for Personnel and Readiness (USD (P&R))) updates the responsibilities, functions, relationships, and authorities of the USD (P&R).

DoDI 6400.06 (Periodic Health Assessment Program) establishes policy, assigns responsibilities, and prescribes procedures for implementing the Periodic Health Assessment program.

DoDI 6490.03 (Deployment Health) implements policies for joint and Service-specific deployments to monitor, assess, and prevent disease and injury; control or reduce occupational and environmental health risks; document and link occupational and

environmental exposures with deployed personnel; record the daily locations of deployed personnel; and conduct individual deployment-related health assessments.

DoDI 6490.04 (Mental Health Evaluations) establishes policy, assigns responsibilities, and prescribes procedures for referral, evaluation, treatment, and command management of Service members who may require assessment for mental health issues.

DoDI 6490.05 (Maintenance of Psychological Health) establishes policy and assigns responsibilities for developing combat and operational stress control (COSC) programs.

DoDI 6490.06 (Counseling Services for DoD Military & Others) establishes and implements counseling policies, and identifies and assigns responsibilities for providing counseling support in accordance with DoD Directive 5124.02.

DoDI 6490.08 (Command Notification Requirements) establishes policy, assigns responsibilities, and prescribes procedures for healthcare providers for determining command notifications as applied to Service members in mental health care or voluntarily seeking drug and alcohol abuse education.

OPNAVINST 1720.4B (Suicide Prevention) delineates Navy suicide prevention policies.

OPNAVINST 6400.1D Training, Certification, Supervision and Employment of Independent Duty Corpsmen (IDC), Hospital Corpsman HM-8402 Submarine Force IDC, HM-8403 Fleet Marine Force Reconnaissance IDC, HM-8425 Surface Force IDC, and HM-8494 Deep Sea Diving IDC.

Manual of the Medical Department (MANMED), Chapter 15, delineates physical qualification standards for all Naval personnel to include all special duty physicals.

CSLCSPINST 6000.2 (Standard Submarine Medical Procedures Manual) provides consolidated guidance for submarine medical departments.

CSLCSPINST 6490.1 (Submarine Force eMHP) sets forth the guidance on execution of the Submarine eMHP.

Findings-Opinions-Recommendations

Finding 3.1 (Potential Contributing/Noncompliance/Deficiency): The eMHP provider under-diagnosed and did not properly manage Romero’s mental health condition during eight visits to the eMHP Clinic between September and November 2019. The eMHP provider only diagnosed “Phase of Life Problems” and “Unspecified Problem Related to Unspecified Psychosocial Circumstances” when Romero showed signs of an undiagnosed mental disorder that likely would have disqualified him from submarine duty.⁷ Seven of eight visits to the eMHP Clinic were with the behavioral health technician and not the eMHP provider.⁸

Discussion: Romero saw military mental health professionals on nine separate occasions from March to December 2019.⁹ He drove himself to the Tripler Army Medical Center (TAMC) emergency room on March 4, 2019, after attending traffic court for a speeding ticket and reported that he was having difficulty “concentrating, focusing, and staying engaged.”¹⁰ At TAMC, Romero denied any suicidal or homicidal ideations.¹¹ TAMC staff called a Tripler Police Department Officer to conduct a contraband search as a precautionary measure and contacted the command to provide support.¹² Romero’s division chief went to the emergency room where TAMC staff told him that Romero was not a risk to harm others or himself.¹³ TAMC staff noted possible Attention Deficit Disorder in Romero’s electronic medical record and referred him to the NSSC eMHP Clinic in Pearl Harbor before discharging him on his own recognizance.¹⁴ This referral involved TAMC staff entering it into the electronic medical record and informing Romero.¹⁵ The eMHP Clinic cannot receive outpatient referrals through the electronic medical record system, and the TAMC staff did not inform the division chief, the eMHP staff, or USS COLUMBIA’s medical department representative (MDR) of the referral by other means.¹⁶ Romero only told his division chief that he was having difficulty sleeping and that he was worried about this (b) (6) health.¹⁷

NSSC eMHP Clinic Visits

Romero did not go to the eMHP Clinic until September 2019 when his division chief noticed Romero was upset about his (b) (6) declining health and would not express himself to his chief.¹⁸ The chief of the boat (COB) arranged an urgent appointment with the eMHP Clinic.¹⁹ An eMHP licensed independent provider, the Submarine Force, U.S. Pacific Fleet (SUBPAC) Force Psychologist, evaluated Romero on September 23, 2019.²⁰ His evaluation consisted of a 90-minute clinical interview and a health record review.²¹ In evaluation notes, the Force Psychologist described Romero as “odd, awkward, guarded, and confused.”²² On his intake questionnaire, Romero reported his reason for coming to mental health as “myself Fireman Romero was referred by [behavioral health technician] and having problems with mood, stress.”²³ He identified his top three treatment goals as “call father more; think about the future; take the time to relax.” On his intake questionnaire, Romero scribbled circles around several problem areas, to include, “I feel no interest in things” (Frequently); “I have difficulty concentrating” (Almost Always); “I feel something is wrong with my mind” (Frequently); “I feel hopeless about the future” (Sometimes); “Disturbing thoughts come to my mind that I can’t get rid of” (Sometimes); and “I feel like something bad is going to happen” (Sometimes).²⁴ His intake revealed an overall elevation on Outcome Question (OQ-45) of 81, a score consistent with mental health diagnosis for patients in treatment.²⁵ He denied any history of violent behavior, mental health treatment, thoughts of suicide or harming others, and he indicated that he felt safe with work access to firearms.²⁶

During this initial evaluation, the Force Psychologist did not note Romero’s March 4, 2019 TAMC emergency room visit in his electronic notes.²⁷ The Force Psychologist stated that he reviewed the electronic notes from the emergency room visit but did not find the visit significant.²⁸ The Force Psychologist did not diagnose Romero with a mental disorder, but gave him a diagnostic impression of having a “Phase of Life Problem” and an “Unspecified Problem Related to Unspecified Psychosocial Circumstances.”²⁹ Romero remained qualified for submarine duty without limitations.³⁰

The Force Psychologist recommended continuing individual therapy with the staff behavioral health technician to focus on issues related to his (b) (6), his

(b) (6) health problems, and to teach coping skills.³¹ The Force Psychologist did not have another in-person encounter with Romero, but the behavioral health technician, a non-licensed Navy enlisted (E-5) corpsman, saw Romero for individual therapy sessions without the Force Psychologist or other licensed provider.³² The Force Psychologist's supervision was always after the appointments and typically consisted of informal documentation review and editing.³³ These seven sessions with the behavioral health technician continued up until the time of the shooting incident (with the final two sessions labeled "peer support" after Romero agreed to discontinue care).³⁴ The Force Psychologist did not reevaluate Romero before the therapy sessions were discontinued or when he returned for the peer support sessions.³⁵

The responsibilities of the assigned eMHP staff behavioral health technician are enumerated in the eMHP Submarine Force instruction.³⁶ The behavioral health technician is responsible for providing administrative and clinical support as necessary to meet the mission of the eMHP team.³⁷ This support includes: "Under the supervision of the eMHP provider, function as a 'care extender' by conducting intake and special program interviews, deliver training topics relative to eMHP and supervise group sessions; and perform appropriate triage upon intake to determine acuity of individual patients."³⁸ Supplemental guidance on the appropriate scope of practice calls into question whether a behavioral health technician can provide individual counseling in a clinic setting without the presence of a licensed independent provider.³⁹

Forensic Psychiatrist Case Review Summary⁴⁰

The investigation team's forensic psychiatrist conducted a thorough review of Romero's personal, service, and medical history as part of the investigation. Based on a forensic review of all the available evidence after the shooting incident, he identified a pattern of behavior in Romero that associated with a mental disorder.

The prioritized likelihood of diagnosis (beginning with most likely) were the following: Autistic Spectrum Disorder; Attention Deficit and Hyperactivity Disorder; Social Anxiety Disorder; Personality Disorder (Avoidant and Borderline features); Anxiety Disorder; Depressive Disorder; and Adjustment Disorder. Such diagnosis are likely to be

disqualifying for submarine duty except Adjustment Disorder, and this minimum diagnosis would have needed to resolve in 90 days for him to remain on submarine duty.

In the investigation team forensic psychiatrist's opinion, Romero was likely under-diagnosed during his only appointment with a licensed mental health provider, and as a consequence, his condition was managed inadequately. The concern expressed by the command to get Romero an appointment and Romero's odd, awkward, guarded, and confused presentation on September 23, 2019, likely warranted additional diagnostic assessment. Romero's visit to the TAMC emergency room on March 4, 2019, was not acknowledged in the eMHP Clinic records until his third appointment, which was with the behavioral health technician. The "Phase of Life Problems" and "Unspecified Problem Related to Unspecified Psychosocial Circumstances" diagnoses were effectively non-diagnoses, so resilience-enhancing counseling and coaching from the behavioral health technician is indicated, not mental health treatment. No documentary evidence showed improvement or response to interventions, or assessment of outcome measures.

A more collaborative approach with the benefit of collateral history from the chain of command may have resulted in a more accurate diagnosis, and more intensive treatment. For example, his shipmates described Romero's pattern of social avoidance and socially awkwardness with him often appearing odd or eccentric. His shipmates universally saw him as extremely reserved socially. He also demonstrated anger management deficits, e.g., punching a locker, and distractibility, getting into a single motorcycle accident in December 2018 (which was documented in his medical record) and a minor single car accident in November 2019 (which was not documented in his medical record).

In the forensic psychiatrist's opinion, no one could have anticipated Romero's homicidal and suicidal actions on December 4, 2019. He had no history of violent behavior nor had he made any homicidal or suicidal ideations.

However, the risk was elevated because of several factors, including occupational stress and a lack of social support. He was repeatedly counseled for poor work performance including at executive officer inquiry (XOI) the day before the shooting. He was delinquent on qualifications and isolated from his shipmates. He complained that people treated him badly, called him stupid, and he described a hostile work environment to his

mother. He was single and separated from family, with his (b) (6) in declining health. Romero dated two women while assigned to USS COLUMBIA in Pearl Harbor, but these relationships were chaotic. He regularly exhibited jealousy and insecurity during the relationships.

Romero visited his girlfriend in the early morning hours on the day of shooting. He previously reported to eMHP staff that he was tired and having trouble sleeping. Sleep deprivation degrades cognitive performance and emotional control while exacerbating distractibility and impulsivity.

NSSC eMHP Clinic Perspective and “Z-Code” Analysis

The Force Psychologist made a reasonable argument for his non-diagnosis of any disorder.⁴¹ He explained that the submarine community selects many Sailors who present themselves just like Romero.⁴² These Sailors have decent analytic skills, good scores on the Armed Services Vocational Aptitude Battery (ASVAB), and yet some have poor social skills.⁴³ In the Force Psychologist’s opinion, if the Navy disqualified all submariners similar to Romero based on the indicators at the time, disqualification from submarine duty would noticeably increase and have a negative impact on readiness.⁴⁴

The diagnostic data for the last two years indicates that the eMHP Clinic relies heavily on what are known as “Z-codes” as primary diagnosis to allow the eMHP to execute the “Resiliency Approach” by providing coping skills, and in turn, reduce unplanned losses in the submarine community.⁴⁵ Z-codes like those in Romero’s case are diagnostic descriptors that describe patients who do not have known mental disorders, but do have some circumstance or problem in their lives that influence their health status.⁴⁶ Z-codes are more often diagnosed as secondary codes, such as when a phase of life problem or occupational problem supplements a primary diagnosis like Major Depressive Disorder.⁴⁷

The eMHP diagnostic data shows unusually high rates of Z-codes that are not mental disorders.⁴⁸ For example, the eMHP provider with the most encounters in 2018 and 2019 provided 1072 diagnostic codes among 1002 patients; of the overall diagnostic codes, 617 were Z-codes (57%).⁴⁹ Z-codes are a less frequent primary diagnosis in other psychiatry or psychology settings.⁵⁰ By comparison, the Mental Health Clinic at

Makalapa and Kaneohe Bay, the Substance Abuse Clinic at Makalapa, and the Integrated Medicine Clinic at Makalapa and Kaneohe Bay gave 5,308 diagnoses in 2018 and 1,379 were Z-codes (26%).⁵¹

The eMHP staff acknowledged that determining a Sailor was Not Physically Qualified (NPQ) was at least a factor in diagnosis.⁵² The SUBPAC Force Psychiatrist, who exercises oversight of the eMHP Clinic, explained that when disqualification decisions are close, eMHP providers must have a good medical explanation for why they are disqualifying a Sailor from submarine duty.⁵³ The enlisted behavioral health technician stated that they generally use Z-codes to avoid NPQ, but he believed these non-diagnoses were accurate for submariners in most cases.⁵⁴

The SUBPAC Force Medical Officer challenged the suggestion that the preference to maintain patients on submarine duty affected the accuracy of diagnosis.⁵⁵ Although some eMHP staff acknowledged a predisposition toward Z-codes and a belief that Romero would have received an Adjustment Disorder diagnosis at a military treatment facility (MTF), they steadfastly maintained Romero's case did not warrant a mental disorder diagnosis during eMHP Clinic visits.⁵⁶ The SUBPAC Force Medical Officer also contended that the eMHP reduces risk because more Sailors get treatment earlier.⁵⁷ The higher rate of Z-codes may be attributable to providers being closer to the waterfront, interacting more with Sailors, and intervening earlier before problems morph into mental health disorders.⁵⁸ In the SUBPAC Force Medical Officer's opinion, the eMHP's assets include timely access to mental health care and submarine cultural competence.⁵⁹

Opinion 3.1.1: The eMHP provider, the Force Psychologist, under-diagnosed and inadequately managed Romero's mental condition.⁶⁰ An accurate diagnosis likely would have disqualified Romero from submarine duty.⁶¹

Opinion 3.1.2: Through early intervention and prevention, the eMHP is designed to enhance resilience and well-being, but Romero's care and eMHP Clinic diagnostic data indicate a potential pattern of under-diagnosis to maintain patients on submarine duty.⁶²

Opinion 3.1.3: The Force Psychologist did not properly supervise the behavioral health technician's care of Romero.⁶³

Opinion 3.1.4: The eMHP staff behavioral health technician operated outside of his clinical scope of practice, as delineated in the eMHP Submarine Force instruction.⁶⁴

Opinion 3.1.5: The eMHP staff who treated Romero could not have reasonably predicted his violent behavior.⁶⁵ He had no prior history of violence, and he denied homicidal or suicidal ideations.⁶⁶ However, several factors increased risk of destructive behavior, including significant occupational stress and lack of social support.⁶⁷

Opinion 3.1.6: The eMHP Clinic's lack of capability to receive outpatient referrals through the electronic medical record system negatively impacted the transition of care.⁶⁸ The eMHP Clinic and USS COLUMBIA MDR were not notified of Romero's referral to the eMHP Clinic after his March 4, 2019 TAMC emergency room visit.⁶⁹

Recommendation 3.1.1: Command Surgeon, U.S. Fleet Forces Command, as Privileging Authority, in coordination with Commander Submarine Forces, conduct a quality assurance investigation into the clinical practice of the Force Psychologist with particular attention to any pattern of under-diagnosis and the behavioral health technician's scope of practice without direct supervision.

Recommendation 3.1.2: BUMED, in coordination with Type Commanders, conduct a comprehensive review of the eMHP to determine whether there is a broader pattern of under-diagnosis and to clarify the proper role and scope of practice of behavioral health technicians. The review should also include manning, patient/provider ratios, facilities, and reporting tripwires to commands.

Recommendation 3.1.3: BUMED, in coordination with Commander Submarine Forces, evaluate MANMED policy regarding Disqualifying Mental Health Conditions for Submarine Duty.

Recommendation 3.1.4: Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC), install outpatient electronic record terminals in the NSSC eMHP Clinic and request official clinic designation from TAMC in order to receive electronic referrals.

Finding 3.2 (Potential Contributing/Noncompliance/Deficiency): Contrary to the Submarine Force eMHP instruction, the eMHP Clinic did not present a unified plan among the chain of command, patient, and provider regarding Romero’s mental health treatment as required.⁷⁰ The eMHP Clinic staff did not collaborate with Romero’s chain of command because he did not meet any exception to the Department of Defense (DoD) policy on confidentiality.⁷¹ The eMHP Clinic staff’s interpretation of DoD policy imposed a barrier on information sharing and collaboration with the chain of command.⁷²

Discussion: Throughout Romero’s eight sessions at the eMHP Clinic from September to November 2019, no one from the eMHP Clinic consulted with the USS COLUMBIA’s chain of command.⁷³ Although some members of Romero’s chain of command were aware that Romero was receiving some type of counseling, they were not aware of any particular concerns about his mental health, the frequency of visits, or safety plans discussed with him.⁷⁴ The MDR for the USS COLUMBIA, Romero’s primary care provider and the person responsible for the ship’s medical program, denied any knowledge of Romero’s eMHP Clinic visits before the shooting.⁷⁵ When the MDR completed Romero’s annual Physical Health Assessment (PHA)/Mental Health Assessment (MHA) on October 9, 2019, Romero indicated “No” or “Not Applicable” on every question related to mental health.⁷⁶ If the MDR would have reviewed Romero’s health records, they would have included his initial eMHP Clinic encounter.⁷⁷

The cornerstone of the Submarine eMHP is the “Resiliency Approach” that is centered on presenting a unified plan between the chain of command, patient, and mental health provider.⁷⁸ Not soliciting information from the command gives a one-sided picture and limits the command’s ability to tailor leadership, support, and accommodation to the member’s specific needs.⁷⁹ The USS COLUMBIA chain of command had information that could have aided Romero’s evaluation and treatment plan.⁸⁰ For example, eMHP providers might have learned more about Romero’s two previous visits to the TAMC emergency room (a December 2018 visit for a motorcycle accident and the March 4, 2019 visit); his many counseling chits; the disciplinary review board (DRB) prior to his last eMHP visit; his presence on the delinquent qualification list for over 6 months; the frequency of his armed watches; and the fact that he rarely, if ever, socialized with any USS COLUMBIA shipmates.⁸¹

DoD Instruction 6490.08 directs mental health providers to follow a presumption of not informing a patient's chain of command.⁸² If the presumption is not overcome by an enumerated exception, then "there shall be no command notification."⁸³ If the presumption is overcome, then the minimum amount of information is to be provided to the commander to serve the purpose of the disclosure.⁸⁴ Some of the nine exceptions allowing for communication to the command are common, for example, harm to self or harm to others.⁸⁵ However, several of the exceptions are open to interpretation, and do not provide amplifying guidance for mental health providers, such as "harm to mission," "conditions interfering with duty," and "other special circumstances."⁸⁶ DoD Instruction 6490.08 does not address the use of informed consent and waiver of confidentiality.⁸⁷

The BUMED Psychological Health Advisory Board (PHAB) issued guidance and best practices to help mental health providers interpret the DoD policy on confidentiality.⁸⁸ The PHAB guidance emphasizes that recognizing the need for maintaining balance between a patient's confidentiality and a commanding officer's need to know is most important and that taking the time to have cooperative discussion with commanding officers within the bounds of regulations has the potential "to markedly improve care, ensure that high-risk personnel are identified and appropriately monitored, and improve the relationship between commander and provider."⁸⁹ The guidance briefly addresses consent in the context of recommended actions when a patient's condition has qualified for one of the exceptions, but does not address informed consent in other situations.⁹⁰

During interviews, the eMHP staff relied on the DoD policy of confidentiality (often quoting the instruction) to explain why they did not disclose Romero's treatment with the USS COLUMBIA chain of command.⁹¹ Their reasons for not informing the MDR on USS COLUMBIA were less clear.⁹² However, the reasons seemed two-fold, manning shortages at the eMHP Clinic and a belief that calling the MDR about a patient would be the equivalent of informing the chain of command.⁹³ The PHAB guidance provides that the DoD Instruction 6490.08 does not apply to communication among medical providers in the course of treatment, so such communication can happen relatively freely.⁹⁴

The SUBPAC Force Medical Officer candidly acknowledged that the current eMHP practices do not involve enough command collaboration.⁹⁵ Though he attributed the lack

of coordination mostly to manning shortages, he did concede that the “pendulum may have swung too far” regarding the balance between collaboration and confidentiality in favor of confidentiality.⁹⁶

The Submarine Force eMHP instruction provides that a team is comprised of the following: (1) Mental health provider (clinical psychologist); (2) Senior corpsman (HM1 or HMC); and (3) Junior corpsman (HM3 or HM2).⁹⁷ The current eMHP Clinic authorized manning document includes all three of these billets, but the junior behavioral health technician billet is the only one that is currently filled—and until recently on loan from a nearby MTF.⁹⁸ The eMHP provider who conducts the majority of patient care is not in an eMHP billet but rather in the SUBPAC Force Psychologist billet.⁹⁹ He is effectively dual-hatted, but he spends most of his time at the eMHP Clinic.¹⁰⁰ A 2019 Structure and Manning Decision Review (SMDR) process validated the need for a psychologist provider at the eMHP Clinic, as authorized but not funded or filled.¹⁰¹

The eMHP records, at least initially, did not accurately reflect Romero’s access to firearms on watch.¹⁰² The Force Psychologist who evaluated Romero on September 23, 2019 entered, “Patient does not have access to firearms” in the safety plan portion of the electronic record.¹⁰³ It was not until Romero’s third visit that the behavioral health technician updated the safety plan to read, “Patient does not have access to firearms at home.¹⁰⁴ The patient was advised that if his conditions should worsen to talk to his [chain of command] about being temporarily removed from standing an armed watch.”¹⁰⁵ The safety plans shows that eMHP informed Romero to self-report to his command if his mental health condition worsened such that he should not be armed.¹⁰⁶

Opinion 3.2.1: The DoD policy on confidentiality is central to removing the stigma of seeking mental health treatment and building trust between medical providers and patients.¹⁰⁷ However, commanding officers have a clear need to know of any condition that could impact Sailors’ abilities to safely and effectively execute their duties.¹⁰⁸ A better balance must be achieved between confidentiality and sharing information about mental health especially where Sailors have access to firearms or conduct high-risk tasks.

Opinion 3.2.2: The eMHP Clinic’s interpretation of DoD policy on confidentiality conflicts with the Submarine Force eMHP instruction that requires a unified plan among

the chain of command, patient, and provider.¹⁰⁹ The use of informed consent (waiver of confidentiality) to increase information sharing and collaboration between commanding officers and providers would improve patient care and ensure that high-risk personnel are identified and appropriately monitored consistent with medical ethics.¹¹⁰

Opinion 3.2.3: The eMHP Clinic manning levels also affect level of outreach, information sharing, and collaboration with commands.¹¹¹

Opinion 3.2.4: If the eMHP Clinic informed the USS COLUMBIA chain of command or MDR that they advised “if Romero’s conditions should worsen to talk to his chain of command about being temporarily removed from standing an armed watch” then the chain of command may have been more likely to rescreen and remove Romero from watchstanding following his DRB or XOI.¹¹²

Recommendation 3.2.1: Commander Submarine Forces, in coordination with BUMED, align eMHP practice to present a unified plan among the chain of command, patient, and provider in accordance with the existing instruction. Use informed consent (waiver of confidentiality) with patients to improve care, and as necessary, disclose information through existing exceptions to DoD policy on confidentiality—specifically, the harm to mission, special personnel, or other special circumstances.

Recommendation 3.2.2: BUMED PHAB issue guidance to mental health providers concerning the proper use of informed consent outside of enumerated exceptions in DoDI 6490.08 to improve care, ensure that high-risk personnel are identified and appropriately monitored, and improve the relationship between commander and provider. Seek change to DoDI 6490.08 to expressly address informed consent to improve patient care.

Recommendation 3.2.3: BUMED, in coordination with Type Commanders, include manning levels in comprehensive review of eMHP. See Recommendation 3.1.2.

¹ This psychiatric case review conformed to BUMEDINST 6010.13 and did not incorporate quality assurance records into his findings and recommendations. See BUMEDINST 6010.13 at ¶ 11.

² Embedded Mental Health Submarine Guidebook § 1.2.

³ *Id.*

⁴ *Id.* at ¶ 2.

⁵ CSLCSPINST 6490.1, page 1 ¶ 2.

⁶ SI with CAPT (b)(6) of 21 Jan 20 ¶7; SI with LCDR (b)(6) of 15 Jan 20.

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- ⁷ SI with CDR (b)(6) of 15 Jan 20; TAMC Emergency Room Chronology of Care of 4 Mar 19; NCIS Report of Investigation of 2 Jan 20, Exhibit 65 ¶ 12; NSSC Mental Health Notes of 30 Sep 19 to 26 Nov 19; SI with CPT (b)(6), USA of 5 Feb 20.
- ⁸ NSSC Mental Health Clinic Encounters of 19 Nov 19 and 26 Nov 19; SI with HM2 (b)(6) of 15 Jan 20.
- ⁹ TAMC Emergency Room Chronology of Care of 4 Mar 19; NSSC Mental Health Notes of 23 Sep 19 to 26 Nov 19.
- ¹⁰ TAMC Emergency Room Chronology of Care of 4 Mar 19.
- ¹¹ SI with (b)(6) of 5 Feb 20; TAMC Emergency Room Chronology of Care of 4 Mar 19.
- ¹² TAMC Emergency Room Chronology of Care of 4 Mar 19; SI with (b)(6) of 5 Feb 20.
- ¹³ SI with MMAC (b)(6) of 14 Jan 20.
- ¹⁴ SI with CPT (b)(6), USA of 5 Feb 20; TAMC Emergency Room Chronology of Care of 4 Mar 19.
- ¹⁵ *Id.*
- ¹⁶ SI with CPT (b)(6), USA of 5 Feb 20.
- ¹⁷ SI with MMAC (b)(6) of 14 Jan 20.
- ¹⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 33 ¶ 5.
- ¹⁹ NCIS Report of Investigation of 2 Jan 20, Exhibit 64 ¶ 3.
- ²⁰ NSSC Mental Health Clinic Encounter of 23 Sep 19.
- ²¹ *Id.*
- ²² NCIS Report of Investigation of 2 Jan 20, Exhibit 68, Enclosure B.
- ²³ *Id.*
- ²⁴ *Id.*
- ²⁵ *Id.*
- ²⁶ NCIS Report of Investigation of 2 Jan 20, Exhibit 68, Enclosure B.
- ²⁷ NSSC Mental Health Clinic Encounter of 23 Sep 19.
- ²⁸ SI with CDR (b)(6) of 15 Jan 20; Email from CDR (b)(6) to LCDR (b)(6) of 22 Jan 20.
- ²⁹ SI with CDR (b)(6) of 15 Jan 20.
- ³⁰ SI with CDR (b)(6) of 15 Jan 20; NSSC Mental Health Clinic Encounter of 23 Sep 19.
- ³¹ SI with CDR (b)(6) of 15 Jan 20.
- ³² NSSC Mental Health Clinic Encounters from 30 Sep 19 to 26 Nov 19.
- ³³ SI with HM2 (b)(6) of 15 Jan 20.
- ³⁴ NSSC Mental Health Clinic Encounters of 19 Nov 19 and 26 Nov 19; SI with HM2 (b)(6) of 15 Jan 20.
- ³⁵ NCIS Report of Investigation of 2 Jan 20, Exhibit 64 ¶ 13.
- ³⁶ CSLCSPINST 6490.1, Chapter 2 ¶ 2.8.
- ³⁷ Embedded Mental Health Submarine Guidebook § 7.5.
- ³⁸ *Id.* at ¶ 3.
- ³⁹ *Id.* at page 23 and 35; CSLCSPINST 6490.1, Chapter 2 ¶ 2.8; Defense Health Agency Healthcare Provider's Practice Guide for the Utilization of Behavioral Health Technicians, pages 2-3, 7-9, 12-14.
- ⁴⁰ Forensic Psychiatric Case Review by Dr. (b)(6), CAPT, MC, USN.
- ⁴¹ SI with CDR (b)(6) of 15 Jan 20.
- ⁴² *Id.*
- ⁴³ *Id.*
- ⁴⁴ *Id.*
- ⁴⁵ Care Provider Data of 2018; Care Provider Data of 2019; CSLCSPINST 6490.1 § 1.1.
- ⁴⁶ SI with HM2 (b)(6) of 15 Jan 20.
- ⁴⁷ NCIS Report of Investigation of 2 Jan 20, Exhibit 64 ¶ 6; U.S. National Comorbidity Survey Replication Alegria, Margarita, Jackson, James S. (James Sidney), Kessler, Ronald C., and Takeuchi, David. Collaborative Psychiatric Epidemiology Surveys (CPES), 2001-2003 [United States]. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor]. <https://doi.noclick.org/10.3886/ICPSR20240.v8>
- ⁴⁸ Care Provider Data of 2018; Care Provider Data of 2019.
- ⁴⁹ *Id.*
- ⁵⁰ Makalapa Mental Health Encounter Data of 25 Feb 20.

⁵¹ *Id.*

⁵² SI with CAPT (b)(6) of 21 Jan 20; SI with CDR (b)(6) of 15 Jan 20; SI with LCDR (b)(6) of 15 Jan 20; SI with HM2 (b)(6) of 15 Jan 20.

⁵³ SI with LCDR (b)(6) of 15 Jan 20.

⁵⁴ SI with HM2 (b)(6) of 15 Jan 20.

⁵⁵ SI with CAPT (b)(6) of 21 Jan 20.

⁵⁶ SI with HM2 (b)(6) of 15 Jan 20; SI with CDR (b)(6) of 15 Jan 20.

⁵⁷ SI with CAPT (b)(6) of 21 Jan 20.

⁵⁸ *Id.*

⁵⁹ SI with CAPT (b)(6) of 21 Jan 20.

⁶⁰ SI with HM2 (b)(6) 15 Jan 20; SI with CDR (b)(6) of 15 Jan 20.

⁶¹ MANMED Chapter 15, § 15-106 ¶ k; Forensic Psychiatric Case Review by Dr. (b)(6), CAPT, MC, USN.

⁶² NSSC Mental Health Clinic Encounters of 23 Sep 19 to 26 Nov 19.

⁶³ *Id.*; SI with HM2 (b)(6) of 15 Jan 20.

⁶⁴ CSLCSPINST 6490.1 § 2.8.

⁶⁵ SI with CPT (b)(6), USA of 5 Feb 20.

⁶⁶ NSSC Mental Health Clinic Encounter of 23 Sep 19; DD Form 2807-1 of Romero, Gabriel Antonio

⁶⁷ Forensic Psychiatric Case Review by Dr. (b)(6), CAPT, MC, USN.

⁶⁸ SI with CPT (b)(6), USA of 5 Feb 20.

⁶⁹ Email from CDR (b)(6) to LCDR (b)(6) of 22 Jan 20; SI with HM1 (b)(6) of 15 Jan 20.

⁷⁰ CSLCSPINST 6490.1 § 1.1 ¶ a.

⁷¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 64 ¶ 4.

⁷² SI with LCDR (b)(6) of 15 Jan 20; SI with LCDR (b)(6) of 15 Jan 20.

⁷³ SI with HM2 (b)(6) of 15 Jan 20; SI with LCDR (b)(6) of 15 Jan 20.

⁷⁴ SI with ETRCS (b)(6) of 17 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; SI with MMAC (b)(6) of 14 Jan 20.

⁷⁵ SI with HM1 (b)(6) of 15 Jan 20.

⁷⁶ PHA and MHA Assessment Electronic Record of HM1 (b)(6). [DoD ID number 154192886 identifies this record as Romero's annual medical screening.]

⁷⁷ DoDI 6200.06 § 3.3 ¶ b.

⁷⁸ CSLCSPINST 6490.1 § 1.1 ¶ a.

⁷⁹ *Id.*

⁸⁰ Record of Counselings for Romero, Gabriel Antonio; TAMC Emergency Room Chronology of Care of 4 Mar 19; SI with MMA3 (b)(6) of 13 Jan 20; SI with ETN1 (b)(6) of 15 Jan 20.

⁸¹ *Id.*; TAMC Emergency Room Chronology of Care of 17 Dec 18; Motorcycle Mishap Safety Report for Romero, Gabriel Antonio.

⁸² DoDI 6490.08 § 3 ¶ b.

⁸³ *Id.* at ¶ b(1).

⁸⁴ *Id.* at ¶ b(2).

⁸⁵ *Id.* at Enclosure 2 § 1 ¶ b(1)-b(9).

⁸⁶ *Id.*

⁸⁷ DoDI 6490.08.

⁸⁸ PHAB Information Paper, Guidance for Mental Health Providers in Communicating with Line Leaders.

⁸⁹ *Id.* at Appendix A.

⁹⁰ *Id.* at Appendix B, page 12.

⁹¹ SI with LCDR (b)(6) of 15 Jan 20; SI with LCDR (b)(6) of 15 Jan 20.

⁹² *Id.*

⁹³ SI with HM2 (b)(6) of 15 Jan 20; SI with LCDR (b)(6) of 15 Jan 20; SI with CAPT (b)(6) of 21 Jan 20.

⁹⁴ PHAB Information Paper, Appendix A, page 8.

⁹⁵ SI with CAPT (b)(6) of 21 Jan 20.

⁹⁶ *Id.*

⁹⁷ CSLCSPINST 6490.1 § 2.2 ¶ a.

⁹⁸ FLTMPs Billets and Authorized Assignments; Email from CAPT (b)(6) to LCDR (b)(6) of 5 Feb 20.

⁹⁹ SI with CAPT (b)(6) of 21 Jan 20; SI with CDR (b)(6) of 15 Jan 20.

¹⁰⁰ *Id.*

¹⁰¹ Email from CAPT (b)(6) to LCDR (b)(6) of 5 Feb 20; NSSC PH Activity Manpower Document.

¹⁰² NSSC Mental Health Note Encounter of 23 Sep 19 and 30 Sep 19.

¹⁰³ NSSC Mental Health Note Encounter of 23 Sep 19.

¹⁰⁴ NSSC Mental Health Note Encounter of 8 Oct 19.

¹⁰⁵ *Id.*

¹⁰⁶ NSSC Mental Health Note Encounter of 23 Sep 19 to 26 Nov 19.

¹⁰⁷ DoDI 6490.06 ¶ 4(b).

¹⁰⁸ CSLCSP 6490.1, Chapter 1 § 1.1 ¶ a(2); Navy Regulations, Article 0802.

¹⁰⁹ CSLCSPINST 6490.1 § 1.1 ¶ a; DoDI 6490.08 § 3 ¶ b.

¹¹⁰ DoDI 6490.06; DoDI 6490.08; Ethical Principles of Psychologists and Code of Conduct § 3.09 and § 4.05.

¹¹¹ SI with CAPT (b)(6) of 21 Jan 20.

¹¹² NSSC Mental Health Note Encounter of 8 Oct 19; SI with LT (b)(6) of 17 Jan 20; SI with TMC (b)(6) of 16 Jan 20.

Chapter 4 - Arms, Ammunition, & Explosives Program (AA&E)

This chapter examines USS COLUMBIA’s compliance with the Navy’s AA&E program before Romero assumed armed watch on December 4, 2019. The AA&E program requires personnel to be screened before assignment to duties involving control of or unescorted access to AA&E.¹ The screening policy is designed to ensure personnel who are assigned such duties are mature, stable, and have shown a willingness and capability to perform assigned tasks dependably.² The procedures include initial screening before assignment to AA&E duties, annual rescreening, and rescreening “when circumstances indicate review would be prudent.”³

Regulatory Background

DoDD 5210.56 (Arming and Use of Force) establishes policy on the use of force and carrying of firearms by Department of Defense (DoD) personnel.

SECNAVINST 5500.37 (Arming and Use of Force) establishes policy on the use of force and the carrying of firearms by personnel of the Department of the Navy (DON).

OPNAVINST 3591.1F (Small Arms Training and Qualifications) establishes Navy policy and prescribes minimum requirements for individual small arms training and qualification.

OPNAVINST 5530.13D (Physical Security for Conventional AA&E) issues Navy policy and guidance for the protection of conventional AA&E against loss or theft.

OPNAVINST 8023.24C (Personnel Conventional AA&E Handling Qualification and Certification Program) provides Navy policy, assigns the responsibilities and issues procedures for developing, implementing, and maintaining the Navy personnel AA&E handling qualification and certification program.

CSLCSPINST C3300.3A (Submarine Antiterrorism (AT) Manual) implements Submarine Force policy and guidance with respect to AT.

CSLCSPINST 5400.49 (Submarine Organization and Regulations Manual) defines the standard duties and responsibilities of submarine watchstanders.

CSLCSPINST 8500.4D (Conventional Weapons Manual) implements Submarine Force policy and guidance with respect to conventional weapons.

DD Form 2760 (Qualification to Possess Firearms or Ammunition) is used to obtain information to determine if personnel have been convicted of a domestic violence crime that would disqualify personnel from being issued a firearm.

OPNAV Form 5530/1 (Rev 8/2018) (Screening for Personnel Assigned AA&E Duties) is used to screen personnel to ensure they are mature, stable, and show a willingness and capability to perform assigned tasks dependably.

Findings-Opinions-Recommendations

Finding 4.1 (Potential Contributing/Noncompliance/Deficiency): Romero completed required AA&E screening in September 2018 and qualified to stand the Topside Rover Patrol watch in December 2018.⁴ He completed required annual rescreening in September 2019, but OPNAV Instruction 5510.13C also requires rescreening “when circumstances indicate a review would be prudent.”⁵ He was not rescreened on that basis despite risk factors known to the Navy including his mental health;⁶ his (b) (6) health issues;⁷ two single motor vehicle accidents (motorcycle and car) within a year;⁸ general isolation from his shipmates;⁹ delinquent qualifications;¹⁰ repeated counseling;¹¹ a disciplinary review board (DRB);¹² a failure to advance to E-4;¹³ and an executive officer inquiry (XOI) the day before the shooting.¹⁴ OPNAV Instruction 5530.13C and training do not provide amplifying guidance on when circumstances require rescreening.¹⁵

Discussion: Romero was screened and qualified to carry a weapon on the Topside Rover Patrol.¹⁶ He completed screening, became qualified for specific weapon(s), and qualified for his particular watch assignment.¹⁷

Initial Screening and Qualification

During check-in, the screening process required Romero to complete DD Form 2760 (Lautenberg), OPNAV Form 5530/1 (AA&E screening), and Ship's Self Defense Force (SSDF)/Reaction Force (RF) qualifications.¹⁸ Neither the SSDF/RF qualifications nor AA&E screening address human factors specifically.

Romero completed SSDF/RF qualifications and AA&E screening in September 2018.¹⁹ The USS COLUMBIA medical department representative (MDR) had to conduct a medical screening and attest that Romero did not have a psychiatric illness that required medication.²⁰ In addition, the weapons officer had to conduct an independent records review of Romero's Official Military Personnel File (OMPF) through the check-in and SSDF/RF qualification process.²¹

To complete initial AA&E screening, Romero had to complete an in-person interview with the weapons officer.²² The weapons officer explained that he assesses suitability by going through the limited screening questions on OPNAV Form 5530/1 (see further discussion below) and asking about weapons experience, stress levels, and any emotional problems.²³ The weapons officer was not required to consult with the MDR directly.²⁴ He recalled Romero's initial screening interview, and nothing raised concern.²⁵

Romero qualified for Topside Roving Patrol watch on December 10, 2018.²⁶ He was qualified on the M-4 rifle and the M-9 pistol, and he requalified for these weapons when required.²⁷

Annual Rescreening

Romero completed annual AA&E rescreening on September 26, 2019, as required by OPNAV Instruction 5530.13C.²⁸ OPNAV Form 5530/1, which is used for screening and rescreening, contains only three vague questions concerning "any derogatory information noted in the personnel record;" "pending legal action and/or convictions;" and is the

“individual mature, stable, and does he/she show willingness and capability to be assigned duties involving control of or unescorted access to AA&E?”²⁹

The weapons officer did not receive any formal training on AA&E screening policy or procedures before assuming responsibilities for the small arms program.³⁰ He admitted that he typically does not conduct personnel record reviews at annual rescreening because he assumes that he is aware of concerns about particular Sailors at such a small command.³¹ He has since corrected this practice and now does personnel record reviews at rescreening.³² The annual AA&E rescreening procedures do not require a medical record review.³³ The investigation team did not find any information in Romero’s OMPF that would have prompted his rescreening.

OPNAV Forms 5530/1 are to be kept for 6 months after a person transfers from an assignment.³⁴ However, the weapons officer’s practice is to discard previous OPNAV Forms 5530/1 during the annual rescreening process because the initial screening and annual rescreening procedures use the same form.³⁵ The weapons officer did not maintain Romero’s initial screening OPNAV Form 5530/1, but Nosis Continuing Training and Qualification Software (CTQS) records documented his initial screening and watch qualifications.³⁶

Circumstances-Based Rescreening

OPNAV Instruction 5530.13C requires persons to be “mature, stable, and [to] have shown a willingness and capability to perform assigned tasks dependably.”³⁷ In addition to an annual rescreening requirement, rescreening is required “when circumstances indicate a review would be prudent.”³⁸ Romero was not rescreened on that basis.³⁹

According to OPNAV Instruction 5530.13C, “determination of which traits and actions are disqualifying is at the discretion of the commanding officer and to contact CNO (N09N3) or CMC (PS) for guidelines.”⁴⁰ However, the investigation team confirmed with OPNAV N4 staff that Navy does not have additional guidelines on disqualification, and N09N3 is no longer an office code in OPNAV after staff reorganization.⁴¹ OPNAV Instruction 5530.13C is under revision.⁴²

From June to November 2019, Romero was counseled in writing or received extra military instruction ten times for poor work performance and being late.⁴³ One of his written counseling chits, on September 11, 2019, was for inattentiveness and lack of professionalism while on an unarmed Barge Security Watch.⁴⁴ He was removed from the barge watchbill and issued a formal watchstanding upgrade (i.e., he had to re-qualify).⁴⁵ Romero was nearly complete but still delinquent on submarine qualifications by several months.⁴⁶ His poor performance actually made it more likely he would stand non-technical armed watches due to his lack of technical competence in other areas.⁴⁷

Romero went to DRB on November 21, 2019, where he began to cry when questioned by the chief petty officers.⁴⁸ He was informed on November 26, 2019, that he failed to advance in paygrade to E-4.⁴⁹ He went to XOI on December 3, 2019, the day before the shooting, where he also began to cry.⁵⁰ He was shown, but declined to sign, the formal “Page 13” counseling form after XOI that warned him that he would go to commanding officer’s (CO’s) non-judicial punishment (NJP) if he was late again.⁵¹

In addition to his performance and disciplinary issues, he was generally isolated from his shipmates.⁵² His division chief arranged for him to get help at the Embedded Mental Health Clinic (eMHP) in Pearl Harbor after the health of Romero’s (b) (6) declined and Romero stopped expressing himself to the division chief. Romero went to the eMHP Clinic for eight visits, beginning in September 2019, to learn coping skills related to his (b) (6) and his (b) (6) health problems.⁵³

Romero was also involved in two motor vehicle accidents within a year. He was in a single motorcycle accident in December 2018, which was documented in his medical record because of a minor injury, and a single car accident that damaged the front of his car in November 2019, which was not documented in his medical record.⁵⁴

Romero was never diagnosed with a mental disorder nor did he ever make any known homicidal or suicidal ideations.⁵⁵ He did not have a criminal record, and he had no history of alcohol or drug abuse, financial problems, weapons mishandling, or known interest in previous shooting incidents.⁵⁶ He had no prior history of violence or threatening violence.⁵⁷

The USS COLUMBIA chain of command had varying degrees of awareness regarding Romero's risk factors.⁵⁸ The CO could not recall if Romero was seeking mental health counseling but was aware of his counseling chits from June to November.⁵⁹ The executive officer (XO) was aware of Romero seeking mental health counseling.⁶⁰ The XO was also aware of Romero's counseling chits from June to November, his delinquent qualifications, and his recent DRB and XOI.⁶¹ The chief of the boat (COB) was generally aware of Romero's mental health counseling, multiple counseling chits (describing them as a "slow trend of minor issues"), DRB, and XOI.⁶²

Romero's department head, the engineering officer, was not tracking any of Romero's mental health appointments, and he was unaware of any details related to DRB or XOI.⁶³ He was aware of Romero's concerns about his (b) (6) health.⁶⁴ As part of the Barge Security watchstanding upgrade, Romero had to conduct interviews.⁶⁵ During Romero's department head interview, the engineering officer sympathized and offered resources to Romero concerning his (b) (6) health, but he also explained that it was Romero's responsibility to let someone know if he could not stand watch.⁶⁶

Romero's auxiliary division officer was deployed on another submarine from August 2018 to March 2019.⁶⁷ He was not aware of Romero's mental health counseling.⁶⁸ He did not provide input for Romero's DRB and XOI, but he was aware of them.⁶⁹

Romero's division chief was aware of Romero's mental health counseling, his (b) (6) health issues, the DRB, and the XOI.⁷⁰ He stated that Romero's performance was inconsistent like a rollercoaster, and that he was not dependable.⁷¹ However, his appearance was always clean and neat.⁷² The chain of command consistently described Romero as quiet and private.⁷³

The CO stated that he relied on the weapons officer to administer the small arms program.⁷⁴ However, the weapons officer was unaware of Romero's mental health counseling.⁷⁵ The weapons officer described Romero as a below average Sailor.⁷⁶ After the shooting incident, the weapons officer and senior watch officer stated that they would have removed Romero from armed watch if they had known of his mental health counseling.⁷⁷ The weapons officer stated that other Sailors had been removed (one-lined)

from the arms list two or three times, for suicidal ideations, medical, and domestic-violence (Lautenberg) issues.⁷⁸

Romero was on the command triad's informal list of high-risk Sailors as a precautionary measure for his repeated tardiness and his (b) (6) health issues.⁷⁹ The command triad used the informal list to track crewmembers with family, medical, performance or disciplinary issues.⁸⁰

However, the CO, XO, and COB maintained they had no reason to remove Romero from the armed watchbill.⁸¹ From their perspective, he was qualified and fit for submarine duty and to stand the watch, and his continuing eMHP therapy demonstrated increased access to care and reduced stigma associated with mental health treatment.⁸² The CO stated that he thought the shooting incident was impossible to prevent.⁸³

From 2017 to 2019, 4 of 9 suicides in the Navy involving service-issued weapons were in the submarine force.⁸⁴ Six Sailors in the submarine force have killed themselves with service-issued weapons since 2015.⁸⁵ Commander, Submarine Force Atlantic (COMSUBLANT) and Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC) provided additional direction and guidance on screening of armed watchstanders to commanding officers after the December 4, 2019 shooting incident.⁸⁶

Opinion 4.1.1: The circumstances before Romero assumed the watch on December 4, 2019, indicated an arms rescreening would have been prudent.⁸⁷ The chain of command could not have known about Romero's under-diagnosed mental disorder.⁸⁸ However, the risk factors still should have raised questions about Romero's maturity, stability, and dependability.⁸⁹ The chain of command should have communicated with the weapons officer and made a decision to rescreen and consider removing Romero from armed watch based on the combination of Romero's personal and work-related problems.⁹⁰

Opinion 4.1.2: Romero was qualified, screened, and rescreened annually to stand the Topside Rover Patrol watch.⁹¹ However, the weapons officer did not comply with requirements to conduct an independent personnel records review during annual rescreening and to maintain the initial OPNAV Form 5530/1.⁹² Romero's OMPF would not have included the counseling chits or the DRB and XOI records. If the weapons

officer had reviewed the OMPF, it would not have changed his annual rescreening determination.⁹³

Opinion 4.1.3: The AA&E screening policy, procedures, and training should clarify vague screening and rescreening standards, and incorporate prevention principles, human factors assessments, and decision points (tripwires) to help commanding officers make more informed decisions about whether personnel should have access to service weapons.⁹⁴ Mental health treatment without a diagnosis should not be a tripwire by itself, but should be considered a tripwire for rescreening if present with other factors such as continuing poor performance, disciplinary actions, or family issues that raise concerns about maturity, stability, or dependability.⁹⁵

Opinion 4.1.4: Weapons officers should receive formal training on AA&E policy and procedures before assuming responsibility for implementing small arms programs.⁹⁶

Recommendation 4.1.1: OPNAV N4 revise AA&E policy, procedures, and training requirements on screening and rescreening to clarify vague standards and incorporate prevention principles, human factor assessments, and tripwires for rescreening. Mental health treatment without a diagnosis should not be a tripwire by itself, but should be considered a tripwire for rescreening if present with other factors such as continuing poor performance, disciplinary actions, or family issues.

Recommendation 4.1.2: COMSUBPAC issue clarifying guidance on record retention requirements for OPNAV Form 5530/1.

Finding 4.2 (Potential Contributing/Noncompliance): Romero assumed security duties as the Topside Roving Patrol without getting the required safety brief.⁹⁷

Discussion: All personnel assigned, or who could be assigned, security duties must receive a brief on weapons safety and security before assuming duties.⁹⁸ Romero was not present at duty section muster on December 4, 2019, because he was at the Fire Arms Training Simulator (FATS) to conduct his semi-annual sustainment training.⁹⁹ The duty section leader confirmed that Romero was expected to check in before reporting to his watch station.¹⁰⁰ He did not report to the duty section chain of command upon his return

to the submarine from FATS training, so he did not receive required briefs before assuming watch.¹⁰¹ The security and safety brief consists of face-to-face interactions with duty section leadership, an alcohol screening breathalyzer (a unit-level requirement), and pass-down for the day.¹⁰² He did not receive this brief.¹⁰³ An autopsy toxicology report would later show he did not have alcohol or controlled substances in his system.¹⁰⁴

Opinions 4.2.1: The missed security and safety brief demonstrates a lack of procedural compliance and was a missed opportunity for duty section leadership to assess Romero's suitability for watch before he was issued a firearm.¹⁰⁵

Recommendation 4.2.1: USS COLUMBIA revise duty section procedures to ensure armed watchstanders complete safety and security brief requirements before watch.

Recommendation 4.2.2: Fleet Commanders direct all submarine units to ensure duty section procedures require armed watchstanders complete safety and security brief requirements before watch.

¹ OPNAV Form 5530/1; OPNAVINST 5530.13C § 0107 ¶ a.

² OPNAVINST 5530.13C § 0107 ¶ a.

³ *Id.*

⁴ Nosis CTQS Record of Romero, Gabriel Antonio; NCIS Report of Investigation of 2 Jan 20, Exhibit 34, Enclosure A and Enclosure C.

⁵ OPNAVINST 5530.13C § 0107 ¶ a.

⁶ SI with MMAC (b)(6) of 14 Jan 20; SI with LCDR (b)(6) of 17 Jan 20.

⁷ SI with MMAC (b)(6) of 14 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20.

⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 43 ¶ 11; NCIS Report of Investigation of 2 Jan 20, Exhibit 53, Enclosure C; SI with MMA2 (b)(6) of 13 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20; Motorcycle Mishap Safety Report for Romero, Gabriel Antonio.

⁹ SI with MMA3 (b)(6) of 13 Jan 20; SI with MMAFN (b)(6) of 13 Jan 20; SI with MMA2 (b)(6) of 13 Jan 20.

¹⁰ SI with MMAC (b)(6) of 14 Jan 20; Email from LCDR (b)(6) to MTCS (b)(6) of 21 Feb 20.

¹¹ Record of Counselings of Romero, Gabriel Antonio.

¹² SI with MMAC (b)(6) of 14 Jan 20.

¹³ Profile Sheet of Romero, Gabriel Antonio.

¹⁴ SI with LCDR (b)(6) of 17 Jan 20.

¹⁵ OPNAV 5530.13C, Enclosure 1 § 0107 ¶ a.

¹⁶ Nosis CTQS Record of Romero, Gabriel Antonio.

¹⁷ *Id.*

¹⁸ SI with LT (b)(6) of 17 Jan 20.

¹⁹ Nosis CTQS Record of Romero, Gabriel Antonio; NCIS Report of Investigation of 2 Jan 20, Exhibit 34, Enclosure A and Enclosure C.

²⁰ Nosis CTQS Record of Romero, Gabriel Antonio; OPNAVINST 8023.24C at § 7 ¶ e(4).

²¹ *Id.*

²² CSLCSPINST 8500.4D § 3000 ¶ 7.
²³ SI with (b)(6) of 17 Jan 20.
²⁴ *Id.*
²⁵ *Id.*
²⁶ Nosis CTQS Record of Romero, Gabriel Antonio.
²⁷ USS COLUMBIA Small Arms Qualification Records; NOSIS Qualification Record of Romero, Gabriel Antonio.
²⁸ OPNAVINST 5530.13C, Enclosure 1 § 0107; OPNAV Form 5530/1 Romero AA&E Screening of 26 Sep 19. Note the OPNAV Form 5530/1 is not required by the current version of OPNAVINST 5530.13C, but it is required by OPNAVINST 8023.24C at § 7 ¶ e(2). OPNAVINST 5530.13C is currently under revision and the new OPNAVINST 5530.13D will require use of the OPNAV Form 5530/1. Use of the OPNAV Form 5530/1 for all AA&E related duties is currently required by CSLCSPINST 8500.4D § 3000.
²⁹ OPNAV Form 5530/1 Romero AA&E Screening of 26 Sep 19.
³⁰ Memo to File, Discussion with CSS-7 Weapons Officer, of 20 Feb 20.
³¹ SI with LT (b)(6) of 17 Jan 20.
³² *Id.*
³³ *Id.*
³⁴ CSLCSPINST 8500.4D § 3000 ¶ 5; OPNAVINST 5530.13C, Enclosure 1 § 0107.
³⁵ *Id.*; Email from LT (b)(6) to MTCS (b)(6) of 21 Feb 20.
³⁶ Nosis CTQS Record of Romero, Gabriel Antonio.
³⁷ OPNAVINST 5530.1C, Enclosure 1 § 0107 ¶ a.
³⁸ *Id.*
³⁹ SI with LT (b)(6) of 17 Jan 20; OPNAV Form 5530/1 Romero AA&E Screening of 26 Sep 19.
⁴⁰ OPNAVINST 5530.1C, Enclosure 1 § 0107 ¶ a.
⁴¹ Email from CAPT (b)(6) to CAPT (b)(6) of 24 Jan 20.
⁴² *Id.*
⁴³ Record of Counselings of Romero, Gabriel Antonio; NCIS Report of Investigation of 2 Jan 20, Exhibit 32, Enclosure A.
⁴⁴ *Id.* at 11 Sep 19.
⁴⁵ *Id.*
⁴⁶ Command Counseling Data SSN 771. Romero was listed as "in need of assistance" on the COLUMBIA delinquent qualification list starting on 18 April 2019; SI with MMAC (b)(6) of 14 Jan 20.
⁴⁷ NCIS Report of Investigation of 2 Jan 20, Exhibit 53 ¶ 1.
⁴⁸ SI with ETRCS (b)(6) of 17 Jan 20; SI with MMAC (b)(6) of 14 Jan 20.
⁴⁹ Profile sheet of Romero, Gabriel Antonio.
⁵⁰ SI with CDR (b)(6) of 17 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; Record of Counselings of Romero, Gabriel Antonio; Disciplinary Review Board Notes of 21 Nov 19.
⁵¹ NAVPERS 1626/7 Report and Disposition of Offenses of 3 Dec 19.
⁵² SI with MMA3 (b)(6) of 13 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20; SI with FT1 (b)(6) of 15 Jan 20.
⁵³ NSSC Mental Health Clinic Encounters from 23 Sep 19 to 26 Nov 19.
⁵⁴ NCIS Report of Investigation of 2 Jan 20, Exhibit 43 ¶ 11; NCIS Report of Investigation of 2 Jan 20, Exhibit 53, Enclosure C; SI with MMA2 (b)(6) of 13 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20; Motorcycle Mishap Safety Report for Romero, Gabriel Antonio.
⁵⁵ *Id.*; TAMC Emergency Room Chronology of Care of 4 Mar 19.
⁵⁶ Electronic Questionnaires for Investigation Processing Request #24226751.
⁵⁷ NSSC Mental Health Clinic Encounter of 23 Sep 19; DD Form 2807-1 of Romero, Gabriel Antonio.
⁵⁸ SI with LCDR (b)(6) of 17 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20; SI with MMAC (b)(6) of 14 Jan 20.
⁵⁹ SI with CDR (b)(6) of 17 Jan 20.
⁶⁰ *Id.*; SI with LCDR (b)(6) of 17 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20; SI with MMAC (b)(6) of 14 Jan 20.
⁶¹ SI with LCDR (b)(6) of 17 Jan 20.
⁶² *Id.*

63 SI with LCDR (b)(6) of 13 Jan 20.
64 *Id.*
65 NCIS Report of Investigation of 2 Jan 20, Exhibit 32, Enclosure B.
66 SI with LCDR (b)(6) of 13 Jan 20.
67 SI with LT (b)(6) of 14 Jan 20.
68 *Id.*
69 *Id.*
70 SI with MMAC (b)(6) of 14 Jan 20.
71 *Id.*
72 SI with TM3 (b)(6) of 10 Jan 20.
73 SI with CDR (b)(6) of 17 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20; SI with LT (b)(6) of 14 Jan 20; SI with MMAC (b)(6) of 14 Jan 20. (6)
74 SI with CDR (b)(6) of 17 Jan 20.
75 SI with LT (b)(6) of 17 Jan 20.
76 *Id.*
77 *Id.*; SI with LT (b)(6) of 16 Jan 20.
78 SI with LT (b)(6) of 17 Jan 20.
79 SI with ETRCS (b)(6) of 17 Jan 20.
80 Email from ETRCS (b)(6) to LT (b)(6) of 19 Feb 20.
81 SI with CDR (b)(6) of 17 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20. (6)
82 *Id.*
83 SI with CDR (b)(6) of 17 Jan 20.
84 Email from (b)(6) to CAPT (b)(6) of 17 Jan 20; USFF Suicide Statistics.
85 N17 Suicide Statistics 2015-2019.
86 COMSUBLANT/COMSUBPAC message of December 6, 2019.
87 SI with MMAC (b)(6) of 14 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20.
88 See Findings 3.1 and 3.2 of this report.
89 SI with MMAC (b)(6) of 14 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20.
90 SI with LT (b)(6) of 17 Jan 20.
91 OPNAV Form 5530/1 Romero AA&E Screening of 26 Sep 19; Nosis CTQS Record of Romero, Gabriel Antonio; DD Form 2760 of Romero, Gabriel Antonio.
92 OPNAVINST 5530.1C, Enclosure 1 § 0107; SI with LT (b)(6) of 17 Jan 20.
93 SI with LT (b)(6) of 17 Jan 20.
94 OPNAVINST 5530.13C, Enclosure 1 § 0107.
95 DoDI 6490.04 ¶ 3(a); OPNAVINST 5530.13C § 0107 ¶ a.
96 Memo to File, Discussion with CSS-7 Weapons Officer, of 20 Feb 20
97 SI with MMA2 (b)(6) of 13 Jan 20; SI with LTJG (b)(6) of 14 Jan 20; SI with LSC (b)(6) of 16 Jan 20; CSLCSPINST C3300.3A, Tab E to Addendum 2; SSN771INST C3300.3 § Tab E ¶ 1.
98 CSLCSPINST C3300.3A, Tab E to Addendum 2; SSN771INST C3300.3 § Tab E ¶ 1.
99 SI with LSC (b)(6) of 16 Jan 20; SI with TMC (b)(6) of 16 Jan 20.
100 SI with ST2 (b)(6) of 16 Jan 20.
101 *Id.*
102 SI with LSC (b)(6) of 16 Jan 20; SI with LT (b)(6) 16 Jan 20.
103 SI with LSC (b)(6) of 16 Jan 20.
104 SI with LSC (b)(6) of 16 Jan 20; Toxicology Lab Report of Romero, Gabriel Antonio.
105 SI with LSC (b)(6) of 16 Jan 20; SI with LT (b)(6) 16 Jan 20.

Chapter 5 - USS COLUMBIA Command Climate

This chapter examines USS COLUMBIA’s command climate and other factors that contributed to the command environment before the December 4, 2019 shooting incident.

The investigation team reviewed recent command climate assessments and external assessments that consisted of command climate surveys, focus groups, and interviews. The investigation team also reviewed Navy support programs as implemented aboard USS COLUMBIA and conducted several interviews with the USS COLUMBIA leadership and crew to examine factors such as morale, teamwork, and communication that affect the overall “health” and effectiveness of the command.

Regulatory Background

DoDD 1350.2 (Department of Defense (DoD) Military Equal Opportunity (MEO) Program) regulates the DoD MEO program and assigns responsibilities for ensuring DoD-wide compliance with broad program objectives.

SECNAVINST 5350.16A (Equal Opportunity (EO) within the Department of the Navy (DON)) implements the DON EO policy, and assigns related duties and responsibilities.

OPNAVINST 5354.1G (Navy EO Program Manual) issues policies and standards to aid in the prevention of harassment and unlawful discrimination throughout the Navy, defines requirements, and assigns responsibilities in the Navy EO program.

NAVADMIN 222/19 (Operational Stress Control Policy Update) announces Expanded Operational Stress Control Program (E-OSC) that leverages Command Resilience Teams (CRTs) and deckplate leadership.

NAVADMIN 254/19 (Culture of Excellence) explains the Chief of Naval Operation’s vision of a “Culture of Excellence.”

Findings-Opinions-Recommendations

Finding 5.1 (Potential Contributing/Noncompliance/Deficiency): Command climate assessments and external assessments show USS COLUMBIA's command climate was generally below average when compared to other submarines.¹

Discussion: USS COLUMBIA entered Pearl Harbor Naval Shipyard (PHNSY) shipyard in October 2018.² In November 2018, USS COLUMBIA completed a command climate assessment after a change of command, as required, and again in December 2019 to fulfill the annual requirement.³ In October 2019, 48% of the crew completed the Defense Organizational Climate Survey (DEOCS) as part of the 2019 command climate assessment compared to 85% in 2018, a 37% decrease.⁴ Of those surveyed, 35.5% knew of someone who “thought of” suicide and 6.6% knew someone who “attempted” suicide in their organization.⁵ Thirty-four (34%) did not feel comfortable sharing difficulties about work with immediate supervisors.⁶ The command was below submarine fleet standards in 8 of 16 unit summary categories for command climate.⁷

The DEOCS asked short answer questions where the individual crewmembers could provide anonymous answers.⁸ The dozens of comments included this anonymous response to a question about sources of job-related stress:

“Not having a purpose and just being here to clean, we work in an industrial environment, you can only sweep the decks so much. They take cleaning way to [sic] serious for ship that is going through an overhaul and do not hold shipyard workers accountable for the mess they leave. There is really a lot more than a 1000 character block can hold. Everyday [sic] I have to convince my self [sic] to get out of bed to come to work. I pray that on the driver [sic] I get in a car accident and die. Often times I considering [sic] putting my pistol in my mouth and ending it all or just throwing myself into the dry dock basin. The command doesn't listen, they ignore or refuse to help someone until that person reaches the point where something bad happens and then blame them for not getting help when people do not trust most senior leadership because they cause most of the suffering.”⁹

The chief of the boat (COB) recalled reviewing the command's informal list of high-risk Sailors to see if the command triad could identify who made the comment to get the person help.¹⁰ The informal list consisted of about 15-20 Sailors with family, medical, performance or disciplinary issues who the command triad monitored for progress.¹¹ Romero was on the list as a precautionary measure for his repeated tardiness and his (b) (6) health issues, but Romero did not cross the COB's mind at all when he reviewed the DEOCS comments.¹² Other Sailors worried the COB more at the time.¹³ The executive officer (XO) reported that the CRT discussed all the negative comments in the DEOCS, including the suicide-related comment.¹⁴ The CRT collectively decided it was a single Sailor, and not a widespread crew issue.¹⁵ The current Command Managed Equal Opportunity (CMEO) Manager, a chief petty officer, shared the comment in the Chiefs Quarters but never received any corroborating information.¹⁶ The XO did not believe further suicide prevention training would help the crew because they had just completed it in late September, three months earlier.¹⁷

The DEOCS included several other comments expressing frustration with shipyard working conditions.¹⁸ The anonymous comments described unpredictable schedules, late work hours, a lack of planning, last-minute tasking, and a focus on staying on schedule by meeting shipyard expectations without considering the strain on the crew.¹⁹

The commanding officer (CO) considered the DEOCS to be consistent with other shipyard environments.²⁰ In October 2019, contributing to this assessment, USS COLUMBIA was ranked 6 of 13 submarines in shipyard Type Commander "People Centered Metrics."²¹ Furthermore, the USS COLUMBIA was on an upward trend improving from 10 to 6 between April and October 2019. He developed a Plan of Action and Milestones (POA&M) with the other members of the command triad after reviewing the DEOCS results with other senior leaders on the submarine.²² The CO's focus was communicating the findings and emphasizing to the crew that his priority was their health and well-being.²³ The DEOCS assessment was debriefed to the crew before Thanksgiving.²⁴ The CO provided resources in various outlets (e.g., plan of the day, all-hands calls).²⁵ Throughout the year, the CO also held weekly CO calls where Sailors of

all paygrades are invited as well as smaller focus groups with each paygrade.²⁶ He also described the Chiefs Quarters as an absolute asset.²⁷

On December 10, 2019, the CO submitted his command assessment report to his Immediate Superior in Command (ISIC), Commander, Submarine Squadron SEVEN (CSS-7).²⁸ He described areas of concern as managing inconsistent, long work hours; occupational stress; and crew fatigue due in part to the major overhaul and several instances of unanticipated, time critical work that had burdened the crew.²⁹ His recommended corrective actions included enhancing transparency, expanding awards and recognition, and maintaining open feedback channels.³⁰ The CO conducted an in-person debriefing with CSS-7, as required.³¹

CSS-7 did not question the POA&M concerning the DEOCS.³² From the ISIC perspective, USS COLUMBIA was executing duties and meeting milestones, reliably providing crewmembers to “hot fill” positions on other submarines, and effectively balancing manning priorities.³³ The negative comments did not reflect the overall status of the ship.³⁴ USS COLUMBIA was considered a good submarine that was working through common shipyard problems, such as low morale, a lack of sense of belonging among the junior Sailors, and a lack of commitment.³⁵

USS COLUMBIA had conducted an earlier Type Commander-led Submarine Culture Workshop in April 2019.³⁶ The primary objective of the workshop was to identify hazards that pose a risk to sustained operational excellence, which is “built on a foundation of *trust, integrity and leadership*, created and sustained through effective communication.”³⁷ At the time, the vast majority of the crew believed the performance of the USS COLUMBIA was on a downward trend (~80%) or at a low point (~10%) driven by two main factors: loss of experienced personnel and being in a shipyard environment.³⁸ However, job satisfaction and quality of life was slightly positive.³⁹

The CO’s philosophy, standards, and expectations were considered to be clearly communicated throughout the chain of command.⁴⁰ However, the crew viewed the Chiefs Quarters as disengaged, lacking leadership, and not holding to the same standards as the crew.⁴¹ Chiefs Quarters self-identified similar traits.⁴² Non-supervisory watchstanders were viewed as inattentive, complacent, and lacking accountability.⁴³

The crew expressed trepidation in addressing mental health issues with some E-5 and below crewmembers stating that they would be unwilling to seek help for mental health issues due to fear of negative impacts on their security clearance or job.⁴⁴ They also described processes that support the care and feeding of the crew, including awards, the indoctrination/sponsorship program, career development, and evaluations as adequate or needing improvement.⁴⁵ Discipline was described as lacking consistency, trending toward less discipline, with the command unable to address delinquent qualifications.⁴⁶ The crew participants described a healthy attitude and awareness towards alcohol, drugs, hazing/harassment, sexual assault/violence, and discrimination/equal opportunity.⁴⁷

Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC) also combines submarine advancement data, reenlistment data, Sailor qualifications, unplanned Sailor losses into “People Centered Metrics.” USS COLUMBIA over the past year has been low in the bottom third of all operational fast-attack submarines and in the bottom half on most reports for fast-attack submarines in a major shipyard availability.⁴⁸ However, beginning in August 2019, rankings in those reports began to trend upward.⁴⁹

- March 2019: 44 of 50 in the bottom 33% of Pacific submarines.⁵⁰
- In April 2019, USS COLUMBIA was moved into a separate category marked “Special Consideration Units” (for shipyard units) and ranked 10 of 13.
 - May 2019 USS COLUMBIA was ranked 9 of 13.
 - June 2019 USS COLUMBIA was ranked 10 of 13.
 - July 2019 USS COLUMBIA was ranked 10 of 13.
 - August 2019 USS COLUMBIA was ranked 6 of 12.
 - September 2019 USS COLUMBIA was ranked 7 of 12.
 - October 2019 USS COLUMBIA was ranked 6 of 13.⁵¹

In total, the surveys and assessments indicate shortfalls with monitoring and addressing the well-being, morale, and stress levels of the crew.⁵²

The investigation team also reviewed and found 16 of 18 shipboard support programs compliant. The command sponsorship and mentorship programs were non-compliant. The command sponsor coordinator does not have access to the Career Information

Management System (CIMS), and the command sponsorship program does not use the Military and Family Support Center for assistance with required command training.⁵³

In several interviews, crewmembers reported morale as generally good “for a shipyard environment.”⁵⁴

On November 12, 2019, the Chief of Naval Operations (CNO) released NAVADMIN 254/19 and described the drive toward a culture of excellence where Sailors feel included, respected, and empowered.⁵⁵ The message emphasized that the Navy must not rely on reactive strategies that demand large amounts of time to target a relatively small population but instead proactively prevent incidents from occurring in the first place.⁵⁶

Opinion 5.1.1: The organizational culture tolerated a below-average command climate because USS COLUMBIA was in an industrial environment. This cultural tolerance was reflected in the crew’s comments, a separate category in “People Centered Metrics” for submarines in the shipyard, and the ISIC’s reaction to the USS COLUMBIA’s below-average DEOCS results.⁵⁷

Opinion 5.1.2: More intrusive leadership, teamwork, and communication is required in more difficult environments such as extended maintenance periods in shipyards. Leaders should foster a culture of excellence where Sailors feel included, respected, and empowered regardless of location or operational status.⁵⁸

Recommendation 5.1.1: USS COLUMBIA, in coordination with CSS-7, develop a more comprehensive command climate POA&M, and bring sponsorship and mentorship programs into compliance. Consider use of the Fleet Chief Petty Officer Training Team to improve chief petty officer and first class petty officer leadership.

Recommendation 5.1.2: Commander Submarine Forces identify methods to improve crew morale, and command climate for units in an industrial environment.

Finding 5.2 (Potential Contributing/Noncompliance/Deficiency): USS COLUMBIA’s chain of command and medical department representative (MDR) did not share information effectively regarding Romero’s disciplinary issues, medical/mental condition, and family situation.⁵⁹

Discussion: Romero wrote in his private journal and expressed to Embedded Mental Health Clinic (eMHP) staff that he lacked a sense of belonging, felt alienated from his shipmates, and walked into a working environment that was not the best.⁶⁰ In his private journal, he made apparent reference to shipmates as “dumb, fucking rats and animals” who assumed he was “some horrible lazy, shitbag, that doesn’t give two shits about the Columbia and the crew....”⁶¹ Romero described a hostile work environment to his mother where he was frustrated with his prolonged submarine qualification process and not being engaged in meaningful, productive work.⁶² Romero generally isolated himself from his shipmates, but a third class petty officer described one episode in May or June 2019 where Romero was crying, and when the third class petty officer went over to talk with him, Romero shared that he was tired of work, and people treating him badly and calling him stupid.⁶³

The CO did not recall being informed about Romero’s eMHP Clinic visits.⁶⁴ The XO and COB knew generally about them but did not know specific details.⁶⁵ Romero’s department head and division officer were unaware of them.⁶⁶ Romero’s division chief did know about them and demonstrated concern about Romero’s well-being.⁶⁷ He met him after his Tripler Army Medical Center (TAMC) emergency room visit in March 2019, and later coordinated with the COB to arrange an appointment for Romero at the eMHP Clinic in September 2019.⁶⁸

No one in Romero’s chain of command discussed his emergency room visit or his eight eMHP Clinic visits between September and November 2019 with Romero’s primary care provider, the USS COLUMBIA MDR.⁶⁹ Romero’s division chief stated that Romero did not want to go to the MDR, an enlisted corpsman (E-6), and that the MDR would often tell Sailors to stop complaining.⁷⁰ The COB admitted that the MDR could be brash with junior Sailors, but he was a top performer.⁷¹ The CO thought the MDR did his job well.⁷² Others described the MDR as often absent for training but available when needed.⁷³

The MDR reported that he normally sees fewer than five patients a month.⁷⁴ The NSSC Undersea Medical Officer (UMO) thought that number of patients was very low and would expect the MDR to see at least five patients per month.⁷⁵

The MDR denied any knowledge of Romero's eMHP Clinic visits before the shooting.⁷⁶ His lack of knowledge indicates that he did not review Romero's medical record during Romero's annual Preventive Health Assessment (PHA)/Mental Health Assessment (MHA) on October 9, 2019, as required.⁷⁷ Romero indicated "No" or "Not Applicable" on every question related to mental health, which at the time was not accurate.⁷⁸ The MDR also previously failed to document a follow-up appointment to Romero's TAMC emergency room visit in December 2018 after a motorcycle accident.⁷⁹ The MDR had been counseled previously for not documenting patient care properly.⁸⁰

Opinion 5.2.1: With information sharing and collaboration on Romero's long-developing problems, the chain of command may have taken more intrusive actions to direct additional mental health evaluation or remove Romero from armed watchstanding.⁸¹

Opinion 5.2.2: The USS COLUMBIA MDR, as Romero's primary care provider, did not provide forceful backup to the chain of command concerning Romero's mental health treatment.⁸² At a minimum, the MDR should have known after Romero's PHA/MHA on October 9, 2019, about his March 2019 emergency room visit and his initial September 2019 eMHP Clinic visit.⁸³

Recommendation 5.2.1: In combination with aligning eMHP practice to increase information sharing with the chain of command, Commander Submarine Forces take action as appropriate to increase communication and collaboration across the submarine force concerning mental health.

Finding 5.3 (Noncontributing/Compliance/Deficiency): USS COLUMBIA’s CRT conducted command climate assessments in accordance with OPNAV Instruction 5354.1G.⁸⁴ However, unit-level CRTs with additional guidance and training can do more to promote healthy command climates and Sailor well-being.⁸⁵

Discussion: CRTs are designed to provide commanders with information and insight into concerns of command personnel.⁸⁶ CRT members each bring a different perspective on the overall well-being, morale, and stress levels of the command.⁸⁷

As noted in Finding 5.1, USS COLUMBIA conducted a command climate assessment after a change of command in 2018 and an annual command climate assessment in 2019, as required.⁸⁸

The USS COLUMBIA CRT had the required membership, and held at least three meetings in 2019.⁸⁹ According to OPNAV Instruction 5354.1G, the mandatory CRT membership includes the XO, one department head, one department leading chief petty officer, command career counselor, personnel officer, legal officer, sexual assault prevention and response point of contact (SAPR POC), drug and alcohol program advisor (DAPA), command financial specialist (CFS), suicide prevention coordinator (SPC), CMEO program manager, chaplain (if assigned), command diversity officer (if assigned), mental health specialist (if assigned), and equal employment opportunity (EEO) specialist (if assigned).⁹⁰

The three critical components that forge an effective CRT are collaboration, climate assessment, and engaged deckplate leadership.⁹¹ The current CRT guide provides a step-by-step approach to execute a command climate assessment but contains limited guidance on how deckplate leaders identify stress indicators and potential risk of harm.⁹²

NAVADMIN 222/19 announced that, as of October 1, 2019, an Expanded Operational Stress Control (E-OSC) program “will empower and encourage the Navy community of Sailors, civilians, and their families to identify signs of stress within themselves and other and know where to turn for help.”⁹³ The E-OSC will use CRTs and deckplate leadership to “provide more accessible, collaborative resources and real-time assessment of unit culture to promote healthy command climates and mitigate risk.”⁹⁴

The focus of the E-OSC and CRTs will be to address the broad range of stressors (relationships problems, career transitions, disciplinary/legal issues, performance issues, and financial strain) that Sailors often experience.⁹⁵ The CRTs are to adopt primary prevention principles and human factors to give CRTs greater capability and responsibility to assess overall well-being, morale, and stress-levels in commands.⁹⁶

The current plan to train CRTs in the new E-OSC approach relies heavily on command climate specialists (CCSs) and CMEO managers, and does not include other resources like Fleet Chief Petty Officer Training Teams, Afloat Training Groups, or community-specific training teams.⁹⁷

Opinion 5.3.1: The E-OSC should be expedited, and training resources should be augmented to incorporate primary prevention principles and human factors into CRTs.⁹⁸

Opinion 5.3.2: The CRT instruction, guide, and training should be updated to incorporate primary prevention principles and human factors, and training should be developed for command leadership and Sailor development schools that is tailorable to communities and their respective operational environments, platforms, and command compositions.⁹⁹

Recommendation 5.3.1: OPNAV N17, in coordination with Echelon 2 Commanders, revise the E-OSC training plan to incorporate leadership resources in addition to CCSs and CMEO Managers.

Recommendation 5.3.2: OPNAV N17 update the CRT instruction and CRT guide to incorporate guidance on primary prevention principles and human factors.

Recommendation 5.3.3: OPNAV N17 develop CRT training for command leadership and Sailor development schools that is tailorable to platforms and across command environments.

¹ Defense Organizational Climate Survey Report of 2019, page 6-10; Submarine Afloat Cultural Workshop of April 2019; People Centered Metrics from March to October 2019.

² USS COLUMBIA (SSN 771) FY19 Extended Overhaul Information Sheet.

³ OPNAVINST 5354.1G, Appendix I; Defense Organizational Climate Survey Report of 2019; Defense Organizational Climate Survey Report of 2018.

⁴ Defense Organizational Climate Survey Report of 2019; Defense Organizational Climate Survey Report of 2018.

⁵ Defense Organizational Climate Survey Report of 2019, page 24.

⁶ Defense Organizational Climate Survey Report of 2019, page 13.

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- ⁷ Defense Organizational Climate Survey Report of 2019, § 3 Overall Unit Summary.
- ⁸ Defense Organizational Climate Survey Report of 2019, Appendix B.
- ⁹ Defense Organizational Climate Survey Report of 2019, page 44.
- ¹⁰ SI with ETRCS (b)(6) of 17 Jan 20.
- ¹¹ Email from ETRCS (b)(6) to LT (b)(6) of 19 Feb 20.
- ¹² SI with ETRCS (b)(6) of 17 Jan 20.
- ¹³ *Id.*
- ¹⁴ SI with LCDR (b)(6) of 17 Jan 20.
- ¹⁵ *Id.*
- ¹⁶ SI with MMACS (b)(6) and FTC (b)(6) of 21 Jan 20.
- ¹⁷ SI with LCDR (b)(6) of 17 Jan 20.
- ¹⁸ Defense Organizational Climate Survey Report of 2019, Appendix B.
- ¹⁹ Defense Organizational Climate Survey Report of 2019, Appendix B, pages 33, 37-40, 43-49, 52-55, 60.
- ²⁰ SI with CDR (b)(6) of 17 Jan 20.
- ²¹ *Id.*
- ²² *Id.*
- ²³ *Id.*
- ²⁴ SI with YNS1 (b)(6) of 13 Jan 20.
- ²⁵ SI with CDR (b)(6) of 17 Jan 20.
- ²⁶ *Id.*; SI with MMACS (b)(6) and FTC (b)(6) of 21 Jan 20.
- ²⁷ SI with CDR (b)(6) of 17 Jan 20.
- ²⁸ Command Climate Assessment (Plan of Actions and Milestones) Ltr of 10 Dec 19.
- ²⁹ *Id.*
- ³⁰ *Id.*
- ³¹ OPNAVINST 5354.1G; Appendix I; SI with MMACS (b)(6) and FTC (b)(6) of 21 Jan 20; SI with CDR (b)(6) 17 Jan 20.
- ³² SI with CAPT (b)(6) of 21 Jan 20; The CSS-7 Commodore was in command for one week at the start of our investigation.
- ³³ *Id.*
- ³⁴ *Id.*
- ³⁵ *Id.*
- ³⁶ Submarine Cultural Workshop of April 2019.
- ³⁷ Submarine Cultural Workshop of April 2019, Part 1, Primary Objectives.
- ³⁸ Submarine Cultural Workshop of April 2019, Key Observations ¶ 1.
- ³⁹ *Id.*
- ⁴⁰ Submarine Cultural Workshop of April 2019, Key Observations ¶ 2.
- ⁴¹ Submarine Cultural Workshop of April 2019, Key Observations ¶ 5.
- ⁴² *Id.*
- ⁴³ Submarine Cultural Workshop of April 2019, Key Observations ¶ 8.
- ⁴⁴ Submarine Cultural Workshop of April 2019, Key Observations ¶ 9. See Finding 3.1.
- ⁴⁵ Submarine Cultural Workshop of April 2019, Key Observations ¶ 10.
- ⁴⁶ *Id.*
- ⁴⁷ Submarine Cultural Workshop of April 2019, Key Observations ¶ 9.
- ⁴⁸ People Centered Metrics from March to October 2019.
- ⁴⁹ *Id.*
- ⁵⁰ *Id.*
- ⁵¹ *Id.*
- ⁵² Defense Organizational Climate Survey Report of 2019; Defense Organizational Climate Survey Report of 2018; Submarine Cultural Workshop of April 2019.
- ⁵³ SI with YNS1 (b)(6) of 13 Jan 20.
- ⁵⁴ *Id.*; SI with MMAFN (b)(6) 13 Jan 20; SI with MMA1 (b)(6) of 13 Jan 20; SI with MMAFN (b)(6) of 13 Jan 20.
- ⁵⁵ NAVADMIN 254/19.

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- ⁵⁶ *Id.*
- ⁵⁷ SI with CAPT (b)(6) of 21 Jan 20; People Centered Metrics from March to October 2019.
- ⁵⁸ NAVADMIN 254/19.
- ⁵⁹ SI with HM1 (b)(6) of 15 Jan 20; SI with MMAC (b)(6) of 14 Jan 20; SI with LCDR (b)(6) of 17 Jan 20.
- ⁶⁰ NCIS Report of Investigation of 2 Jan 20, Exhibit 2, Enclosure D; NSSC Mental Health Clinic Encounter of 30 Sep 19.
- ⁶¹ NCIS Report of Investigation of 2 Jan 20, Exhibit 2, Enclosure D.
- ⁶² SI with (b)(6) of 18 Jan 20.
- ⁶³ SI with ETV3 (b)(6) of 15 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20; NSSC Mental Health Encounter of 8 Oct 19; SI with MMA3 (b)(6) of 13 Jan 20; SI with MMN2 (b)(6) of 13 Feb 20.
- ⁶⁴ SI with CDR (b)(6) of 17 Jan 20.
- ⁶⁵ SI with ETRCS (b)(6) of 17 Jan 20; SI with LCDR (b)(6) of 17 Jan 20.
- ⁶⁶ SI with LCDR (b)(6) of 13 Jan 20; SI with LT (b)(6) of 14 Jan 20.
- ⁶⁷ SI with MMAC (b)(6) of 14 Jan 20.
- ⁶⁸ *Id.*
- ⁶⁹ SI with ETRCS (b)(6) of 17 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; SI with HM1 (b)(6) of 15 Jan 20.
- ⁷⁰ *Id.*
- ⁷¹ SI with ETRCS (b)(6) of 17 Jan 20.
- ⁷² SI with CDR (b)(6) of 17 Jan 20.
- ⁷³ SI with FT1 (b)(6) of 15 Jan 20; SI with MMAFN (b)(6) of 13 Jan 20.
- ⁷⁴ SI with HM1 (b)(6) of 15 Jan 20.
- ⁷⁵ Memorandum for the Record, Conversation with LT (b)(6) of 16 Jan 20.
- ⁷⁶ SI with HM1 (b)(6) of 15 Jan 20.
- ⁷⁷ PHA and MHA of 9 Oct 19; DoDI 6200.06 § 3.2-3.3.
- ⁷⁸ PHA and MHA Assessment Electronic Record of HM1 (b)(6). DoD ID number 154192886 identifies this record as Romero's annual medical screening.
- ⁷⁹ SI with HM1 (b)(6) of 15 Jan 20; TAMC Emergency Room Chronology of Care of 17 Dec 18; Motorcycle Mishap Safety Report of Romero, Gabriel Antonio.
- ⁸⁰ NSSC IDC Training Record, page 8.
- ⁸¹ SI with CDR (b)(6) of 17 Jan 20; SI with LCDR (b)(6) of 17 Jan 20; SI with ETRCS (b)(6) of 17 Jan 20; SI with MMAC (b)(6) of 14 Jan 20; SI with HM1 (b)(6) of 15 Jan 20.
- ⁸² SI with HM1 (b)(6) of 15 Jan 20.
- ⁸³ *Id.*
- ⁸⁴ SI with MMACS (b)(6) and FTC (b)(6) of 21 Jan 20.
- ⁸⁵ NAVADMIN 222/19.
- ⁸⁶ Command Resilience Team Guide, Introduction ¶ 1.
- ⁸⁷ Command Resilience Team Guide, Part 1 ¶ 2.
- ⁸⁸ OPNAVINST 5354.1G, Appendix I; Defense Organizational Climate Survey Report of 2019; Defense Organizational Climate Survey Report of 2018.
- ⁸⁹ Command Resilience Team Guide, Part 1 ¶ 2; SI with MMACS (b)(6) and FTC (b)(6) of 21 Jan 20.
- ⁹⁰ Command Resilience Team Guide, Part 1 ¶ 2.
- ⁹¹ Command Resilience Team Guide, Introduction ¶ 2.
- ⁹² Command Resilience Team Guide of 26 Jun 18.
- ⁹³ NAVADMIN 222/19.
- ⁹⁴ NAVADMIN 222/19 ¶ 3(a).
- ⁹⁵ NAVADMIN 222/19 ¶ 3(c).
- ⁹⁶ NAVADMIN 222/19 ¶ 4.
- ⁹⁷ NAVADMIN 222/19 ¶ 4(a).
- ⁹⁸ NAVADMIN 222/19.
- ⁹⁹ Command Resilience Team Guide of 26 Jun 18.

Chapter 6 - Personnel Security Program (PSP) and Insider Threat Program (ITP)

This chapter examines the Department of the Navy (DON) PSP and ITP in the context of the December 4, 2019 shooting incident. The PSP authorizes initial and continued access to classified information and assignment to sensitive duties “to those persons whose loyalty, reliability and trustworthiness are such that entrusting them with classified information or assigning them to sensitive duties is clearly consistent with the interests of national security.”¹ DON insider threat policy is “to establish an integrated set of policies and procedures to deter, detect, and mitigate insider threats before damage is done to national security, personnel, resources, or capabilities.”²

The investigation team reviewed Romero’s medical, personnel, and security clearance records, beginning from his screening before he joined the Navy through recruit and accession training and the continuous evaluation program aboard USS COLUMBIA.

The investigation team also reviewed insider threat research and implementation actions based on recommendations from recent Department of Defense (DoD) investigations, including the Fort Hood and Washington Navy Yard (WNY) investigations.

Regulatory Background

DoDI 1438.06 (Department of Defense (DoD) Workplace Violence Prevention and Response Policy) establishes DoD policy and assigns responsibilities for workplace violence prevention and response policy regarding DoD civilian personnel.

DoDI 5145.03 (Oversight of the DoD PSPs) establishes policies and assigns responsibilities for the oversight of DoD PSPs.

DoDI 5200.02 (DoD PSP) establishes policies, assigns responsibilities, and prescribes procedures for the DoD PSP.

DoDI 5205.83 (DoD Insider Threat Management and Analysis Center (DITMAC)) establishes policy, assigns responsibilities, and prescribes procedures for the DITMAC, which serves as the DoD's enterprise-level capability for insider threat information integration and management.

DoDM 5200.02 (Procedures for the DoD PSP) implements policy, assigns responsibilities, and provides procedures for the DoD PSP.

SECNAVINST 5510.30C (DON PSP) establishes the DON PSP program and supplements DoD PSP standards in DoDM- 5200.02 where needed.

SECNAV M-5510.30 (PSP) established specific DON PSP policy and provided uniformity in the application of PSP policies in the DON (canceled on January 24, 2020).

SECNAVINST 5510.37A (DON ITP) establishes the DON ITP, promulgates policy, defines governance, and assigns responsibilities.

ALNAV 040/16 (DoD Continuous Evaluation Program (CEP)) announces to DON Personnel that the DoD CEP is active and will use automated records checks of authoritative data from DoD, other government, and commercial sources.

OPNAVINST 5510.165A (Navy ITP) issues policy, assigns responsibilities, and institutes the Navy Insider Threat Board of Governance (NITBOG).

Findings-Opinions-Recommendations

Finding 6.1 (Noncontributing/Compliance): Security officials complied with PSP policies during Romero's recruitment, training, and initial adjudication of his clearance.³

Discussion: Nothing in Romero's pre-service history or behavior during training violated Navy's security clearance adjudication guidelines.⁴ At the time of his enlistment and start of active-duty service on December 11, 2017, Romero had no documented mental or physical medical conditions that would have disqualified him from military service.⁵ In addition, Romero had no criminal record.⁶ He successfully completed the Armed Services Vocational Aptitude Battery (ASVAB) examination with a score of 51 and was

processed into military service at Military Entrance Processing Station (MEPS) San Antonio, Texas.⁷ The minimum ASVAB score required for enlistment in the active-duty Navy for non-prior service applicants is 31.⁸

Romero satisfactorily completed all training, standard mental health screening, and related testing during enlisted basic training at Recruit Training Command (RTC) in Great Lakes, Illinois, and at Naval Submarine School, in Groton, Connecticut.⁹ During initial days at RTC, mental health providers from the Captain James A. Lovell Federal Health Care Center (FHCC) Recruit Evaluation Unit (REU) screen new recruits at basic training.¹⁰ The REU conducts comprehensive mental health evaluations to determine suitability for service.¹¹

The Basic Enlisted Submarine School (BESS) in Groton partners with Naval Submarine Medical Research Laboratory (NSMRL) to administer the SUBSCREEN test to measure prospective submariners on traits that may be incompatible with service in the submarine force (e.g., anxiety, depression, suicidal thoughts).¹² If a potential submariner exceeds one or more of the test's referral methods, that person is referred to a mental health technician for an interview.¹³ Romero's test results did not meet the criteria for a referral.¹⁴ BESS updated the normative population that is used to determine significant deviation from the average submariner in January 2019 after Romero attended the school.¹⁵ The test is currently being modernized such that prospective submariners will be evaluated using the Minnesota Multiphasic Personality Inventory (MMPI) and a supplemental, submarine-specific risk assessment tool.¹⁶ The MMPI is a clinical assessment of current psychopathology that is frequently used by law enforcement and other public safety organizations to identify those who have characteristics incompatible with the respective services.¹⁷ The supplemental risk assessment tool will include factors previously identified as predictive of mental health outcomes as well as new context that measure qualities and characteristics unique to the submarine environment.¹⁸

On January 24, 2018, before Romero completed basic training at RTC Great Lakes, DoD Consolidated Adjudications Facility (DoD CAF) closed Romero's initial adjudication and granted him a Secret (T3) security clearance.¹⁹ In filling out his electronic questionnaire for investigation processing (e-QIP), Romero answered negatively on all the section 21

questions related to psychological and mental health.²⁰ In interviews after the shooting, Romero's mother reported he had no mental health treatment or pre-service mental health concerns, which was consistent with his enlistment screening.²¹ The investigation team was unable to uncover any documented mental health counseling before Romero reported to USS COLUMBIA on June 28, 2018.²²

Opinion 6.1.1: In the context of PSP policies and guidelines, nothing screened Romero from joining the Navy, obtaining a clearance, and qualifying for submarine duty.²³

Opinion 6.1.2: Although no potential threat indicators were apparent when Romero joined the Navy, adjudicative guidelines and the security clearance process should be continuously improved based on reviews of previous insider threat incidents.²⁴

Recommendation 6.1.1: DoD CAF audit the initial clearance adjudication of Romero to determine whether adjudicative guidelines and clearance processes should be revised.

Recommendation 6.1.2: Naval Education and Training Command (NETC), in coordination with BUMED, review this report to identify potential improvements to mental health screening procedures at RTC and accession training.

Finding 6.2 (Noncontributing/Compliance/Deficiency): Security managers complied with PSP policies related to the continuous evaluation program (CEP) during Romero's time on USS COLUMBIA.²⁵ The CEP thresholds for questionable judgment, untrustworthiness, and unreliability, as established by SECNAV M-5510.30, generally did not create a decision point absent other reportable behavior.²⁶

Discussion: Commands are required to implement a proactive CEP.²⁷ When questionable or unfavorable information becomes available concerning a person who has been granted access to classified information or assigned to sensitive duties, commands will report that information through the Joint Personnel Adjudication System (JPAS).²⁸

Potential criteria that may have prompted a JPAS incident report would have been criminal conduct; apparent mental, emotional or personality disorder(s); conduct involving questionable judgement, untrustworthiness, unreliability or unwillingness to comply with rules and regulations; or unwillingness to cooperate with security clearance

processing.²⁹ The USS COLUMBIA security manager stated that written counseling chits and one executive officer inquiry (XOI) appearance generally do not warrant a JPAS incident report (depending on the underlying conduct).³⁰ Mental health issues also do not lead to an incident report absent a provider's diagnosis or suicidal ideations.³¹

Removal of access or suspending of a submariner's security clearance in practice is equivalent to removing them from submarine duty.³² A Sailor cannot be on a submarine without a fully adjudicated Secret security clearance (T3).³³

The Commander, Submarine Force, U.S. Pacific (COMSUBPAC) security manager confirmed that, based on the guidance he provides subordinate units, Romero would not have prompted a JPAS incident report from the unit security manager.³⁴ Romero's division, supervisors, and shipmates described him as an introverted, quiet person.³⁵ Several shipmates stated Romero's behavior was consistent from when he reported to USS COLUMBIA until the shooting incident.³⁶ Several shipmates stated they never questioned or observed Romero behave in a way that would have caused them to consider him a security threat.³⁷ A review of Romero's social media accounts resulted in no pertinent information that would have prompted any reports relating to a security issue.³⁸

However, as discussed in Finding 6.3 below, Romero did demonstrate some potential risk indicators. The 2009 DoD Fort Hood investigation found that vague adjudicative guidelines did not provide commanders and their personnel with clear distinctions or thresholds for what constitutes information that should be forwarded absent other reportable behavior.³⁹ Vague criteria reflect "whole person" evaluations that are characterized by shades of gray.⁴⁰ Limitations on definitions of questionable behaviors result in aversion to reporting potentially adverse information that does not cross other reporting thresholds once a clearance has been granted.⁴¹

Since the December 4, 2019 shooting incident, SECNAV Instruction 5510.30C canceled SECNAV M-5510.30.⁴² The applicable CEP reporting guidelines are in DoDM 5200.02.⁴³ Information that suggests a person may have an "emotional, mental, or personality condition that can impair judgment, reliability, or trustworthiness will be reported to the supporting adjudication facility."⁴⁴ This reporting requirement contains a non-exhaustive list of ten indicators including, among other things, a report that a person

sought treatment for a mental, emotional, or substance abuse condition (commensurate with reporting limitations of Section 21 on Standard Form 86); direct or indirect threats of violence, physical altercations, assaults, or significant destruction of U.S. Government property; abrupt changes in appearance or behavior suggesting impaired judgment or stability (e.g., deteriorating physical appearance or self-care, or social withdrawal); suicide threats, attempts, or gestures, or actions; and a catch-all category of “any other behaviors which appear to be abnormal and indicate impaired, judgment, reliability or maturity.”⁴⁵ Commanders are encouraged to ensure all personnel are aware that seeking behavioral and other types of counseling is a positive step in supporting continued security eligibility.⁴⁶

As a result of the WNY shooting and other events, the DoD accelerated deployment of the automated CEP.⁴⁷ The automated CEP uses records checks of data from government and commercial sources to review the backgrounds of persons who have been determined eligible for access to classified information or assignment or retention in a sensitive position to determine whether those persons continue to meet personnel security standards.⁴⁸ Romero was not enrolled in the automated CEP because he was not within a class of personnel that had been phased into the system.⁴⁹ However, no evidence suggests an alert would have occurred in the automated CEP, which complements other CEP efforts and does not replace unit-level responsibilities.⁵⁰

Opinion 6.2.1: The chain of command and security managers with responsibility for Romero did not have a requirement under reporting thresholds established in SECNAV M-5510.30 to initiate a JPAS incident report, remove his access to classified information, or suspend his security clearance.⁵¹

Opinion 6.2.2: The thresholds for questionable judgment, untrustworthiness, and unreliability, as established by SECNAV M-5510.30, were too vague to result in JPAS incident reports of questionable or unfavorable information in most situations absent other reportable behavior.⁵²

Opinion 6.2.3: Romero likely would not have prompted a JPAS report under the more detailed CEP reporting requirements in DoDM 5200.02.⁵³ Further clarifying definitions on general catch-all categories concerning judgment, reliability, trustworthiness, and

maturity as well as amplifying guidance through training would aid unit-level decision-making in the CEP.

Opinion 6.2.4: Romero’s potential risk indicators did not meet reporting thresholds in the CEP, but reporting guidelines should be continuously improved based on review and lessons learned from insider threat incidents.⁵⁴

Recommendation 6.2.1: DoD CAF use this incident as a case study to evaluate CEP reporting thresholds. Further define catch-all categories or provide illustrative examples through amplifying guidance and training to aid unit-level decision-making.

Finding 6.3 (Potential Contributing/Noncompliance/Deficiency): Romero constituted an insider threat.⁵⁵ Romero demonstrated potential risk indicators to shipmates that were not significant enough to prompt reports through any established insider threat reporting procedures or to law enforcement, but they should have been reported to supervisors.⁵⁶

Discussion: The DON established the DON ITP in 2013.⁵⁷ The Fiscal Year 2017 National Defense Authorization Act (NDAA) expanded the insider threat definition from threats related to the unauthorized disclosure of classified information to also include threats from a person with authorized access who “commits a destructive act, which may include physical harm to another in the workplace.”⁵⁸

As part of the DON ITP, DON policy requires, among other things, establishment of a single DON Insider Threat Hub to serve as an integrated capability to monitor and audit information; implementation of Prevention, Assistance, and Response (PAR) or PAR-like capabilities and synchronization of these capabilities with the DON ITP; and insider threat training and awareness for all DON personnel.⁵⁹

DON personnel are responsible for reporting activity that could cause harm to national security through “physical harm to another in the workplace resulting in loss or degradation of resources and capabilities.”⁶⁰ OPNAV Instruction 5510.165A, which predates SECNAV Instruction 5510.37A, requires Echelon 2 Commanders to develop procedures for reporting insider threats through the chain of command to Navy ITP

“analytic and response centers.”⁶¹ The DON Insider Threat Hub recently achieved initial operational capability (IOC) in October 2019.⁶²

The DON Insider Threat Hub mostly uses existing programs and data streams to monitor and audit information.⁶³ Consistent with this concept, the current Naval Office of Inspector General checklist for insider threat assessments is not a specific separate program review but part of other program reviews, such as the PSP and Arms, Ammunition, and Explosives (AA&E) Program, among others.⁶⁴

The investigative team reviewed previous instances of insider threats involving workplace violence and insider threat research.⁶⁵ The investigation team also reviewed DON Counterintelligence and Insider Threat Awareness and Reporting training, DoD Antiterrorism Level I training, the “Key Indicators of Potentially Violent behavior” attachment to the Deputy Secretary of Defense’s February 2, 2017 memorandum concerning PAR capabilities, and other insider threat decision aids.⁶⁶ Based on that review, these facts are notable about Romero’s potential insider threat indicators:

- He was isolated and withdrawn from his shipmates, and he stopped expressing himself to his division chief;⁶⁷
- He expressed to one shipmate in May or June 2019 that he was tired of work and angry about shipmates mistreating him and calling him stupid;⁶⁸
- He reacted angrily and yelled when, in late August or early September 2019, a shipmate suggested counseling support to Romero when he appeared stressed.⁶⁹
- A lieutenant noticed Romero had scratched knuckles, and Romero told him it was from hitting a locker.⁷⁰
- He exhibited unusually poor work performance. He was delinquent on qualifications and had ten counseling chits, the second most in the command.⁷¹
- He was notified in late November 2019 that he did not advance to E-4.⁷²
- He had ongoing disciplinary problems. He went to a disciplinary review board (DRB) in late November and to executive officer inquiry (XOI) the day before the

shooting.⁷³ The executive officer (XO) warned him that he would go to commanding officer's non-judicial punishment if he was late again for work.⁷⁴

On the other hand, Romero did not exhibit the vast majority of other indicators of potentially violent behavior. He had no prior history of violent behavior or of threatening violent behavior.⁷⁵ He never expressed homicidal or suicidal thoughts.⁷⁶ He had no record of alcohol or drug abuse, criminal affiliations, financial problems, weapons mishandling, or interest in previous shooting incidents.⁷⁷

USS COLUMBIA conducted insider threat training in 2019.⁷⁸ They were able to articulate indicators when asked, and several Sailors who worked with Romero regularly explained why he did not exhibit enough indicators such that they ever felt concerned.⁷⁹

To borrow from a previous physical security assessment report after the WNY shooting, "Real world experience has shown that the threshold at which an individual exhibits behavior aberrant enough to warrant intervention by his coworkers or supervisors is above the level of behavior that may actually be indicative of real risk—particularly when evaluated during post-incident forensics."⁸⁰

SECNAV Instruction 5510.37A requires PAR or PAR-like capabilities to be implemented at installations, including bases, stations, and joint bases, and other designated-organizations, but that requirement is not implemented through an update to OPNAV Instruction 5510.165A.⁸¹ The PAR framework requires information sharing between installation and organizational commanders and DoD component Insider Threat Hubs on personnel at risk of potentially violent behavior.⁸² The PAR framework does not create new capabilities but instead requires DoD components to use and synchronize existing support functions to help personnel at risk of potentially violent behavior.⁸³

Opinion 6.3.1: No one could not have reasonably predicted Romero's violent behavior on December 4, 2019, but he did demonstrate potential risk indicators that should have been reported to supervisors.⁸⁴

Opinion 6.3.2: This incident should be incorporated into DON insider threat awareness and reporting training to increase content on reporting workplace violence.⁸⁵ The

shipmates' encounters with Romero are examples of the key principle of threat management, which is "see something, say something."⁸⁶

Opinion 6.3.3: Prevention (e.g., PAR-like capabilities) should augment predictive tools to help prevent workplace violence.⁸⁷ Command Resilience Teams (CRTs) may offer existing PAR-like capabilities at the unit level especially after the Expanded Operational Stress Control (E-OSC) program incorporates prevention principles and human factors.⁸⁸

Opinion 6.3.4: If shipmates would have reported potential risk indicators to supervisors, the chain of command may have aggregated them with other known risk factors to recognize that circumstances warranted his rescreening for armed watchstanding.⁸⁹

Recommendation 6.3.1: Director, Navy Staff (DNS) and Echelon 2 Commanders, in coordination with DON Insider Threat Hub, use this incident as a case study when developing fleet reporting procedures to the DON Insider Threat Hub as it works toward full operational capability.

Recommendation 6.3.2: The Naval Criminal Investigative Service (NCIS) incorporate this incident, including the indicators into DON Insider Threat Training.

Recommendation 6.3.3: DNS, in coordination with DON Insider Threat Hub, consider use of the E-OSC program and CRTs when implementing PAR-like capabilities at the installation and organization-level. See Finding 5.3.

¹ SECNAV M-5510.30 § 1-1 ¶ 2.

² SECNAV 5510.37A § 6.

³ USMEPCOM PCN 680-3ADP, Processee/Enlistee Record of Romero, Gabriel Antonio; JPAS for Romero, Gabriel Antonio.

⁴ DD Form 1966/2 of Romero, Gabriel Antonio; SECNAV M-5510.30, Appendix G-1; MANMED § 15-106.

⁵ DD Form 2807-1 of Romero, Gabriel Antonio.

⁶ Electronic Questionnaires for Investigation Processing Request #24226751.

⁷ DD Form 1966/2 of Romero, Gabriel Antonio.

⁸ Email from CMDCM (b)(6) to LN1 (b)(6) of 25 March 20.

⁹ BESS Training Summary for Romero, Gabriel Antonio; Email from CAPT (b)(6) to CDR (b)(6) of 24 Jan 20; NRTC Response of 16 Jan 20; Federal Health Center Response of 22 Jan 20 (included Recruit Evaluation Unit (REU) Standard Operating Procedures).

¹⁰ NRTC Response of 16 Jan 20; Federal Health Center Response of 22 Jan 20.

¹¹ Federal Health Center Response of 22 Jan 20.

¹² Email from CAPT (b)(6) to CDR (b)(6) of 24 Jan 20

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*
¹⁷ *Id.*
¹⁸ *Id.*
¹⁹ Electronic Questionnaires for Investigation Processing Request #24226751.
²⁰ *Id.* at § 21.
²¹ SI (b)(6) of 18 Jan 20.
²² Email from CAPT (b)(6) to CDR (b)(6) of 24 Jan 20; NRTC Response of 16 Jan 20.
²³ *Id.*; Electronic Questionnaires for Investigation Processing Request #24226751; USMEPCOM PCN 680-3ADP, Processee/Enlistee Record of Romero, Gabriel Antonio; JPAS for Romero, Gabriel Antonio.
²⁴ DON WNY Shooting Investigation (2013), ¶ 7.1.6, page 111; DoD Independent Review of the WNY Shooting, November 2013; Defense Science Board Task Force: Predicting Violent Behavior (2012), page 6.
²⁵ SECNAV M-5510.30, Exhibit 10A.
²⁶ *Id.*
²⁷ SECNAV M-5510.30 § 8-1 ¶ 6.
²⁸ *Id.* at Exhibit 10A.
²⁹ *Id.*; SECNAV M-5510.30, Appendix E.
³⁰ SI with LT (b)(6) of 16 Jan 20.
³¹ *Id.*; SI with (b)(6) of 14 Jan 20.
³² SI with (b)(6) of 14 Jan 20.
³³ *Id.*
³⁴ *Id.*
³⁵ SI with MMN2 (b)(6) of 15 Jan 20; SI with LT (b)(6) of 14 Jan 20; SI with MMAC (b)(6) of 14 Jan 20; SI with MMACS (b)(6) and FTC (b)(6) of 21 Jan 20.
³⁶ SI with MMAC (b)(6) of 14 Jan 20; SI with HMI (b)(6) of 15 Jan 20; SI with MMA3 (b)(6) 13 Jan 20.
³⁷ SI with YNS1 (b)(6) of 13 Jan 20; SI with TM3 (b)(6) of 10 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20.
³⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 70.
³⁹ Protecting the Force: Lessons from Fort Hood (2010), Finding 2.2, page 13 (citing various service regulations including SECNAV Instruction 5510.30B Personnel Security Program).
⁴⁰ *Id.*
⁴¹ *Id.*
⁴² SECNAVINST 5510.30C (canceled); SECNAV M-5510.30.
⁴³ *Id.* at Enclosure 12; DoDM 5200.02, § 11.1.
⁴⁴ DoDM 5200.02, § 11.1.c(4).
⁴⁵ *Id.*
⁴⁶ SECNAVINST 5510.30C, Enclosure 12, ¶ 1.d(1).
⁴⁷ ALNAV 040/16, DoD Continuous Evaluation Program; DON WNY Shooting Investigation, page 110-112.
⁴⁸ ALNAV 040/16, DoD Continuous Evaluation Program.
⁴⁹ SI with (b)(6) of 14 Jan 20.
⁵⁰ SECNAV M-5510.30 § 10-6; Executive Order 13764, Amending the Civil Service rules, EO 13488, and EO 13467 to Modernize the Executive Branch-Wide Governance Structure and Process for Security Clearances, Suitability and Fitness for Employment, and Credentialing, and Related Matters, at Section 3(e).
⁵¹ SI with (b)(6) of 14 Jan 20; SI with LT (b)(6) of 16 Jan 20.
⁵² SECNAV M-5510.30, Exhibit 10A.
⁵³ DoDM 5200.02, § 11.1.c(4).
⁵⁴ DON WNY Shooting Investigation (2013), ¶ 7.1.6, page 111; DoD Independent Review of the WNY Shooting, November 2013; Defense Science Board Task Force: Predicting Violent Behavior (2012), page 6.
⁵⁵ National Defense Authorization Act for Fiscal Year 2017 § 95. 1; SECNAVINST 5510.37A
⁵⁶ *Id.*
⁵⁷ SECNAV 5510.37 of 8 Aug 13 (Canceled); SECNAV 5510.37A.
⁵⁸ National Defense Authorization Act for Fiscal Year 2017, Subtitle F “Other Matters” § 951 ¶ (f)(b)(ii).
⁵⁹ SECNAVINST 5510.37A § 6 ¶ c.

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- ⁶⁰ *Id.* at ¶ 7.
- ⁶¹ OPNAVINST 5510.165A § 7 ¶ n(2).
- ⁶² SECNAVINST 5510.37A ¶ 6(c); UNSECNAV Memo of 2 May 19.
- ⁶³ SECNAVINST 5510.37A, ¶ 7.
- ⁶⁴ NAVINSGEN Security Team Inspection Management Checklist for Echelon Two Commands (revised April 2018, For Official Use Only).
- ⁶⁵ Greitzer and Hohimer, Modeling Human Behavior to Anticipate Insider Attacks, *Journal of Strategic Study*, Vol. 4, No. 2, pp. 25-48 page 27; Greitzer, et al., Developing an Ontology for Individual and Organizational Sociotechnical Indicators of Insider Threat Risk, *Semantic Technology for Intelligence, Defense, and Security (STIDS) Conference Paper* (Nov 2016); Defense Science Board Task Force: Predicting Violent Behavior (2012).
- ⁶⁶ See, e.g., Center for Development of Security Excellence Insider Threat Job Aids.
- ⁶⁷ SI with MMAC (b)(6) of 14 Jan 20.
- ⁶⁸ NCIS Report of Investigation of 2 Jan 20, Exhibit 2, Enclosure D.
- ⁶⁹ NCIS Report of Investigation of 2 Jan 20, Exhibit 10.
- ⁷⁰ SI with LT (b)(6) of 16 Jan 20.
- ⁷¹ Record of Counselings for Romero, Gabriel Antonio; Command Counseling Data SSN 771.
- ⁷² Profile Sheet of Romero, Gabriel Antonio.
- ⁷³ NAVPERS 1626/7 Report and Disposition of Offense of 3 Dec 19; SI with MMAC (b)(6) of 14 Jan 20.
- ⁷⁴ SI with LCDR (b)(6) of 17 Jan 20; NAVPERS 1626/7 Report and Disposition of Offenses of 3 Dec 19.
- ⁷⁵ Electronic Questionnaires for Investigation Processing #24226751.
- ⁷⁶ NSSC Mental Health Clinic Encounters of 23 Sep 19 to 26 Nov 19; TAMC Emergency Room Chronology of Care of 4 Mar 19.
- ⁷⁷ Electronic Questionnaires for Investigation Processing #24226751; DD Form 1966-1 of Romero, Gabriel Antonio; NSSC Mental Health Clinic Intake Form of 23 Sep 19.
- ⁷⁸ SI with TMC (b)(6) of 16 Jan 20; USS COLUMBIA E-Learning Records.
- ⁷⁹ SI with ETR2 (b)(6) of 22 Jan 20; SI with YNS1 (b)(6) of 13 Jan 20; SI with TM3 (b)(6) of 10 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20.
- ⁸⁰ The U.S. Fleet Forces Navy Base, Station and Installation Physical Security Assessment Report, Part 2, page 29 ¶ 2.
- ⁸¹ SECNAVINST 5510.37A ¶ 16(b).
- ⁸² DEPSECDEF Memo of 2 Feb 17.
- ⁸³ *Id.*
- ⁸⁴ SI with MMAC (b)(6) of 14 Jan 20; NCIS Report of Investigation of 2 Jan 20, Exhibit 10 ¶ 4; SI with LT (b)(6) of 16 Jan 20; NCIS Counterintelligence and Inside Threat Awareness and Reporting Training; DoD Level I Antiterrorism Training.
- ⁸⁵ DON Insider Threat Analytic Hub Concept of Operations and Implementation Plan.
- ⁸⁶ Defense Science Board Task Force: Predicting Violent Behavior (2012), Appendix 4, page 60.
- ⁸⁷ DEPSECDEF Memo of 2 Feb 17; SECNAVINST 5510.37A ¶ 6(f); Defense Science Board Task Force: Predicting Violent Behavior (2012).
- ⁸⁸ NAVADMIN 222/19.
- ⁸⁹ NCIS Report of Investigation of 2 Jan 20, Exhibit 2, Enclosure D; NCIS Report of Investigation of 2 Jan 20, Exhibit 10.

Chapter 7 - Force Protection

This chapter examines force protection (FP) at Pearl Harbor Naval Shipyard (PHNSY) and Joint Base Pearl Harbor-Hickam (JBPHH). The PHNSY and JBPHH Navy Security Forces (NSF) access control and physical security procedures for the shipyard were in compliance. The instances of noncompliance and deficiencies in other areas had no direct impact on the chain of events that led to the shooting incident, but they should be addressed to improve readiness and safety.

Force Protection Fundamentals

Force Protection (FP) is defined as preventive measures taken to mitigate hostile actions against Department of Defense (DoD) personnel (to include family members), resources, facilities, and critical information.¹ FP does not include actions to defeat the enemy or protect against accidents, weather, or disease.²

Commanders, including installation commanders, have the authority and responsibility to implement and enforce FP and security measures to ensure the protection of their assigned DoD elements and personnel, and tenant organizations on installations, while pursuing mission accomplishment.³ They also ensure the Antiterrorism (AT) awareness and readiness of all assigned or attached DoD elements and personnel.⁴

Three core lines of effort are necessary for protection: critical infrastructure protection, continuity of operations, and FP. AT, Law Enforcement (LE), and Physical Security (PS) complement, integrate with, and support FP and the other two core lines of effort.⁵

Commanders must establish AT programs tailored to the local mission, conditions, and terrorist threat.⁶ Command AT programs must be based on principles of effective risk management and include detailed guidance on training, exercises, resource management, periodic Program Reviews, and standards for achieving and maintaining the ability to accomplish the security mission.⁷

LE and PS programs for an installation and ship are the responsibility of the installation commanding officer and ship's commanding officer respectively.⁸ The commanding

officers of tenant commands retain only those internal security functions intrinsic to their organizations and missions, which include PS of facilities, personnel security, information security, industrial security, and information assurance.⁹ Navy installation security departments provide PS and LE services to tenant commands.¹⁰

Tactical Control for Force Protection

Commander, U.S. Indo-Pacific Command (CDRUSINDOPACOM) exercises Tactical Control (TACON) for FP through component commanders.¹¹ Commander, U.S. Pacific Fleet (COMPACFLT) exercises TACON for FP in region environments through the applicable region commander.¹²

PHNSY, JBPHH, and USS COLUMBIA fall under the TACON for FP authority of COMPACFLT. COMPACFLT has established that Commander, Navy Region Hawaii (CNRH) is the supported commander and that Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC) is a supporting commander for force protection ashore within the region. (See Figure 1.5 for more detail).

Regulatory Background

DoDI 2000.12 (DoD AT Program) establishes policy, assigns responsibilities, and prescribes procedures for the DoD AT program.

DoDI O-2000.16 Volume I (DoD AT Standards) implements mandatory AT program elements within the mission assurance construct, establishes AT planning frameworks, establishes AT standards, and prescribes procedures and assigns responsibilities for implementing DoD AT standards.

USPACOMINST 0536.2 (USPACOM AT Program) provides DoD elements and personnel in the USINDOPACOM Area of Responsibility (AOR) guidance for planning, implementation, and execution of the USINDOPACOM AT program.

USPACFLT OPORD 201 provides direction and guidance to Fleet Commanders.

SECNAVINST 3300.2C (DON AT Program) establishes DON AT program policies and procedures and assigns responsibilities.

OPNAVINST F3300.53C (Navy AT Program) provides over-arching Navy AT policy, guidance, information, procedures, and responsibilities.

OPNAVINST 5530.14.E (Navy PS and LE Program) identifies responsibilities and provides guidance for the protection of people and assets throughout the Navy.

Navy Tactics, Techniques, and Procedures, Antiterrorism (NTTP 3-07.2.1) provides tactical-level AT tactics, techniques, and procedures (TTPs) for ashore and afloat forces.

Navy Tactics, Techniques, and Procedures, Law Enforcement and Physical Security (NTTP 3-07.2.3) provides TTPs governing the conduct of PS and LE.

COMPACFLTINST C3300.55C (AT Program) implements Fleet policy and guidance with respect to AT.

CNICINST 5530.14A (Ashore Protection Program) implements responsibilities, sets forth best practices, and provides requirements and direction of people and assets throughout CNIC.

COMNAVREGHIINST 3000.1E (AT Program) implements region policy and guidance with respect to AT.

JBPHHINST C3300.1B (Directed In-port Security Plan for Sub Surface Combatants) directs submarines to coordinate AT efforts with JBPHH.

JBPHHINST 3300.1E (Integrated Defense AT Plan) provides guidelines and procedures for implementing measures for JBPHH.

CSLCSPINST C3300.3A (Submarine Force AT Manual) implements Submarine Force policy and guidance with respect to AT.

CSLCSPINST 5400.49 (Submarine Organization and Regulations Manual (SORM)) defines the standard duties and responsibilities of submarine watchstanders.

COMSUBPACINST 4790.2.B (Standard Work Practices for Performance of Repairs, Alterations and Maintenance on Pacific Fleet Submarines) specifies the responsibilities and actions between the ship's commanding officer and PHNSY in a number of different areas, including security, while in the shipyard. (Canceled)

NAVSEA M-5510.2 (Access and Movement Control Manual) addresses access and movement control within the NAVSEA Enterprise except NAVSEA Headquarters and Naval Reactors Headquarters.

NAVSHIPYD&IMFPEARLINST 3300.1 sets forth PHNSY & IMF AT/FP procedures and coordination requirements.

Findings-Opinions-Recommendations

Finding 7.1 (Noncontributing/Noncompliance): The PHNSY AT plan does not include required Active Shooter Pre-Planned Response (PPR).¹³

Discussion: COMPACFLT requires commanders under their TACON for FP to develop Emergency Action Plans for active shooter response procedures.¹⁴ The current PHNSY AT plan only has PPRs for hostage/barricaded suspect and bomb threat.¹⁵

PHNSY security staff are not part of a law enforcement organization and are prohibited from carrying weapons.¹⁶ JBPHH NSF have to be ready to respond to incidents at PHNSY including in the Controlled Industrial Area (CIA) where submarines also have security responsibilities.¹⁷ Based on COMSUBPACINST 4790.2B, the armed ship's force is required to maintain a security posture in exclusion areas in the vicinity of submarines to include pier and dry dock areas.¹⁸ This area is not coordinated with JBPHH NSF and varies by afloat unit in the CIA.¹⁹ Before this incident, two JBPHH NSF supervisors were unaware of the submarine's security responsibilities in the CIA and that ship's force watchstanders were allowed to carry weapons on the pier.²⁰

Opinion 7.1.1: Active shooter PPR and security de-confliction procedures for the CIA would help responding security forces identify and reduce the risk of conflicting responses to security incidents in the CIA's complex industrial environment.²¹

Opinion 7.1.2: PHNSY, JBPHH NSF, and afloat units in the CIA should conduct routine coordinated training on active-shooter and security de-confliction procedures.²²

Recommendation 7.1.1: PHNSY, in coordination with Type Commanders and JBPHH NSF, develop active shooter PPRs and security de-confliction procedures for the CIA.

Recommendation 7.1.2: PHNSY, in coordination with Type Commanders and JBPHH NSF, conduct routine coordinated training within the CIA that includes active shooter responses and security de-confliction procedures.

Recommendation 7.1.3: Echelon 2 Commanders ensure that all subordinate commands have active shooter PPRs and security de-confliction procedures in AT Plans.

Finding 7.2 (Noncontributing/Noncompliance): PHNSY, JBPHH NSF, and afloat units in the CIA do not conduct required coordinated training.²³

Discussion: Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC) requires submarines in the shipyard to participate in coordinated security incident-related training scenarios.²⁴ Additionally, the PHNSY Antiterrorism Officer (ATO) is required by NAVSHIPYD&IMFPEARLINST 3300.1 to coordinate training participation in local FP exercises.²⁵ However, no coordinated training takes place between the JBPHH NSF, PHNSY, and afloat units in the shipyard.²⁶ According to the JBPHH NSF Chief of Police, integrated training has only happened once in the six years he has been in his current position.²⁷

COMSUBPACINST 4790.2B is a Standard Work Practices document that specifies the responsibilities and actions between the ship's commanding officer and PHNSY in a number of different areas while in the shipyard.²⁸ One of the enclosures relates to security practices.²⁹ According to the Standard Work Practices document, PHNSY is required to conduct training consisting of tabletop discussions and walk-through exercises of various scenarios with ship's force participation.³⁰ In the shipyard, submarines are required to maintain a security posture within exclusion areas in the immediate vicinity of the submarine to include pier side and dry dock areas.³¹

PHNSY, USS COLUMBIA, and COMSUBPAC representatives formalized this requirement in a memorandum of agreement in August 2018 acknowledging the Standard Work Practices document.³² Despite this acknowledgement, PHNSY and USS COLUMBIA did not conduct the required tabletop discussions and walk-through exercises.³³ Consequently, the ship's force and shipyard security responsibilities are not mutually understood.³⁴

Although these requirements were in place at the beginning of USS COLUMBIA maintenance period, on December 13, 2019, COMSUBPAC canceled the underlying instruction, citing outdated policy and redundancy with other instructions.³⁵

In addition, the Naval Shipyard Installation Memorandum of Agreement (MOA) among Echelon 2 Commanders expired in 2017.³⁶ The MOA covered coordinated security responsibilities, among other things, of the participating commands.³⁷ These Echelon 2 Commanders continue to act consistent with the expired MOA, so no substantial changes to duties and responsibilities are anticipated if the MOA is renewed.³⁸ The MOA does not delineate training responsibilities.³⁹

Opinion 7.2.1: PHNSY and USS COLUMBIA are not in compliance with training requirements.⁴⁰ Routine coordinated training among PHNSY, JBPHH NSF, and afloat units in the shipyard would improve response capabilities.

Opinion: 7.2.2: The Standard Work Practices represent “the basics” of successful depot periods and should not be disregarded.⁴¹ Standard Work Practices are intended to set expectations in maintenance overhauls between organizations that do not typically work together (e.g., shipyard and specific submarines).⁴² Without Type Commander guidance, such as COMSUBPACINST 4790.2B, there should be some instruction that delineates coordinated security responsibilities.⁴³

Recommendation 7.2.1: PHNSY, JBPHH NSF, and afloat units in shipyard conduct routine coordinated training and participate in local FP exercises.

Recommendation 7.2.2: Commander, Naval Sea Systems Command (COMNAVSEASYS COM), in coordination with Type Commanders, assess the completion of coordinated training with afloat units in shipyards.

Recommendation 7.2.3: PHNSY and Puget Sound Naval Shipyard, in coordination with COMSUBPAC, review 21 enclosures of canceled COMSUBPACINST 4790.2B and issue necessary local guidance on Standard Work Practice requirements.

Recommendation 7.2.4: Echelon 2 Commanders renew the Naval Shipyard Installation MOA and consider adding a section that delineates training responsibilities.⁴⁴

Finding 7.3 (Noncontributing/Noncompliance): PHNSY does not conduct required Antiterrorism Working Group (ATWG), Threat Working Group (TWG), or Antiterrorism Executive Council (ATEC) meetings.⁴⁵

Discussion: COMPACFLT requires commanders under their TACON for FP to establish an ATWG, TWG, and ATEC consistent with DoD, combatant commander, and Navy guidance.⁴⁶

The ATWG is required to meet semi-annually to oversee the AT program, help develop and refine AT Plans, and address emergent or emergency AT-related issues.⁴⁷ The TWG will meet quarterly to review current and potential threats affecting operations and personnel.⁴⁸ The ATEC is required to meet semi-annually, at a minimum, to act on recommendations from the ATWG and TWG.⁴⁹ Although PHNSY AT personnel attend JBPHH ATWGs, TWGs, and ATECs, they do not conduct ATWGs, TWGs, or ATECs internally.⁵⁰ PHNSY does not have a practice or procedure to share AT-related information among the different codes or departments when PHNSY AT personnel receive threat information from the JBPHH ATWGs, TWGs, and ATECs.⁵¹ PHNSY is revising internal AT-procedures and practices after an extended period of vacancies in key AT and FP positions.⁵²

Opinion: 7.3.1: PHNSY is not in compliance with the COMPACFLT requirement for all commands to conduct ATWGs, TWGs, and ATECs.⁵³ PHNSY ATWGs, TWGs, and ATEC meetings would facilitate internal and external information sharing, planning, and coordination among all stakeholders on force protection issues such as access controls, threat and vulnerability assessments, PPRs, training, and armed watchstanding requirements within the CIA and shipyard.⁵⁴

Recommendation: 7.3.1: PHNSY conduct ATWGs, TWGs, and ATECs.

Recommendation: 7.3.2: COMNAVSEASYS COM verify all shipyards are conducting ATWGs, TWGs, and ATECs as required by the Fleet Commander and/or OPNAV Instruction F3300.53C.

Finding 7.4 (Noncontributing/Noncompliance): PHNSY did not conduct required Random Antiterrorism Measure (RAM) inspections.⁵⁵

Discussion: COMNAVSEASYSCOM, in NAVSEA M-5510.2, requires RAM inspections of persons entering and exiting the shipyard CIA.⁵⁶ The purpose of the RAM inspections is to detect and deter the introduction of prohibited items, prevent the theft of government property, or unauthorized removal of classified material.⁵⁷ PHNSY did not conduct RAM inspections properly.⁵⁸

Opinion 7.4.1: Failure to comply with this requirement diminishes the overall security posture of PHNSY and JBPHH.⁵⁹

Recommendation 7.4.1: PHNSY, in coordination with JBPHH NSF, develop and implement a RAM inspection program that includes JBPHH NSF support within the CIA.

Recommendation 7.4.2: COMNAVSEASYSCOM verify other shipyards have RAM inspection programs that include NSF support within the CIA.

Finding 7.5 (Noncontributing/Noncompliance/Deficiency): USS COLUMBIA's Topside Roving Patrol does not execute AT duties and responsibilities consistent with the Submarine Organization and Regulations Manual (SORM), CSLCSPINST 5400.49.⁶⁰

Discussion: Topside Roving Patrol requirements are established in the SORM.⁶¹ The Topside Roving Patrol is to maintain continuous armed patrol on the topside area, report to the Petty Officer of the Deck on all security hazards, and maintain situational awareness for areas of concern.⁶² The Petty Officer of the Deck primarily controls entry and exit to the submarine and reports to the Ship's Duty Officer.⁶³ In dry dock, the submarine's access procedures are unique to the shipyard environment.⁶⁴ By separate (and now canceled) instruction on Standard Work Practices, COMSUBPACINST 4790.2B, the submarine is to maintain a security posture within exclusion areas in the vicinity of the submarine to include pier side and dry dock areas.⁶⁵

JBPHH NSF provide an armed watch at the entry to the CIA, and conduct routine physical security checks and armed patrols within the CIA.⁶⁶ JBPHH NSF are responsible for responding to incidents in the PHNSY including the CIA.⁶⁷

The Topside Roving Patrol on USS COLUMBIA conducts a continuous security patrol in the exclusion area in the vicinity of the submarine to include the pier and dry-dock basin, not the crew berthing barge.⁶⁸ The Topside Roving Patrol also conducts administrative and safety checks that do not require weapons.⁶⁹

Opinion 7.5.1: Fleet and Type Commanders should evaluate the requirement for an armed Topside Roving Patrol in the CIA.⁷⁰

Opinion 7.5.2: USS COLUMBIA's Topside Rover Patrol security patrol is beyond the physical scope of Top Side Rover responsibility as delineated in the Type Commander's instruction, CSLCSPINST 5400.49 (SORM).⁷¹

Recommendation 7.5.1: Commander Submarine Forces, in coordination with COMPACFLT; Commander, U.S. Fleet Forces Command (CUSFF); Commander, Naval Installations Command (CNIC); and COMNAVSEASYSOM, assess whether armed watchstanding requirements in the CIA can be modified in some Force Protection conditions.

Recommendation 7.5.2: If the armed watchstanding requirements are validated, Commander Submarine Forces, clarify AT duties and responsibilities of the armed watches in the CIA to include the pier and dry dock areas.

¹ DoD Dictionary of Military and Associated Terms, January 2020.

² Joint Publication 3-0 CH-1, III-40.

³ DoDI O-2000.16, Volume 1, DoD Antiterrorism (AT) Program Implementation: DoD AT Standards, § 1.2(a)(3).

⁴ *Id.*

⁵ OPNAVINST F3300.53C ¶ 5(a).

⁶ *Id.* at ¶ 5(d).

⁷ *Id.* at ¶ 5(b).

⁸ OPNAVINST 5530.14E, Enclosure 1 § 0101(a).

⁹ *Id.*

¹⁰ *Id.* at § 0101(c).

¹¹ COMPACFLTINST C3300.55C, page 3 ¶ 4(a).

¹² *Id.* at ¶ 4(c).

¹³ CPF Message Active Shooter Training and Preparedness § 2(c); NAVSHIPYD & IMFPEARLINST 3300.1.

¹⁴ CPF Message Active Shooter Training and Preparedness § 2(c).

¹⁵ NAVSHIPYD & IMFPEARLINST 3300.1, Appendix 3 to Annex C.

¹⁶ NAVSEA M-5510.2, Chapter 1 § 1.

¹⁷ *Id.*

¹⁸ COMSUBPACINST 4790.2B, Enclosure 16 ¶ 3(w)(1).

¹⁹ *Id.*

²⁰ SI with MAJ (b)(6) of 14 Jan 20; SI with MA1 (b)(6) of 13 Jan 20.

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- ²¹ SI with MAJ (b)(6) of 13 Jan 20 ¶ 6; SI with CAPT (b)(6), HPD of 21 Jan 20.
- ²² COMSUBPACINST 4790.2B Enclosure 16 ¶ 3(w)(1) and ¶ 3(w)(10).
- ²³ SI with LT (b)(6) of 17 Jan 20; SI with MAJ (b)(6) of 14 Jan 20.
- ²⁴ COMSUBPACINST 4790. 2B, Enclosure 16 § 3 ¶ 1.
- ²⁵ NAVSHIPYD & IMFPEARLINST 3300.1 § 2 ¶ a(2).
- ²⁶ SI with Guard Officer (b)(6) of 13 Jan 20; SI with (b)(6) of 16 Jan 20; SI with MAJ (b)(6) of 14 Jan 20; SI with Mr. Gregory K. Crowell of 21 Jan 20. (6)
- ²⁷ SI with MAJ (b)(6) of 14 Jan 20.
- ²⁸ COMSUBPACINST 4790.2B.
- ²⁹ *Id.* at Enclosure 16.
- ³⁰ *Id.* at Enclosure 16 ¶ 3(l) and ¶ 4(j).
- ³¹ *Id.* at ¶ 3(w)(1) and ¶ 3(w)(10).
- ³² Memorandum of Agreement of 15 Aug 18.
- ³³ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20.
- ³⁴ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 15 Jan 20; SI with LT (b)(6) of 17 Jan 20; SI with CAPT Gregory Burton of 21 Jan 20; SI with Mr. Gregory K. Crowell of 21 Jan 20; SI with (b)(6) of 21 Jan 20; SI with MAJ (b)(6) of 14 Jan 20.
- ³⁵ COMSUBPACNOTE 5215 of 13 Dec 19.
- ³⁶ Naval Shipyard Installation Management MOA between CUSFF, COMPACFLT, COMNAVSEA, CNIC, and COMNAVFAC.
- ³⁷ *Id.*
- ³⁸ Email from (b)(6) to (b)(6) of 23 Jan 20.
- ³⁹ Naval Shipyard Installation Management MOA between CUSFF, COMPACFLT, COMNAVSEA, CNIC, and COMNAVFAC.
- ⁴⁰ COMSUBPACINST 4790.2B, Enclosure 16 ¶ 3(w)(l).
- ⁴¹ COMSUBPACINST 4790.2B, Enclosure 16.
- ⁴² *Id.*
- ⁴³ *Id.*
- ⁴⁴ Naval Shipyard Installation Management MOA between CUSFF, COMPACFLT, COMNAVSEA, CNIC, and COMNAVFAC.
- ⁴⁵ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁴⁶ DoDI O-2000.16, Volume 1, DoD Antiterrorism (AT) Program Implementation: DoD AT Standards, §§ 3.12; 3.13, 3.14; COMPACFLTINST C3300.55C § 5 ¶ 12.
- ⁴⁷ COMPACFLTINST C3300.5C § E ¶ 11.
- ⁴⁸ *Id.*
- ⁴⁹ *Id.*
- ⁵⁰ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁵¹ SI with (b)(6) of 14 Jan 20.
- ⁵² SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁵³ COMPACFLTINST C3300.55C § 5 ¶ 11-14.
- ⁵⁴ DoDI O-2000.16, Volume 1, DoD Antiterrorism (AT) Program Implementation: DoD AT Standards § 3.10(b)(1).
- ⁵⁵ NAVSEA M-5510.2, Chapter 1 § ¶ 6(a)(11); SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁵⁶ *Id.*
- ⁵⁷ *Id.*
- ⁵⁸ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 16 Jan 20; SI with CAPT Gregory Burton of 21 Jan 20; SI with (b)(6) of 15 Jan 20.
- ⁵⁹ NAVSEA M-5510.2.
- ⁶⁰ MFR Topside Rover Posting of 5 Feb 20.

⁶¹ CSLCSPINST 5400.49 § 2301 ¶ 6(b).

⁶² *Id.*

⁶³ CSLCSPINST 5400.49 § 2301 ¶ 5.

⁶⁴ CSLCSPINST C3300.3A § Tab C to Addendum 1 ¶ 3(a); Field Observation by (b)(6) of 30 Jan 20.

⁶⁵ COMSUBPACINST 4790.2B Enclosure 16 ¶ 3(w)(1). See Findings 7.1 and 7.2.

⁶⁶ SI with MA1 (b)(6) of 13 Jan 20.

⁶⁷ NAVSEA M-5510.2, Chapter 1 and § 6 ¶ (a)(11).

⁶⁸ SSN771INST 3121.1 SOP (7) § 4 ¶ c.

⁶⁹ *Id.* at § 4.

⁷⁰ CSLCSPINST 5400.49 § 2301.

⁷¹ *Id.* at ¶ 6(b)(1); SSN771INST 3121.1 SOP (7) § 4 ¶ b-c.

Chapter 8 – Incident Response & Emergency Management

This chapter examines the immediate emergency response to the Pearl Harbor Naval Shipyard (PHNSY) shooting incident. The Joint Base Pearl Harbor-Hickam (JBPHH) Navy Security Forces (NSF) and Federal Fire Department (FFD) responded quickly on December 4, 2019. The instances of noncompliance and deficiencies in the incident and emergency response that are examined in this chapter had no direct impact on the chain of events that led to the PHNSY shooting incident, but they should be addressed to improve readiness and safety.

The investigation team examined the response of Department of Defense (DoD) commands and organizations to the shooting incident. The responses of law enforcement and emergency services outside of the DoD were not investigated other than to obtain information concerning integration with DoD law enforcement and emergency services.

Emergency Management Fundamentals

The Navy Installation Emergency Management (IEM) program is a cross-functional program that integrates procedures and standards for all-hazards emergency preparedness, response, and recovery on Navy installations consistent with the National Incident Management System (NIMS).¹ Navy regional and installation commanders may require extensive Federal, State, local, other military branches, and or private support to respond effectively to and recover from an emergency if it exceeds the response capabilities of organic resources.² Close liaison with these agencies and departments is essential before an emergency to ensure that civil authorities are responsive.³

Regional and installation commanders have the authority and responsibility to protect personnel, equipment, and facilities subject to their control.⁴ Regional commanders must establish Regional Operational Centers (ROCs), and installation commanders must establish Emergency Operations Centers (EOCs).⁵ EOCs consist of the facilities,

equipment, personnel, procedures, and communications where information and resources are coordinated during emergencies.⁶ All installation EOCs must have standard operating procedures for incident management.⁷ The JBPHH EOC is the central command, control, communication and coordination node between the JBPHH Commander (JBC) and all subordinate installations, tenant commands, and units.⁸ (See Figure 8.1).

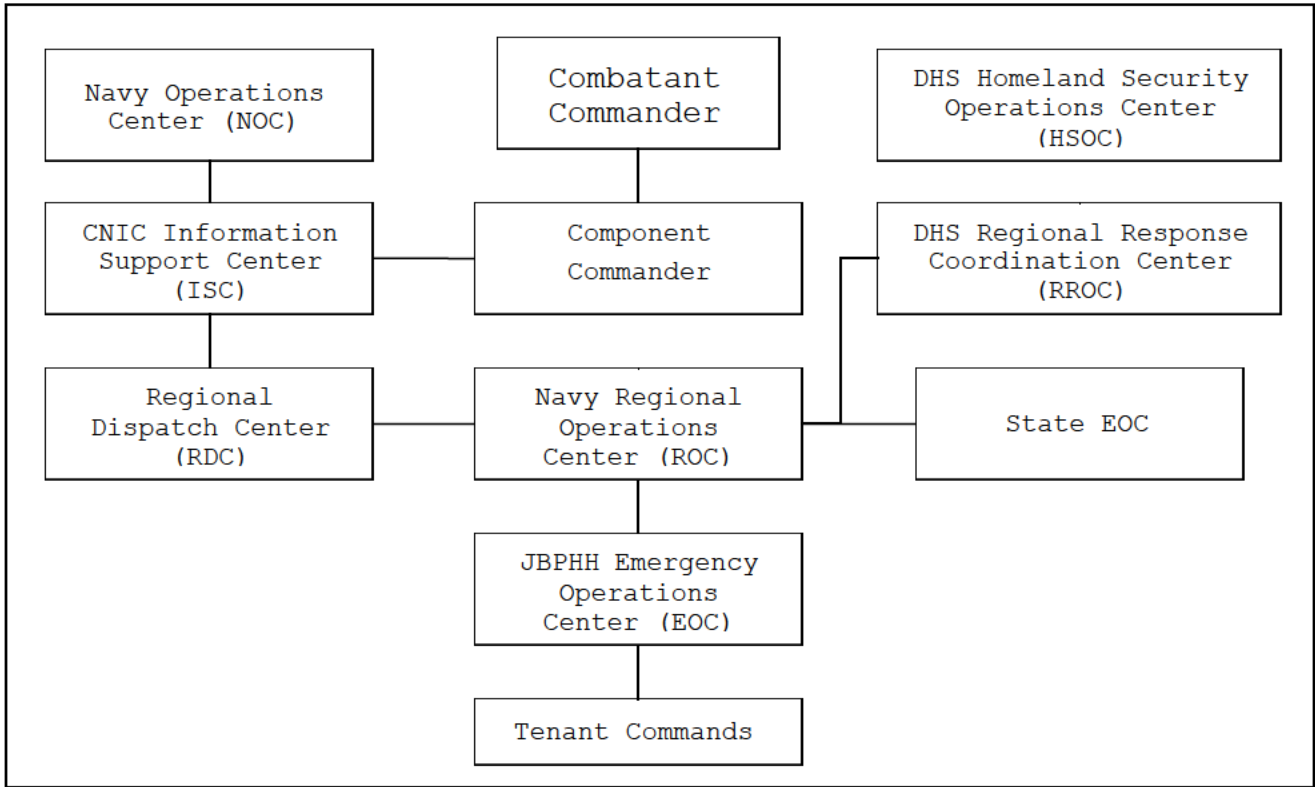


Figure 8.1: Emergency Operations C2.

Regulatory Background

DoDI 6055.17 (DoD IEM Program) is the basis for emergency management programs.

OPNAVINST 3440.17A (Navy IEM Program) implements DOD IEM procedures and programs.

Navy Tactics, Techniques, and Procedures, Antiterrorism (NTTP 3-07.2.1) provides antiterrorism tactics, techniques, and procedures (TTPs) for ashore and afloat forces.

Navy, Tactics, Techniques, and Procedures, Law Enforcement and Physical Security (NTTP 3-07.2.3) provides TTPs for physical security (PS) and law enforcement (LE).

CNICINST 3440.17 (Navy IEM Program Manual) further defines IEM policies and procedures.

CNIC M-3440.18 (Navy Dispatch Centers) implements policy and provides guidance, program management, concept of operations and assignment of responsibilities for the management of Navy dispatch centers.

COMNAVREGHIINST 3440.17B (Navy Region Hawaii Emergency Management Plan (EMP)) provides policy, guidance, operational structure, and assignment of responsibilities for the all-hazards management of natural and/or man-made emergencies within Navy Region Hawaii assigned shore installations and their tenant commands.

JBPHHINST 3440.17D (IEM Program) executes policy, provides guidance, and assigns responsibilities for developing and sustaining a comprehensive, all-hazards EMP for JBPHH.

JBPHHINST 3300.1E (Integrated Defense AT Plan) provides guidelines and procedures for implementing measures for JBPHH.

Findings-Opinions-Recommendations

Navy Security Forces

Finding 8.1 (Noncontributing/Compliance/Deficiency): JBPHH NSF responded within 1 minute to the shooting scene, well within the required 15 minutes, but did not promptly establish radio communications with other law enforcement agencies.⁹ The Naval Criminal Investigative Service (NCIS) and the Honolulu Police Department (HPD) responded without a report or request for support.¹⁰

Discussion: JBPHH NSF should be able to respond to an incident within 15 minutes.¹¹ A JBPHH NSF Guard Officer, the roving patrol in the PHNSY Controlled Industrial Area

(CIA), was on scene within 1 minute of the active shooter report from the Commander, Navy Region Hawaii (CNRH) Regional Dispatch Center (RDC).¹²

Navy Tactics, Techniques, and Procedures, Law Enforcement and Physical Security (NTTP 3-07.2.3) and CNIC M-3440.18 require establishment of inter-departmental or interagency radio communications.¹³ JBPHH NSF and other responding law enforcement organizations had integrated radio communication capability, but JBPHH NSF did not request support or otherwise communicate with outside law enforcement immediately after the initial security response.¹⁴ NCIS was notified by a special agent who was attending a meeting with the JBC.¹⁵ The NCIS special agent called the NCIS administrative officer who then informed other NCIS personnel.¹⁶ NCIS responded to the scene in approximately 12 minutes without a request for support.¹⁷ HPD was monitoring integrated radio channels and responded to JBPHH in approximately 18 minutes without a request for support.¹⁸ After HPD arrived at the Incident Command Post (ICP), they coordinated the dispatch of over 100 HPD officers with the on-scene JBPHH NSF commander.¹⁹

The CNRH RDC is the main 911 call operator and dispatches emergency services.²⁰ The Joint Defense Operations Center (JDOC) serves as the command and control element and recordkeeping and patrol management coordinator for JBPHH NSF patrols.²¹

CNRH has a memorandum of agreement with HPD for Special Weapons and Tactics (SWAT), but does not have a mutual aid agreement for more general law enforcement support.²² The SWAT memorandum of agreement calls for CNRH to make a request for specialized support.²³

Opinion 8.1.1: The JBPHH NSF response to the shooting incident was immediate.²⁴ The proactive actions of other law enforcement agencies, specifically NCIS and HPD, would have saved lives if a more robust response was required.²⁵

Opinion 8.1.2: The lack of JBPHH NSF communication with other responding law enforcement agencies, and the absence of standing communication and coordination procedures with HPD, made command and control at the ICP difficult and complicated response efforts after the shooter was found dead.²⁶ This difficulty impacted coordination in other areas, including base access, staging areas, building clearance, and

accountability of outside agencies on base.²⁷ JBPHH NSF monitored integrated radio channels, but communications can improve with more coordination and training.²⁸

Recommendation 8.1.1: CNRH review current mutual aid agreements with HPD and develop training scenarios to test interagency communication plans. Conclude a mutual aid agreement with HPD that addresses specific communication, coordination, and training procedures for general law enforcement response to incidents of mutual concern. Once this mutual aid agreement is established, incorporate it into a training plan.

Recommendation 8.1.2: Commander, Naval Installations Command (CNIC), assess adequacy of mutual aid agreements including the adequacy of communication plans with local law enforcement at other installations. Fort Hood and Washington Navy Yard investigations noted similar coordination issues.

Finding 8.2 (Noncontributing/Noncompliance/Deficiency): Navy tactics, techniques, and procedures (NTTPs) and local JBPHH pre-planned responses (PPRs) do not specifically address physical restraints, personnel evacuation, or building clearance procedures in the context of an active shooter incident.²⁹ Two JBPHH NSF personnel initially used flex cuffs and duct tape to temporarily control personnel during building clearance.³⁰ JBPHH NSF and supporting law enforcement agencies also conducted building clearance procedures differently.³¹

Discussion: JBPHH NSF used flex cuffs and duct tape to restrain several employees' hands as JBPHH NSF escorted the employees out of Building 1916 inside the CIA.³² These restraints were used to verify the personnel did not have weapons.³³ NTTPs and JBPHH active shooter PPRs do not include flex cuffs or duct tape as a means of restraint in active shooter incidents.³⁴ JBPHH NSF did not restrain all employees who were escorted out of Building 1916.³⁵ Some employees who were escorted out of the CIA reported that evacuation routes took them unnecessarily close to the shooting scene.³⁶

Some buildings were cleared more than once, and clearance procedures differed among law enforcement agencies.³⁷ JBPHH NSF are trained to provide access control and conduct routine physical security checks in the CIA, but their training does not include

building clearance procedures.³⁸ At least one civilian security guard was tasked with building clearance despite no formal training.³⁹

Opinion 8.2.1: JBPHH NSF's use of flex cuffs and duct tape was not in compliance with NTTPs or JBPHH PPRs.⁴⁰ JBPHH NSF require training on building clearance, physical restraint, and evacuation procedures for active shooter incidents.⁴¹ If the expectation is for JBPHH NSF Guard Officers (0085) to be able to clear a building during an active shooter event, they should receive the proper training to be able to perform such a task.⁴²

Recommendation 8.2.1: JBPHH NSF conduct local training on building clearance, physical restraint, and evacuation procedures for active shooter incidents.

Recommendation 8.2.2: OPNAV N4, in coordination with Commander, U.S. Fleet Forces Command (CUSFF) and Naval Warfare Development Command (NWDC), improve NTTPs consistent with partner law enforcement TTPs in the context of active shooter incidents.

Recommendation 8.2.3: CNIC direct regions and installations to train on building clearance, physical restraint, and evacuation procedures for active shooter incidents.

Finding 8.3 (Noncontributing/Deficiency): JBPHH NSF and supporting law enforcement agencies could not access all locked spaces to clear buildings and secure the shooting scene.⁴³

Discussion: Navy Tactics, Techniques, and Procedures, Law Enforcement and Physical Security (NTTP 3-07.2.3) provides general guidance on building clearance.⁴⁴ JBPHH NSF and supporting law enforcement agencies were expected to clear buildings near the shooting incident to ensure there were no more shooters or victims.⁴⁵ Building clearance procedures were delayed because law enforcement teams could not enter buildings that were locked.⁴⁶ Although several law enforcement teams were present, they were unable to access and clear buildings (b) (7)(E)

The PHNSY Emergency Management Officer (EMO) is the primary coordinator for incidents and other events inside the shipyard. The PHNSY EMO acknowledged that the

lack of enough master access key cards delayed law enforcement teams trying to enter and clear locked buildings simultaneously.⁴⁷

Opinions 8.3.1: Physical security plans should include access procedures for first responders to be able to enter locked buildings, including restricted areas.

Recommendation 8.3.1: PHNSY, in coordination with JBPHH NSF, revise access procedures in their physical security plan for first responders to have access to locked buildings and restricted areas in active shooter and other emergency situations. This plan should include guidance for debriefing any first responders who enter restricted areas.

Recommendation 8.3.2: Echelon 2 Commanders ensure subordinate commands' physical security plans include access procedures for first responders to be able to enter locked buildings, including restricted areas, in active shooter and other emergency situations.

Emergency Services

Finding 8.4 (Noncontributing/Compliance/Deficiency): FFD Basic Life Saving (BLS) unit responded within required 7 minutes upon receiving the report of an active shooter.⁴⁸

Discussion: The standard for response of the first arriving emergency medical responder is 7 minutes.⁴⁹ The initial dispatch call was at 1426.⁵⁰ FFD BLS arrived at 1432.⁵¹

The standard for Advanced Lifesaving Support (ALS), normally an ambulance, is 12 minutes.⁵² The first ambulance arrived on scene in 8 minutes.⁵³ Two additional ambulances arrived 3 minutes later.⁵⁴

Upon FFD's arrival, the first team immediately began treating the surviving victim who was later transported to Queens Hospital.⁵⁵ FFD attended to the other two victims moments later and then transported them separately to Pali Momi Hospital and Tripler Army Medical Center (TAMC).⁵⁶ Upon arriving on scene, a JBPHH NSF Guard Officer observed a person in military uniform who was later identified as Romero, laying on the pavement with a traumatic gunshot wound to the head and likely deceased.⁵⁷ FFD was limited to visual observations of Romero by an NCIS agent, and cautioned not to disturb physical objects or the body.⁵⁸

FFD in an after-action review identified the need to designate specific entry and egress gates for additional emergency response units, if they would be required from off-base.⁵⁹

Opinion 8.4.1: FFD responded quickly to the scene and provided appropriate medical care to the victims.⁶⁰ However, response procedures can be improved based on lessons learned from the incident including designation of entry and egress gates.⁶¹

Recommendation 8.4.1: CNIC and JBPHH incorporate FFD lessons learned from this incident, including specifying entry and egress gates for off-base emergency response, into coordinated training with local law enforcement and emergency medical providers.

USS COLUMBIA

Finding 8.5 (Noncontributing/Compliance/Deficiency): USS COLUMBIA's Petty Officer of the Deck responded as trained to the active shooter incident.⁶² He made immediate notifications on the ship's announcing system (1MC), the ship's force protection radio, and the Command Early Warning Net (CEWN).⁶³ However, the standard casualty procedure did not account for an active shooter on the pier with ship's force responding from the berthing barge.

Discussion: The Petty Officer of the Deck called away "Repel Boarders," which is the ship's force casualty procedure, over the ship's 1MC when he observed Romero shooting the victims.⁶⁴ The Petty Officer of the Deck called "Shots fired, Shots fired" over the ship's force protection radio and "active shooter at the head of Dry Dock 2" over the base security CEWN.⁶⁵ In response to a call from the Ship's Duty Officer (SDO) on the force protection radio, the Petty Officer of the Deck replied, "Repel Boarders, shots fired, Romero is shooting shipyard workers."⁶⁶ "Repel Boarders" and "Shots fired," which was mistaken for "Fire," brought unarmed personnel to the area of the active shooter.⁶⁷

Opinion 8.5.1: The Petty Officer of the Deck responded as he was trained when he identified Romero as a threat to the ship and crew.⁶⁸ Although not in the Ship's System Manual (SSM), a more appropriate code word announcement would have been "Active shooter at the head of Dry Dock 2."⁶⁹ The lack of an appropriate code word such as

“Active Shooter” could have led to additional casualties if Romero had not immediately shot himself.⁷⁰

Recommendation 8.5.1: Type Commanders, in coordination with CNIC, add guidance to address an active shooter to casualty response procedures.

Mass Warning Notifications

Finding 8.6 (Noncontributing/Noncompliance/Deficiency): CNRH RDC and JBPHH EOC did not send the initial mass notification lockdown messages within 2 minutes of incident notification and verification as required by DoD Instruction 6055.17 and did not reach required percentages of the protected population.⁷¹

Discussion: Alert notifications requiring immediate action must be issued within 2 minutes of incident notification and verification to the affected DoD population.⁷² Within 10 minutes, Mass Warning Notification (MWN) systems must reach a target audience of 90 percent or more of the protected population with specific protective action recommendations (mass warning) and 100 percent of assigned Emergency Management (EM) resources, including first responders, first receivers, and emergency responders (notification).⁷³ Within 1 hour, all MWN systems should reach 100 percent of the protected population.⁷⁴

The Automatic Target Hand-Off Correlator (AtHoc) and Giant Voice (GV) systems are part of the Wide Area Alert Network (WAAN) that Navy installations use worldwide to maximize the potential to warn and direct affected personnel in a crisis through multiple systems.⁷⁵

AtHoc uses four methods to alert users of a message: Computer Desktop Notification System (CDNS), text message, phone call, and email.⁷⁶ AtHoc messages will appear on NMCI computers when users are logged on to the system.⁷⁷ Users can choose to receive messages through the other communication methods as part of the registration process.⁷⁸ As of January 2020, system registration was only 43% in the JBPHH area.⁷⁹

On December 4, 2019, at 1427, JBPHH NSF first arrived at the shooting scene.⁸⁰ At 1432, the PHNSY EMO directed CNRH RDC to send an AtHoc message to the shipyard distribution list.⁸¹ RDC sent it at 1438 within 6 minutes of direction from the PHNSY EMO and 11 minutes after JBPHH NSF arrived on scene.⁸² The PHNSY EMO believed that releasing the message to just the shipyard would save time in reaching the most affected audience.⁸³ Not all personnel in the CIA have access to computer workstations, and personal cell phones are not allowed in all areas.⁸⁴ The message read, “LOCKDOWN Active Shooter event happening in or near PHNSY near dry dock 2 and dry dock 3 in the CIA. All personnel are advised to lockdown at their location. If inside, stay inside, if outside find a secure location. Be vigilant, report emergencies and suspicious information to the authorities and follow the instructions of local responders.”⁸⁵

JBPHH never sent an AtHoc message to the JBPHH distribution list to alert the surrounding area because of a staff miscommunication.⁸⁶ The JBC directed the Deputy Emergency Management Officer (DEMO) to send an AtHoc message to the JBPHH distribution list.⁸⁷ The DEMO told the JBC that it had already been sent.⁸⁸ AtHoc messages on telephones do not identify the sender’s organization, and the DEMO mistakenly believed a message that he saw earlier was from JBPHH to the JBPHH distribution list.⁸⁹

That AtHoc message was actually from the U.S. Air Force 15th Wing command post on the Hickam side of JBPHH.⁹⁰ The U.S. Air Force 15th Wing command post sent out initial notifications on the Air Force AtHoc system and sent updates every 15 minutes to update Air Force tenant commands on the situation based on information received in the JBPHH EOC.⁹¹

CNRH RDC directed the JBPHH EOC to send a lockdown message on the GV exterior speaker system at 1443.⁹² The JBPHH EOC sent out the message at 1444, 17 minutes after JBPHH NSF was initially on scene.⁹³ GV system has 30 designated “hot keys” that are prerecorded messages including a hot key for lockdown announcements.⁹⁴ These hot keys allow the operator to send an immediate action required message with just one button.⁹⁵ When the JBPHH EOC sent a GV message at 1443, several witnesses reported

difficulty understanding the GV.⁹⁶ Audible interference is also a known issue among emergency management personnel.⁹⁷

Opinion 8.6.1: The CNRH RDC and JBPHH EOC did not meet timelines for mass warning notifications, and the AtHoc and GV systems did not reach 100 percent of the protected population.⁹⁸

Opinion 8.6.2: The DEMO failed to execute his duties as directed by the JBC.⁹⁹ This resulted in the failure to meet mass warning notification timelines and 100 percent of the protected population.¹⁰⁰ A contributing factor was the inability for a user to identify originators of telephonic AtHoc messages.¹⁰¹

Opinion 8.6.3: Additional effective means of mass notifications are necessary where personnel do not have computer or cell phone access.¹⁰²

Opinion 8.6.4: GV messages that announce emergency lockdown procedures would be more effective if they included distinctive tone-based signals in conjunction with human voice announcements.¹⁰³ GV lockdown messages did not provide effective warnings because they were difficult to understand and are subject to weather, interference, and background noise.¹⁰⁴

Recommendation 8.6.1: CNRH RDC and JBPHH EOC conduct a review of the incident response and mass warning notifications. Add routine training on mass warning notifications to the continuing training program for bases and the region.

Recommendation 8.6.2: CNIC, in coordination with Naval Information Warfare Center (NIWC), improve technical capabilities in MWN systems and SOPs to reduce the risk of human error.

Recommendation 8.6.3: Commander, Naval Sea Systems Command (COMNAVSEASYSCOM), in coordination with CNIC, develop and implement visual and voice mass notification systems for shipyard environments.

Recommendation 8.6.4: CNIC develop distinctive tone-based signal or other means to alert personnel of lockdown procedures more effectively.

Finding 8.7 (Noncontributing/Noncompliance/Deficiency): The Navy and Air Force AtHoc systems are not interoperable.¹⁰⁵

Discussion: NIWC is developing an upgrade to make the AtHoc systems interoperable.¹⁰⁶ The Navy system does not correlate with the Air Force system, which is six generations and software updates ahead.¹⁰⁷

Opinion 8.7.1: The lack of interoperable systems is not in compliance with DoD policy to pursue a single enterprise-wide MWN system.¹⁰⁸

Recommendation 8.7.1: NIWC complete the AtHoc Connect upgrade to enable Navy and Air Force interoperability. Ensure the system performs as required during installation exercises where AtHoc messages are sent installation-wide.

Recommendation 8.7.2: OPNAV N2/N6 share the results of this investigation report related to interoperability of Navy and Air Force systems with the appropriate Air Force staff code.

Finding 8.8 (Noncontributing/Deficiency): The lockdown prevented the JBPHH EOC from being staffed with required personnel during the emergency.¹⁰⁹

Discussion: JBPHH activates the EOC at the JBC's direction in response to an emergency.¹¹⁰ The EOC is staffed with personnel from JBPHH and other organizations based on their subject matter expertise.¹¹¹ Personnel who staff the JBPHH EOC are not considered first responders, so they are subject to lockdown procedures.¹¹² The JBPHH EOC is co-located with the U.S. Air Force 15th Air Wing command post on the Hickam side of the base.¹¹³ The JBPHH EOC was manned with only 6 personnel instead of the required 44 personnel during the event due to the lockdown.¹¹⁴ There are five incident levels.¹¹⁵ At the lowest level, "normal," the EOC is staffed with only an EOC manager.¹¹⁶ An active shooter incident is a level "three" and requires all sections inside the EOC to be manned.¹¹⁷

Opinion 8.8.1: JBPHH EOC activation procedures should account for base lockdown procedures.¹¹⁸

Recommendation 8.8.1: JBPHH revise EOC activation procedures to account for base lockdowns. Once procedures are revised, conduct an unannounced drill to validate the EOC can man within time requirements during a base lockdown.

Recommendation 8.8.2: CNIC direct all region and installation commanders to review and revise ROC and EOC standard operating procedures (SOP) to account for how base lockdowns may affect EOC activation.

Finding 8.9 (Noncontributing/Deficiency): Active shooter training helped personnel take immediate action in response to the active shooter incident.¹¹⁹ However, the industrial shipyard environment presented circumstances that are not addressed in COMNAVSEASYS COM and CNIC active shooter training, and some personnel did not respond as they were trained.¹²⁰

Discussion: PHNSY employees took action consistent with the “Run-Hide-Fight” mantra in active shooter online training.¹²¹ For example, several employees followed the guidance to “hide” by barricading themselves in buildings.¹²² However, the training was not effective in all situations.¹²³ Some employees tried to “run,” but unmanned turnstiles in the CIA were locked because of lockdown procedures, making exit impossible.¹²⁴ The investigation team conducted focus groups during the investigation and identified a consistent lack of knowledge among the PHNSY civilian work force on where to find cover from an outside active shooter, the locations of secure buildings, and how to react to responding law enforcement.¹²⁵ COMNAVSEASYS COM and CNIC active shooter training focuses on indoor office-based scenarios, not industrial work environments.¹²⁶ PHNSY conducted active shooter table-top discussions in May 2019, but those discussions did not discuss outdoor scenarios.¹²⁷ Additionally, some employees also consciously acted contrary to training and disregarded lockdown procedures to help fellow employees.¹²⁸

Opinion 8.9.1: Active shooter training should include guidance on outdoor scenarios when employees must find cover or remain in place.¹²⁹ The training should also address employee responses to casualties.¹³⁰

Opinion 8.9.2: Table-top discussions and exercises should be tailored to address unique work conditions in lockdown procedures.¹³¹

Recommendation 8.9.1: COMNAVSEASYSKOM, in coordination with CNIC, direct naval shipyards conduct annual active shooter exercises and table-top exercises that cover outdoor active shooter scenarios under local work conditions and lockdown procedures.

Recommendation 8.9.2: CNIC and COMNAVSEASYSKOM revise active shooter training to include additional scenarios and lessons learned identified in this incident.

¹ OPNAVINST 3440.17A ¶ 3(a).

² OPNAVINST 3440.17A ¶ 3(d)(e).

³ *Id.*

⁴ OPNAVINST 3440.17A, ¶ 7.

⁵ OPNAVINST 3440.17A; DoDI 6055.17.

⁶ DoDI 6055.17 § 9.3 ¶ 1.

⁷ DoDI 6055.17.

⁸ *Id.*; OPNAVINST 3440.17A, JBPHHINST 3440.17D.

⁹ SI with CAPT (b)(6), HPD of 21 Jan 20; SI with SSA (b)(6), NCIS of 12 Feb 20; NTTP 3-07.2.1 § 5.2.2.

¹⁰ *Id.*

¹¹ OPNAVINST 5530.14E, Chapter 4 § 0401 ¶ b.

¹² PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19; CNRH RDC Incident History Log of 4 Dec 19.

SI with (b)(6) of 15 Jan 20.

¹³ CNIC M-3440.18, Chapter 4 ¶ 1(d)(1); NTTP 3-07.2.3 § 5.9.3; NTTP 3-07.2.1 § 5.2.2.

¹⁴ SI with CAPT (b)(6), HPD of 21 Jan 20; SI with SSA (b)(6), NCIS of 12 Feb 20.

¹⁵ SI with SSA (b)(6), NCIS of 12 Feb 20.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ SI with CAPT (b)(6), HPD of 21 Jan 20.

¹⁹ *Id.*

²⁰ JBPHHINST 3300.1E ¶ 2(a).

²¹ *Id.* at ¶ 1(b)(1).

²² Mutual Aid Special Weapons and Tactics Memorandum of 7 May 12.

²³ *Id.*

²⁴ SI with (b)(6) of 15 Jan 20, SI with Guard Officer (b)(6) of 13 JAN 2020.

²⁵ SI with (b)(6) of 16 Jan 20, SI with MAJ (b)(6) of 14 Jan 20.

²⁶ SI with MAJ (b)(6) of 14 Jan 20; SI with CAPT (b)(6), HPD of 21 Jan 20.

²⁷ SI with CAPT (b)(6), HPD of 21 Jan 20.

²⁸ SI with MAJ (b)(6) of 14 Jan 20, SI with CAPT (b)(6), HPD of 21 Jan 20.

²⁹ JBPHHINST 3440.17D, Appendix 19: Active Shooter Response; NTTP 3-07.2.1; NTTP 3-07.2.3.

³⁰ Email from LCDR (b)(6) to CDR (b)(6) of 24 Jan 20; Email from CDR (b)(6) to LN1 (b)(6) of 2 Mar 20.

³¹ SI with CAPT (b)(6), HPD of 21 Jan 20.

³² SI with (b)(6) of 15 Jan 20; SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 16 Jan 20; Email from CDR (b)(6) to LN1 (b)(6) of 2 Mar 20.

³³ Email from LCDR (b)(6) to CDR (b)(6) of 24 Jan 20.

³⁴ JBPHHINST 3440.17D, Appendix 19: Active Shooter Response; NTTP 3-07.2.1 § 8.3.5, NTTP 3-07.2.3 § 5.9.
³⁵ SI with (b)(6) of 16 Jan 20; SI with (b)(6) of Jan 20; Email from LCDR (b)(6) to CDR (b)(6) of 24 Jan 20.
³⁶ *Id.*
³⁷ SI with CAPT (b)(6), HPD of 21 Jan 20.
³⁸ SI with MA1 (b)(6) of 13 Jan 20.
³⁹ SI with Guard Officer (b)(6) of 13 Jan 20.
⁴⁰ JBPHHINST 3440.17D, Appendix 19: Active Shooter Response; NTTP 3-07.2.1; NTTP 3-07.2.3.
⁴¹ SI with MA1 (b)(6) of 13 Jan 20.
⁴² SI with Guard Officer (b)(6) of 13 Jan 20; SI with (b)(6) of 15 Jan 20.
⁴³ SI with MA1 (b)(6) of 13 Jan 20; SI with Guard Officer (b)(6) of 13 Jan 20.
⁴⁴ NTTP 3-07.2.3 § 5.9.6.
⁴⁵ JBPHHINST 3300.1E, page C-13- 1 and Appendix 13 to Annex C §1 ¶ e; NTTP 3-07.2.3 § 5.9.5 and 5.9.6.
⁴⁶ SI with MA1 (b)(6) of 13 Jan 20; SI with Guard Officer (b)(6) of 13 Jan 20.
⁴⁷ SI with (b)(6) of 16 Jan 20.
⁴⁸ DODI 6055.06. § 7.2. Table 1; PHNSY&IMF Security Incident Checklist; CNRH Incident History Log of 4 Dec 19; Computer Aided Dispatch Report of 4 Dec 19.
⁴⁹ DODI 6055.06. § 7.2. Table 1.
⁵⁰ Computer Aided Dispatch Report of 4 Dec 19.
⁵¹ *Id.*
⁵² *Id.*
⁵³ *Id.*
⁵⁴ *Id.*
⁵⁵ SI with (b)(6) of 16 Jan 20.
⁵⁶ Computer Aided Dispatch Report of 4 Dec 19.
⁵⁷ SI with Guard Officer (b)(6) of 22 Jan 20.
⁵⁸ SI with (b)(6) of 12 Feb 20.
⁵⁹ *Id.*
⁶⁰ *Id.*; Computer Aided Dispatch Report of 4 Dec 19; SI with Guard Officer (b)(6) of 13 Jan 20.
⁶¹ SI with (b)(6) of 12 Feb 20.
⁶² SI with ETR2 (b)(6) of 22 Jan 20.
⁶³ *Id.*
⁶⁴ *Id.*
⁶⁵ *Id.*
⁶⁶ *Id.*
⁶⁷ SI with MMN2 (b)(6) of 13 Feb 20; SI with MMAC (b)(6) of 14 Jan 20; SI with MMA3 (b)(6) of 13 Jan 20; SI with MMAFN (b)(6) of 13 Jan 20; SI with LTJG (b)(6) of 14 Jan 20.
⁶⁸ *Id.*
⁶⁹ *Id.*; SI with MMAC (b)(6) of 14 Jan 20.
⁷⁰ *Id.*
⁷¹ DoDI 6055.17 § 5.5 ¶ a; JBPHHINST 3440.17D Emergency Management Plan, Annex 21 ¶ 6(e)(2).
⁷² DoDI 6055.17 § 5.5 ¶ a.
⁷³ DoDI 6055.17 § 5.5 ¶ a(2).
⁷⁴ DoDI 6055.17 § 5.5 ¶ a(3).
⁷⁵ JBPHHINST 3440.17D Emergency Management Plan, Annex 21 ¶ 1.
⁷⁶ *Id.*
⁷⁷ NAVADMIN 261/16.
⁷⁸ *Id.*
⁷⁹ AtHoc Registration of January 2020.
⁸⁰ PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19; CNRH RDC Incident History Log of 4 Dec 19.
⁸¹ CNRH RDC Incident History Log of 4 Dec 19.

⁸² *Id.*; CNRH Incident History Log of 4 Dec 19; DoDI 6055.17. § 5.5 ¶ a(1-3); JBPHHINST 3440.17D Emergency Management Plan, Annex 21; SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 21 Jan 20.

⁸³ SI with (b)(6) of 16 Jan 20.

⁸⁴ SI with (b)(6) of 13 Jan 20.

⁸⁵ AtHoc Alert Notification of 5 Dec 19.

⁸⁶ DoDI 6055.17. § 5.5 ¶ a(1-3); JBPHHINST 3440.17D Emergency Management Plan, Annex 21; SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 27 Jan 20. (6)

⁸⁷ SI with (b)(6) of 27 Jan 20.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ U.S. Air Force 15th Air Wing Command Post Events Log of 5 Dec 19.

⁹¹ 15th Wing QRC-404 Active Shooter/Hostage Situation Checklist; U.S. Air Force 15th Air Wing Command Post Events Log of 5 Dec 19.

⁹² CNRH RDC Incident History Log of 4 Dec 19.

⁹³ *Id.*; Incident Action Plan of 4 Dec 19 to 5 Dec 19; PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19; CNRH RDC Incident History Log of 4 Dec 19; JBPHHINST 3440.17D Emergency Management Plan, Annex 21, ¶ 6.e.2.

⁹⁴ GV Administrator Training by SERCO.

⁹⁵ *Id.*

⁹⁶ SI with (b)(6) of 21 Jan 20; SI with Mr. Gregory Crowell of 21 Jan 20.

⁹⁷ SI with (b)(6) of 21 Jan 20.

⁹⁸ PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19; CNRH RDC Incident History Log of 4 Dec 19.

⁹⁹ SI with (b)(6) of 21 Jan 20.

¹⁰⁰ PHNSY & IMF ECC Timeline, Chronological Record of Events of 4 Dec 19.

¹⁰¹ *Id.*

¹⁰² SI with Mr. Gregory Crowell of 21 Jan 20; SI with CDR (b)(6) of 28 Jan 20.

¹⁰³ SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 14 Jan 20; SI with CDR (b)(6) of 28 Jan 20.

¹⁰⁴ *Id.*; SI with (b)(6) of 21 Jan 20.

¹⁰⁵ Email from (b)(6) to (b)(6) of 5 Feb 20.

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*; SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 21 Jan 20; JBPHHINST 3440.17D Emergency Management Plan, Annex 21 ¶ 7(a).

¹⁰⁸ DoDI 6055.17 § 4.3 ¶ c, and § 5.2; JBPHHINST 3440.17D Emergency Management Plan, Annex 21 ¶ 7(a).

¹⁰⁹ SI with (b)(6) of 21 Jan 20.

¹¹⁰ JBPHHINST 3300.1E, page 14 ¶ a.

¹¹¹ *Id.* at page A-12 ¶ 3(b)(1).

¹¹² SI with (b)(6) of 21 Jan 20.

¹¹³ SI with (b)(6) of 21 Jan 20; Annex A: Joint Base Emergency Operations Center of Sep 18 ¶ 2(c).

¹¹⁴ *Id.*; SI with (b)(6) of 21 Jan 20.

¹¹⁵ Annex A: Joint Base Emergency Operations Center of Sep 18, Table 3-1

¹¹⁶ *Id.*

¹¹⁷ *Id.*

¹¹⁸ *Id.*

¹¹⁹ SI with (b)(6) of 13 Jan 20; SI with Mr. Gregory Crowell of 21 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 16 Jan 20; Shipyard Employee Focus Group Notes of 22 Jan 20.

¹²⁰ SI with (b)(6) of 21 Jan 20; SI with Mr. Gregory Crowell of 21 Jan 20; SI with (b)(6) of 13 Jan 20.

¹²¹ SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 14 Jan 20.

¹²² SI with CDR (b)(6) of 28 Jan 20.

¹²³ SI with (b)(6) of 16 Jan 20; SI with Mr. Gregory Crowell of 21 Jan 20; SI with (b)(6) of 13 Jan 20.

¹²⁴ SI with (b)(6) of 13 Jan 20.

¹²⁵ Shipyard Employee Focus Groups on 22 Jan 20.

¹²⁶ SI with (b)(6) of 15 Jan 20.

¹²⁷ SI with (b)(6) of 14 Jan 20.

¹²⁸ SI with (b)(6) of 16 Jan 20; SI with Mr. Gregory Crowell of 21 Jan 20; SI with (b)(6) of 13 Jan 20.

¹²⁹ Shipyard Employee & Supervisor Focus Groups of 22 Jan 20.

¹³⁰ SI with (b)(6) of 16 Jan 20; SI with Mr. Gregory Crowell of 21 Jan 20; SI with (b)(6) of 13 Jan 20.

¹³¹ SI with Mr. Gregory Crowell of 21 Jan 20.

Chapter 9 – Post-Incident Response

This chapter examines post-incident response after the Pearl Harbor Naval Shipyard (PHNSY) shooting incident. The instances of noncompliance and deficiencies in post-incident response that are examined in this chapter had no direct impact on the chain of events that led to the PHNSY shooting incident, but they should be addressed to improve readiness and safety.

Regulatory Background

DoDI 1300.18 (Department of Defense (DoD) Personnel Casualty Matters, Policies, and Procedures) assigns responsibilities and establishes uniform personnel policies and procedures across DoD components for reporting, recording, notifying, and assisting the next-of-kin whenever DoD casualties are sustained.

SECNAVINST 5720.44C CH-1 (Department of the Navy (DON) Public Affairs Policy and Regulations) provides requirements and guidance on DON Public Affairs.

SECNAVINST 12810.2A (Federal Employees' Compensation Act Program) provides requirements for providing prompt medical attention and full assistance in claiming just compensation for injuries or occupational illnesses incurred in the performance of duties.

DON Civilian Benefits Center Standard Operating Procedures # RET-01, (Employee Death In-Service Processing for Appropriated Fund Employees) provides human resource specialists with guidance for processes related to employee death in-service.

OPNAVINST 1754.1B (Fleet and Family Support Center (FFSC) Program) establishes policy and assigns responsibilities for the administration and support of the Navy FFSC program.

OPNAVINST 1770.1B (Casualty Assistance Calls and Funeral Honors Support (CAC/FHS) Program Coordination) establishes requirements for providing and coordinating casualty assistance and funeral honors for active duty and retired military members and their families.

MILPERSMAN 1770-260 (Civilian Employee Casualty Reporting, Notification, and Assistance) provides specific guidance on casualty notification and assistance in cases of civilian deaths.

BUMED Instruction 6440.6 (Mobile Medical Augmentation Readiness Team (MMART) Manual provides the basic policies and procedures for rapidly augmenting the Operating Forces with organized teams of Medical Department personnel for limited, short-term military operations, humanitarian relief missions, and Fleet and Fleet Marine Force scheduled deployments.

NAVMEDCOMINST 5360.1 (Decedent Affairs Manual) provides guidance and requirements for the search, recovery, identification, care, and disposition of remains of deceased persons for whom the DON is responsible.

COMNAVREGHIINST 1770.1F (Casualty Assistance Calls and Funeral Honors Program) provides guidance on casualty assistance and funeral honors in Hawaii.

COMNAVREGHIINST 3440.17B (Navy Region Hawaii Emergency Management Plan (EMP)) provides policy, guidance, operational structure, and assignment of responsibilities for the all-hazards management of natural and/or man-made emergencies within Navy Region Hawaii assigned shore installations and their tenant commands.

COMNAVREGHIINST 5720.4D (Navy Region Hawaii Guidance for the Conduct of Public Affairs) provides requirements and guidance on Navy Region Hawaii Public Affairs Matters.

NAVSHIPYD&IMFPEARLINST 3440.17 CH-2 (EMP, Pearl Harbor Naval Shipyard & Intermediate Maintenance Facility) provides policies and procedures for emergency management at PHNSY & IMF.

Findings-Opinions-Recommendations

Casualty Assistance and Other Support to Victims and their Families

Finding 9.1 (Noncontributing/Compliance/Deficiency): Casualty support to families was timely and effective, but coordination issues between Civilian Benefits Center (CBC) personnel and Casualty Assistance Calls Officers (CACOs) caused confusion and delay.¹

Discussion: Commander, U.S. Pacific Fleet (COMPACFLT) directed CACOs to be assigned to the victims' families.² CACOs are official Navy representatives who provide information, resources, and assistance to next of kin (NOK) or other designated persons.³ MILPERSMAN 1770-260 requires CACOs to coordinate actions with the DON Office of Civilian Human Resources (OCHR) CBC when CACOs provide support after civilian deaths.⁴ CBC personnel are human resource specialists and experts for all civilian benefits.⁵ CBC personnel provide counseling to beneficiaries regarding benefits such as life insurance upon the death of a DON employee.⁶ Two CBC human resource specialists are in Hawaii, and both provided in-person counseling after this incident.

MILPERSMAN 1770-260 also requires employing activities to notify DON OCHR and follow guidance at a (currently non-functioning website) hyperlink to ensure all administrative and personnel actions can be taken.⁷ In this instance, PHNSY notified the CBC, and the CBC contacted NOK within 24 hours in accordance with CBC standard operating procedures (SOPs).⁸ CBC human resource specialists met in person with families to assist in completing necessary forms and continue to assist the families through the benefits process.⁹ Although CBC contacted the victims' families within 24 hours, coordination issues with assigned CACOs led to confusion and delay.¹⁰ CBC policy does not delineate coordination procedures between CBC personnel and CACOs.¹¹

Opinion 9.1.1: The CBC generally delivered timely and effective support to the families of the two deceased civilian employees.¹²

Opinion 9.1.2: CBC and CACO policies are not well coordinated, leading to unclear guidance regarding support to civilian families after the death of a family member.¹³

CBC and CACO policies should be revised to incorporate coordination procedures between CBC personnel and CACOs when CACOs provide casualty support to NOK and other designated persons after civilian deaths.¹⁴

Recommendation 9.1.1: DON OCHR, in coordination with OPNAV N1, revise CBC policy to incorporate coordination procedures between CACOs and CBC personnel when CACOs provide casualty support after civilian deaths.

Finding 9.2 (Noncontributing/Deficiency): NOK information was not available in the official civilian personnel records system and contributed to delay in casualty support.¹⁵

Discussion: DON policy does not require civilian employees to provide NOK information in official personnel files.¹⁶ Civilian employees may provide emergency contact information voluntarily in the official system of record, the Defense Civilian Personnel Data System (DCPDS) MyBiz+ portal.¹⁷ DCPDS NOK information is then interfaced with the Total Workforce Management System (TWMS), where the employee may then designate the emergency contact as their NOK.¹⁸ TWMS then is where the servicing Human Resource Office (HRO) can access the information in emergency situations.¹⁹

DON employees must also verify emergency points of contact semi-annually in the Navy Family and Accountability and Assessment System (NFAAS).²⁰ However, this information does not populate DCPDS or TWMS, and NFAAS does not indicate whether an emergency contact is NOK. Employees are only required to update NFAAS, not DCPDS MyBiz+ or TWMS.²¹

The Director, Civilian Human Resources (DCHR) Office accessed TWMS to retrieve the deceased victims' NOK information after this incident, but the NOK information was incomplete.²² The incomplete NOK information delayed submission of the DON Notification of Civilian Employee Death form to the CBC and CACO notification.²³

Opinion 9.2.1: The lack of NOK information caused delay in casualty support including notification to victims' families.²⁴ This increased the risk that a family member would not get proper notification.²⁵

Recommendation 9.2.1: DON OCHR develop and implement policy to require civilians to provide NOK information for official personnel records and verify annually.

Recommendation 9.2.2: DON OCHR coordinate with DoD and the Office of Personnel Management (OPM) to evaluate the multiple personnel tracking systems such as DCPDS, TWMS, and NFAAS. Consider consolidation of these systems into a single system or system of systems that shares data using modern applications.

Finding 9.3 (Noncontributing/Compliance): Navy provided timely and effective support to victims, families, and other civilian employees regarding death and injury compensation claims in accordance with SECNAV Instruction 12810.2A.²⁶

Discussion: COMPACFLT HRO Hawaii received 58 claims of workplace injury and death related to the December 4, 2019 shooting incident.²⁷ Twelve claims were submitted to the Department of Labor’s Office of Workers’ Compensation Program as personnel were claiming loss of pay or medical expenses.²⁸ These twelve claims consisted of two death claims and ten claims of injury.²⁹ The additional 46 claims of workplace injury were submitted to the HRO for record only.³⁰ “Record only” means the claimants suffered no loss of pay or medical expenses incurred, but are on file with the HRO should the individuals subsequently seek benefits for their injuries.³¹

Opinion 9.3.1: HRO Hawaii provided comprehensive support to employees and the victims’ families.³² HRO Hawaii provided supervisors and employees with injury compensation and recovery Fact Sheets based on templates developed in response to the Washington Navy Yard (WNY) shooting in 2013 and shared by the Naval Sea Systems Command DCHR Office.³³

Recommendation 9.3.1: DON OCHR gather lessons learned and materials prepared in response to this and similar incidents and distribute them in a handbook to be shared with the DON human resources community.

Employee Support Programs

Finding 9.4 (Noncontributing/Deficiency): Counseling support programs provided effective counseling support to civilians, active duty personnel, and families.³⁴ However, some counseling support programs had to increase services to offset a lack of Civilian Employee Assistance Program (CEAP) resources, and a lack of coordination and communication negatively impacted delivery of counseling support.³⁵

Discussion: Joint Base Pearl Harbor-Hickam (JBPHH) has one full-time contracted CEAP counselor to respond to requests for counseling support.³⁶ According to the contract, the CEAP provider is to assist with emergencies in the workplace, to include unlimited critical incident stress debriefings, and grief counseling to be conducted at DON sites.³⁷ One event requires one provider per day up to 4 hours at one location.³⁸ In response to multiple requests, two additional CEAP counselors were made available on-site on alternating days, but not until the week of December 16, 2019.³⁹ They departed after December 20, 2019, because of low demand.⁴⁰

The JBPHH Military and Family Support Center (MFSC) reduced their primary mission to augment CEAP by accepting walk-ins.⁴¹ The MFSC Emergency Family Assistance Center (EFAC) operated from 1730 to 2300, on December 4, 2019, at two locations, the MFSC and PHNSY Building 2, and activated its call center.⁴² The MFSC EFAC and call center continued to operate through December 6 and December 9, 2019, respectively.⁴³ The MFSC and Building 2 EFAC had a small number of walk-ins related to the shooting incident during this time.⁴⁴ Through December 13, 2019, while the CEAP was understaffed, the MFSC clinicians saw 74 clients, 29 military and 45 civilian.⁴⁵

The Special Psychiatric Rapid Intervention Team (SPRINT) provided educational and consultative services December 9 through December 11, 2019, to over 800 active duty and civilian personnel through small group and individual interventions.⁴⁶ The PHNSY Deputy Executive Director initiated the request for SPRINT support.⁴⁷ The SPRINT team members were augmented by personnel from Naval Health Clinic Hawaii, Tripler Army Medical Center, Schofield Barracks, and the Chaplain Corps.⁴⁸

Several HROs contacted the CEAP counselor directly to initiate CEAP counseling support for employees from PHNSY and other commands in the region.⁴⁹ The one CEAP counselor was quickly overwhelmed at the scale of the incident and unfamiliar with the Navy organization, which contributed to the confusion.⁵⁰ In addition, some offices sent incorrect contact information for CEAP counseling services to their employees.⁵¹ On December 6, 2019, the COMPACFLT HRO Hawaii Director assumed the lead for coordination of CEAP counseling support in the region.⁵²

The MFSC EFAC and SPRINT also experienced challenges with disseminating information about available counseling services.⁵³ After December 4, 2019, the JBPHH Public Affairs Office (PAO) released incorrect information on social media about counseling services, and the MFSC EFAC did not have approved public messaging and responses to queries.⁵⁴ The JBPHH PAO was unaware that the EFAC required this information.⁵⁵ Prior coordination and training had not been done in accordance with EFAC Desk Guide, which requires the EFAC Director to have staffing, training, and recall plans in place to establish an EFAC.⁵⁶ In addition, many human resource specialists and supervisors who were referring PHNSY personnel to counseling services were also unaware of the SPRINT team's arrival to Hawaii and remained unaware until the day the SPRINT personnel departed Hawaii on December 13, 2019.⁵⁷

Opinion 9.4.1: CEAP did not have sufficient counseling support immediately after the shooting.⁵⁸ Four hours of onsite counseling per day, as provided in the Magellan Health contract, was inadequate to support the needs of a large workforce following a traumatic event.⁵⁹ DON OCHR and Magellan Health should have responded more quickly to requests for support.⁶⁰

Opinion 9.4.2: CEAP, EFAC, SPRINT, local medical providers, and religious support personnel who augmented these counseling support programs, combined to provide effective counseling support to civilian employees, active duty personnel, and families at JBPHH after the shooting incident.⁶¹

Opinion 9.4.3: HROs and JBPHH did not release timely and accurate information about available counseling support services because of a lack of coordination.⁶² One official should have the responsibility and authority to lead coordination of counseling support

services in Navy regions after major incidents.⁶³ MFSC EFAC should complete prior coordination, training, staffing, and recall procedures before major incidents.⁶⁴

Recommendation 9.4.1: DON OCHR review CEAP contracts to ensure adequate counseling support, including crisis management and the ability to surge additional support following major incidents (e.g., active shooter or mass casualties).

Recommendation 9.4.2: CNIC develop policy that designates an official (e.g., Region Director, Total Force Manpower Management (N1)) to take lead on coordinating counseling support services throughout Navy regions following major incidents.⁶⁵

Recommendation 9.4.3: JBPHH EFAC Director, in coordination with JBPHH PAO, establish a memorandum of understanding (MOU) on training, staffing and recall procedures in accordance with established guidance.⁶⁶

Impacts to PHNSY & IMF Personnel and Work Place Safety Concerns

Finding 9.5 (Noncontributing/Deficiency): The PHNSY workforce has significant concerns for workplace safety resulting from this incident.⁶⁷ These concerns primarily relate to the level of preparedness to respond to future events and to lack of communication.⁶⁸

Discussion: The investigation team conducted focus groups with PHNSY workforce where they expressed concern about the level of preparedness to respond to future events.⁶⁹ They raised concerns about the adequacy of active shooter training generally and for the specific conditions of the shipyard;⁷⁰ the adequacy of warning systems and emergency communications within the Controlled Industrial Area (CIA), e.g., AtHoc and Giant Voice;⁷¹ and questioned the need for armed watchstanders in the CIA.⁷² Chapter 7 and 8 of this report provide findings, opinions, and recommendations concerning force protection and incident response to improve PHNSY readiness and safety.

The civilian workforce also expressed concern in interviews and focus groups about the lack of communication from leadership in recent weeks to address these and other questions.⁷³ The PHNSY Commander released all hands and employee notifications by

email on December 4 and December 5, 2019, which provided the shipyard workforce with information on reporting to work on December 5, 2019 and counseling support.⁷⁴ The PHNSY Commander met with Code 130 personnel on December 6, 2019, and led three all hands meetings at the Bloch Arena later that same day.⁷⁵ MFSC clinical counselors, CEAP, and the COMPACFLT Hawaii HRO Director attended the meetings.⁷⁶ However, since these initial meetings, there has been a general lack of communication with the last all hands email being on December 12, 2019.⁷⁷ Commander, Naval Sea Systems Command (COMNAVSEASYSCOM), after coordination with COMPACFLT, assumed the lead on workforce communications concerning the shooting investigation.⁷⁸ The PHNSY Commander must coordinate with COMNAVSEASYSCOM before any communications with the workforce related to the shooting incident and investigation.⁷⁹ The coordination procedure, while initially established to protect law enforcement sensitive information, has prevented or delayed release of information to the workforce.⁸⁰

Opinion 9.5.1: The PHNSY workforce has significant concerns about workplace safety as a result of this incident especially the level of preparedness, and the lack of communication about the actions taken in response to the shooting incident.⁸¹

Opinion 9.5.2: Navy lacks comprehensive guidance about internal workforce communication following traumatic events, and the lack of communication after this incident has hampered recovery of the PHNSY workforce.⁸² The information environment is also characterized by the widespread use of social media from unverified sources that can rapidly spread incorrect or incomplete information.⁸³ The Navy lacks a coordinated, easy-to-use method with effective management controls to share critical, unclassified information from commanders to Sailors, civilians, and their families after an incident.⁸⁴

Recommendation 9.5.1: PHNSY, in coordination with COMNAVSEASYSCOM, increase communication with the shipyard workforce concerning the steps being taken to review programs, policies, and procedures for compliance and deficiencies, and to improve readiness and safety as a result of this incident.

Recommendation 9.5.2: CNIC lead a multi-disciplinary team to include subject matter experts in command leadership, human resources, law enforcement, counseling support,

religious support, law, and public affairs to develop policy guidance and best practices regarding effective communications to impacted workforce after major incidents.

Recommendation 9.5.3: (b) (5)

Mission Continuity and Communication

Finding 9.6 (Noncontributing/Deficiency): The PHNSY emergency management plan (EMP) does not clearly designate essential personnel for closures after major incidents.⁸⁵ PHNSY provided unclear direction to the shipyard workforce on whether to report to work on December 5, 2019.⁸⁶

Discussion: The PHNSY workforce in the CIA were held late on December 4, 2019, as law enforcement cleared buildings and interviewed witnesses.⁸⁷ Many employees, or their union representatives on their behalf, reported being stressed or anxious while waiting to be released from work that evening.⁸⁸ When employees on the “surface side” of the CIA were informed they were required to report to work December 5, 2019, many approached their union steward to ask why they were being treated differently than employees who may have been working on the “submarine side,” closer to the active shooter event.⁸⁹ On December 5, 2019, these employees were released to go home by noon.⁹⁰ The reported status of the shipyard on social media and available by calling the PHNSY telephone number on December 5, 2019, was that the shipyard was closed.⁹¹

Opinion 9.6.1: PHNSY guidance to the workforce regarding the status of the workforce on December 5, 2019 caused confusion.⁹² The PHNSY EMP should clearly designate essential personnel for shipyard closures that are not weather-related, to include closures as a result of a major incident or mass casualty.⁹³

Recommendation 9.6.1: PHNSY update the shipyard EMP to clearly designate essential personnel for shipyard closures that are not weather-related, to include closures as a result of a major incident or mass casualty.

Recommendation 9.6.2: Echelon 2 Commanders ensure subordinate commands' EMPs designate emergency personnel for closures that are not weather-related, to include closures as a result of a major incident or mass casualty.

Finding 9.7 (Noncontributing/Noncompliance): NFAAS was not activated to account for personnel after the December 4, 2019 shooting incident.⁹⁴

Discussion: NFAAS is the required mechanism for personnel accountability.⁹⁵ Director, Total Force Manpower Management for CNRH N1 stated NFAAS was not used to account for personnel immediately following the shooting incident based on mistaken direction that the incident only affected shipyard personnel.⁹⁶

Commands used text, telephone calls, and personal knowledge to account for personnel after the PHNSY shooting incident.⁹⁷ There were no reported consolidated efforts to account for personnel.⁹⁸ Some reported that consolidated accountability efforts did not take place because this was a "shipyard event" and only the shipyard needed to account for their personnel.⁹⁹ However, Naval Facilities Engineering Command (NAVFAC), for example, had employees working in the CIA near Dry Dock 2 during the incident.¹⁰⁰ Similarly, the 2013 WNY shooting occurred in a Naval Sea Systems Command building but included NAVFAC victims.¹⁰¹

Opinion 9.7.1: NFAAS should be used to account for personnel throughout an affected area after an active shooter incident because the incident may impact personnel from several commands.¹⁰² As this incident and the WNY incident demonstrate, location alone does not define the affiliation of all affected personnel.¹⁰³ All personnel within the area should be accounted for regardless of the command to which they are assigned.¹⁰⁴

Recommendation 9.7.1: CNIC review procedures and conduct training on recall and post-incident accountability for personnel and families through NFAAS.

Finding 9.8 (Noncontributing/Compliance): Public Affairs (PA) external communications were in accordance with Navy instructions.¹⁰⁵

Discussion: External communication support efforts consisted of PA offices from across the Hawaii region and Washington D.C., to include CHINFO; Commander, U.S. Indo-Pacific Command (CDRUSINDOPACOM); Director, Naval Reactors (NR); COMPACFLT; Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC); Commander, Navy Region Hawaii (CNRH); JBPHH; and PHNSY.¹⁰⁶ CNRH and JBPHH issued initial press release and social media posts within 30 minutes of the incident.¹⁰⁷ While this was within required timelines, the initial social media post was delayed due to a delay in on-base emergency notifications.¹⁰⁸ PA offices coordinated by phone bridge and email with final review by various subject matter experts at the CNRH Regional Operations Center (ROC) and JBPHH Emergency Operations Center (EOC).¹⁰⁹ Before this incident, CNRH PA did not have an active shooter response SOP, but they are drafting one now.¹¹⁰

Opinion 9.8.1: CNRH PA external communication efforts immediately following the incident were timely, accurate, and appropriate, but procedures can be improved.¹¹¹

Recommendation 9.8.1: CHINFO, in coordination with CNIC, develop PA policy for active shooter and other major security incidents that incorporate shorter response timelines, best practices, and lessons learned from previous incidents.¹¹² This should include periodic drills and/or tabletop exercises to test procedures and ensure individual understanding and proficiency.

¹ SI with (b)(6) of 15 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 14 Jan 20.

² *Id.*

³ MILPERSMAN 1770-010.

⁴ MILPERSMAN 1770-260 ¶ 5.

⁵ DON CBC SOP of 29 Apr 11.

⁶ *Id.*

⁷ MILPERSMAN 1770-260 ¶ 2.

⁸ SI with (b)(6) of 10 Jan 20.

⁹ SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 16 Jan 20.

¹⁰ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 15 Jan 20.

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- ¹¹ DoD Personnel Processing Guide for Death In-Service; DON CBC Standard Operating Procedures Number RET-01, Employee Death In-Service Processing for Appropriated Fund Employees.
- ¹² SI with (b)(6) of 16 Jan 20.
- ¹³ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 13 Jan 20.
- ¹⁴ *Id.*
- ¹⁵ SI with (b)(6) of 15 Jan 20; SI with (b)(6) of 10 Jan 20.
- ¹⁶ SI with (b)(6) of 21 Jan 20.
- ¹⁷ DoD DCPAS, MyBiz+, Core Services § 1.1.8; MyBiz+ User Guide for Managers & Supervisors.
- ¹⁸ CNICINST 5230.1A, TWMS Access Responsibility List.
- ¹⁹ *Id.*
- ²⁰ OPNAVINST 3006.1 § 5(c)(4).
- ²¹ *Id.*
- ²² SI with (b)(6) of 10 Jan 20.
- ²³ SI with (b)(6) of 15 Jan 20; SI with (b)(6) of 21 Jan 20.
- ²⁴ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 13 Jan 20.
- ²⁵ *Id.*
- ²⁶ *Id.*
- ²⁷ SECNAV 12810.2A § 5.
- ²⁸ Injury Compensation Claims: Email from (b)(6) to (b)(6) of 6 Jan 10.
- ²⁹ *Id.*
- ³⁰ *Id.*
- ³¹ *Id.*
- ³² SI with (b)(6) of 10 Jan 20; After Action Report ICO SPRINT of 7 Jan 20.
- ³³ SI with (b)(6) of 14 Jan 20.
- ³⁴ After Action Report ICO SPRINT of 7 Jan 20.
- ³⁵ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 15 Jan 20.
- ³⁶ SI with (b)(6) of 17 Jan 20; SI with (b)(6) of 21 Jan 20.
- ³⁷ Magellan Health Care Contract § 5.3.3.
- ³⁸ *Id.*
- ³⁹ SI with (b)(6) of 17 Jan 20.
- ⁴⁰ *Id.*
- ⁴¹ OPNAVINST 1754.1B, FFSC Program ¶ 3.
- ⁴² SI with (b)(6) of 21 Jan 20.
- ⁴³ *Id.*
- ⁴⁴ *Id.*
- ⁴⁵ *Id.*
- ⁴⁶ Memorandum for the Record, Conversation with CDR (b)(6) of 5 Feb 20.
- ⁴⁷ SI with (b)(6) of 13 Jan 20.
- ⁴⁸ After Action Report ICO SPRINT of 7 Jan 20.
- ⁴⁹ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 15 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁵⁰ *Id.*
- ⁵¹ SI with (b)(6) of 21 Jan 20.
- ⁵² SI with (b)(6) of 17 Jan 20.
- ⁵³ *Id.*; After Action Report ICO SPRINT of 7 Jan 20; SI with (b)(6) of 21 Jan 20.
- ⁵⁴ SI with (b)(6) of 21 Jan 20; Facebook Twitter Posts by JBPHH PAO.
- ⁵⁵ Email from (b)(6) to CDR (b)(6) of 27 Jan 20.
- ⁵⁶ The Fleet & Family Support Center Emergency Family Assistance Center (EFAC) Desk Guide § 7, 14, 16.
- ⁵⁷ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 17 Jan 20.
- ⁵⁸ SI with (b)(6) of 21 Jan 20.
- ⁵⁹ *Id.*; Magellan Health Care Contract.

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- ⁶⁰ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 17 Jan 20.
- ⁶¹ The Fleet & Family Support Center Emergency Family Assistance Center (EFAC) Desk Guide § 2 ¶ 5.
- ⁶² SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 17 Jan 20.
- ⁶³ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 15 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁶⁴ The Fleet & Family Support Center Emergency Family Assistance Center (EFAC) Desk Guide § 7, 14, 16.
- ⁶⁵ COMNAVREGHIINST 3440.17B, Enclosure 1 ¶ l(d)(3)(d) and ¶ m(12).
- ⁶⁶ The Fleet & Family Support Center Emergency Family Assistance Center (EFAC) Desk Guide § 7, 14, 16.
- ⁶⁷ Shipyard Employee & Supervisor Focus Groups of 22 Jan 20.
- ⁶⁸ *Id.*
- ⁶⁹ *Id.*
- ⁷⁰ Shipyard Employee Focus Group on 22 Jan 20.
- ⁷¹ SI with (b)(6) of 16 Jan 20; Shipyard Focus Groups on 22 Jan 20.
- ⁷² SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 16 Jan 20; Shipyard Employee Focus Groups on 22 Jan 20; SI with (b)(6) of 16 Jan 20.
- ⁷³ SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 13 Jan 20; Shipyard Focus Groups on 22 Jan 20.
- ⁷⁴ Email from CAPT (b)(6) email to All Hands of 4 Dec 19; Email from (b)(6) to All Hands of 4 Dec 19; Email from CAPT (b)(6) email to All Hands of 5 Dec 19.
- ⁷⁵ SI with (b)(6) of 21 Jan 20.
- ⁷⁶ SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 13 Jan 20.
- ⁷⁷ SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 13 Jan 20; Shipyard Focus Groups on 22 Jan 20; Email from CAPT Gregory Burton email to All Hands of 12 Dec 19.
- ⁷⁸ SI with (b)(6) of 21 Jan 20.
- ⁷⁹ *Id.*
- ⁸⁰ SI with CAPT Burton of 21 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 21 Jan 20.
- ⁸¹ Shipyard Employee & Supervisor Focus Groups of 22 Jan 20.
- ⁸² *Id.*; SI with CAPT (b)(6) of 21 Jan 20; SI with (b)(6) of 16 Jan 20; SI with (b)(6) of 13 Jan 20.
- ⁸³ SI with CAPT (b)(6) of 21 Jan 20.
- ⁸⁴ *Id.*; Shipyard Employee Focus Group of 22 Jan 20.
- ⁸⁵ NAVSHIPYD&IMFPEARLINST 3440.17, Emergency Management Plan, Pearl Harbor Naval Shipyard & Intermediate Maintenance Facility, Enclosure 1, Annex D.
- ⁸⁶ Email from (b)(6) to All Hands of 4 Dec 19.
- ⁸⁷ SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 16 Jan 20; Shipyard Focus Groups on 22 Jan 20.
- ⁸⁸ Shipyard Employee Focus Group of 22 Jan 20.
- ⁸⁹ SI with (b)(6) of 16 Jan 20.
- ⁹⁰ *Id.*
- ⁹¹ Facebook and Twitter Posts by JBPHH PAO.
- ⁹² *Id.*; Email from (b)(6) to All Hands of 4 Dec 19.
- ⁹³ *Id.*
- ⁹⁴ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 14 Jan 20; SI with (b)(6) of 21 Jan 20; SI with (b)(6) of 13 Jan 20.
- ⁹⁵ COMNAVREGHIINST 3440.17B, Annex 6.
- ⁹⁶ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁹⁷ SI with CAPT (b)(6) of 21 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁹⁸ SI with (b)(6) of 10 Jan 20; SI with (b)(6) of 13 Jan 20; SI with (b)(6) of 14 Jan 20.
- ⁹⁹ SI with (b)(6) of 14 Jan 20.
- ¹⁰⁰ SI with (b)(6) of 17 Jan 20.

¹⁰¹ Navy Office of Information (24 JUN 2014) “SECNAV Pays Tribute to Washington Navy Yard Attack Victims, Responders.” Navy News Service. Retrieved from www.navy.mil.

¹⁰² SI with (b)(6) of 17 Jan 20; SI with CAPT Gregory Burton of 21 Jan 20; SI with (b)(6) of 14 Jan 20.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ SECNAVINST 5720.44C § 1-9, 1-14, 2-1, 2-20, 3-4; COMNAVREGHIINST 5720.4D § 7-8.

¹⁰⁶ SI with (b)(6) of 17 Jan 20; SI with (b)(6) of 13 Jan 20; SI with CDR (b)(6) of 17 Jan 20.

¹⁰⁷ CNRH PAO External Communication Timeline; CNRH PAO Press Release Media Advisory; Facebook Twitter Posts by JBPHH PAO; COMNAVREGHIINST 5720.4D; SECNAVINST 5720.44C.

¹⁰⁸ SI with (b)(6) of 17 Jan 20.

¹⁰⁹ SI with (b)(6) of 17 Jan 20; SI with (b)(6) of 13 Jan 20; SI with CDR (b)(6) of 17 Jan 20.

¹¹⁰ SI with (b)(6) of 17 Jan 20.

¹¹¹ CNRH PAO Lessons Learned.

¹¹² SECNAVINST 5720.44C § 2-1; COMNAVREGHIINST 5720.4D § 7.

Chapter 10 – Opinions and Recommendations

This chapter provides the investigation’s main opinions and primary recommendations. (Note: Appendix A provides a complete listing of specific findings, opinions, and recommendations from Chapters 3 through 9).

Opinions

Based on the findings, four main opinions inform the recommendations in this report:

Opinion 1: The evidence did not establish with certainty why Romero chose to shoot three civilians and kill himself, but it did show that he had several stressors in his life in the months leading up to the shooting that, when taken together, likely led him to choose violence. No effective formula exists to predict violent behavior with any level of accuracy. Amplifying guidance and training in arms, ammunition, and explosives (AA&E) rescreening standards may have prompted Romero’s rescreening based on the risk factors known to the Navy before the December 4, 2019 shooting incident.

Opinion 2: The Submarine Expanded Mental Health Program (eMHP) is a valuable program that enhances the readiness of the submarine force through early intervention and prevention. However, a review of Romero’s care and eMHP Clinic diagnostic data indicate a potential pattern of under-diagnosis to maintain patients on submarine duty.

Opinion 3: The Department of Defense (DoD) policy on confidentiality is central to removing the stigma of seeking mental health treatment and building trust between medical providers and patients. However, the chain of command is also central to ensuring the resilience and well-being of Sailors, unit mission readiness, and warfighting effectiveness. A better balance must be achieved between confidentiality and sharing information to improve care, and ensure that high-risk personnel are identified and appropriately monitored, especially where Sailors are given access to means that can kill or cause serious injury.

Opinion 4: DoD and Department of the Navy (DON) insider threat programs and training have developed in recent years in part as a result of lessons learned from the tragic shootings at Fort Hood and the Washington Navy Yard. This incident demonstrates more work is required in some areas. These areas include increased information sharing, and incorporating prevention principles and human factor assessments into programs, policies, and procedures, such as AA&E screening and Sailor resilience programs.

Recommendations

Potential Contributing factors. The primary recommendations concerning potential contributing factors in this incident include the following:

- Bureau of Medicine and Surgery (BUMED), in coordination with Type Commanders, conduct a comprehensive review of the eMHP to determine if there is a pattern of under-diagnosis and to clarify the proper role and scope of practice of behavioral health technicians. The review should also include manning, patient/provider ratios, facilities, and reporting tripwires to commands.
- Commander Submarine Forces, in coordination with BUMED, align eMHP practice to comply with the existing instruction to present a unified plan among the chain of command, patient, and provider. Use informed consent with patients to share information and improve care, and as necessary, disclose information to commanders through existing exceptions to DoD policy on confidentiality—specifically, the harm to mission, special personnel, or other special circumstances exceptions.
- OPNAV N4 revise AA&E policy, procedures, and training on screening and rescreening to clarify vague standards, and incorporate prevention principles, human factor assessments, and tripwires. Mental health treatment without a diagnosis should not be a tripwire by itself, but should be considered a tripwire for rescreening if present with other factors such as continuing poor performance, disciplinary actions, or family issues that raise concerns about maturity, stability, or dependability.

- In combination with aligning eMHP practice to increase information sharing with the chain of command, Commander Submarine Forces take action as appropriate to increase communication and collaboration across the submarine force concerning mental health.
- OPNAV N17 expedite and fully resource changes to the Expanded Operational Stress Control (E-OSC) Program, including incorporation of primary prevention principles and human factors into Command Resilience Team (CRT) efforts to promote healthy command climates and well-being.
- Director, Navy Staff (DNS), in coordination with DON Insider Threat Hub, use this incident as a case study when developing fleet reporting procedures to the DON Insider Threat Hub as it works toward full operational capability. Consider use of the E-OSC program and CRTs when implementing Prevention, Assistance and Response (PAR) or PAR-like capabilities at the installation and organization-level to augment predictive approaches to insider threats.

Noncontributing Factors. The primary recommendations concerning noncontributing factors in this incident include the following:

- DoD Consolidated Adjudications Facility (DoD CAF) use this incident as a case study to evaluate continuous evaluation reporting thresholds. Further define catch-all categories on judgment, trustworthiness, reliability, and maturity as well as provide illustrative examples through amplifying guidance and training to aid unit-level decision-making in continuous evaluation reporting.
- Naval Education and Training Command (NETC), in coordination with BUMED, review this report to identify potential improvements to mental health screening procedures in recruit training and accession training.
- CNRH enter into a comprehensive mutual aid agreement with the Honolulu Police Department (HPD) that addresses local communication, coordination, and training

procedures. Commander, Naval Installations Command (CNIC) assess adequacy of mutual aid agreements with local law enforcement at other installations.

- OPNAV N4, in coordination with Commander, U.S. Fleet Forces Command (CUSFF) and Naval Warfare Development Command, revise Navy Tactics, Techniques, and Procedures (NTTPs), and training on building clearance, physical restraints, and evacuation procedures in the context of active shooter incidents.
- Echelon 2 Commanders ensure that all subordinate commands have active shooter PPRs and security de-confliction procedures in Antiterrorism Plans.
- Commander Submarine Forces, in coordination with pertinent Echelon 2 Commanders, assess whether armed watchstanding requirements inside Controlled Industrial Areas (CIAs) can be modified in some Force Protection conditions.
- CNIC improve technical capabilities of mass notification systems and revise operating procedures to reduce the probability of human error.
- DON Office of Civilian Human Resources (OCHR), in coordination with OPNAV N1, revise Civilian Benefits Center (CBC) policy to incorporate coordination procedures between Casualty Assistance Calls Officers (CACOs) and CBC personnel when CACOs provide casualty support after civilian deaths.
- CNIC develop policy that designates an official (e.g., Region Director, Total Force Manpower Management (N1)) to take lead on coordinating counseling support services throughout Navy regions following major incidents.
- CNIC lead a multi-disciplinary team to include subject matter experts in command leadership, human resources, law enforcement, counseling support, religious support, law, and public affairs to develop policy guidance and best practices regarding effective communications to impacted workforce after major incidents.

(b) (6) [Redacted]

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Appendix A – Table of Findings-Opinions-Recommendations

Chapter 3 – Embedded Mental Health Program: Fitness for Submarine Duty		
Findings	Opinions	Recommendations
<p><u>Finding 3.1 (Potential Contributing/Noncompliance/Deficiency):</u> The eMHP provider under-diagnosed and did not properly manage Romero’s mental health condition during eight visits to the eMHP Clinic between September and November 2019. The eMHP provider only diagnosed “Phase of Life Problems” and “Unspecified Problem Related to Unspecified Psychosocial Circumstances” when Romero showed signs of an undiagnosed mental disorder that likely would have disqualified him from submarine duty. Seven of eight visits to the eMHP Clinic were with the behavioral health technician and not the eMHP provider.</p>	<p><u>Opinion 3.1.1:</u> The eMHP provider, the Force Psychologist, under-diagnosed and inadequately managed Romero’s mental condition. An accurate diagnosis likely would have disqualified Romero from submarine duty.</p> <p><u>Opinion 3.1.2:</u> Through early intervention and prevention, the eMHP is designed to enhance resilience and well-being, but Romero’s care and eMHP Clinic diagnostic data indicate a potential pattern of under-diagnosis to maintain patients on submarine duty.</p> <p><u>Opinion 3.1.3:</u> The Force Psychologist did not properly supervise the behavioral health technician’s care of Romero.</p> <p><u>Opinion 3.1.4:</u> The eMHP staff behavioral health technician operated outside of his clinical scope of practice, as delineated in the eMHP Submarine Force instruction.</p> <p><u>Opinion 3.1.5:</u> The eMHP staff who treated Romero could not have reasonably predicted his violent behavior. He had no prior history of violence, and he denied homicidal or suicidal ideations. However, several factors increased risk of destructive behavior, including significant occupational stress and lack of social support.</p> <p><u>Opinion 3.1.6:</u> The eMHP Clinic’s lack of capability to receive outpatient referrals through the electronic medical record system negatively impacted the transition of care. The eMHP Clinic and USS COLUMBIA MDR were not notified of Romero’s referral to the eMHP Clinic after his March 4, 2019 TAMC emergency room visit.</p>	<p><u>Recommendation 3.1.1:</u> Command Surgeon, U.S. Fleet Forces Command, as Privileging Authority, in coordination with Commander Submarine Forces, conduct a quality assurance investigation into the clinical practice of the (b) (6) with particular attention to any pattern of under-diagnosis and the behavioral health technician’s scope of practice without direct supervision.</p> <p><u>Recommendation 3.1.2:</u> BUMED, in coordination with Type Commanders, conduct a comprehensive review of the eMHP to determine whether there is a broader pattern of under-diagnosis and to clarify the proper role and scope of practice of behavioral health technicians. The review should also include manning, patient/provider ratios, facilities, and reporting tripwires to commands.</p> <p><u>Recommendation 3.1.3:</u> BUMED, in coordination with Commander Submarine Forces, evaluate MANMED policy regarding Disqualifying Mental Health Conditions for Submarine Duty.</p> <p><u>Recommendation 3.1.4:</u> Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC), install outpatient electronic record terminals in the NSSC eMHP Clinic and request official clinic designation from TAMC in order to receive electronic referrals.</p>

<p><u>Finding 3.2 (Potential Contributing/Noncompliance/Deficiency):</u> Contrary to the Submarine Force eMHP instruction, the eMHP Clinic did not present a unified plan among the chain of command, patient, and provider regarding Romero’s mental health treatment as required. The eMHP Clinic staff did not collaborate with Romero’s chain of command because he did not meet any exception to the Department of Defense (DoD) policy on confidentiality. The eMHP Clinic staff’s interpretation of DoD policy imposed a barrier on information sharing and collaboration with the chain of command.</p>	<p><u>Opinion 3.2.1:</u> The DoD policy on confidentiality is central to removing the stigma of seeking mental health treatment and building trust between medical providers and patients. However, commanding officers have a clear need to know of any condition that could impact Sailors’ abilities to safely and effectively execute their duties. A better balance must be achieved between confidentiality and sharing information about mental health especially where Sailors have access to firearms or conduct high-risk tasks.</p> <p><u>Opinion 3.2.2:</u> The eMHP Clinic’s interpretation of DoD policy on confidentiality conflicts with the Submarine Force eMHP instruction that requires a unified plan among the chain of command, patient, and provider. The use of informed consent (waiver of confidentiality) to increase information sharing and collaboration between commanding officers and providers would improve patient care and ensure that high-risk personnel are identified and appropriately monitored consistent with medical ethics.</p> <p><u>Opinion 3.2.3:</u> The eMHP Clinic manning levels also affect level of outreach, information sharing, and collaboration with commands.</p> <p><u>Opinion 3.2.4:</u> If the eMHP Clinic informed the USS COLUMBIA chain of command or MDR that they advised “if Romero’s conditions should worsen to talk to his chain of command about being temporarily removed from standing an armed watch” then the chain of command may have been more likely to rescreen and remove Romero from watchstanding following his DRB or XOI.</p>	<p><u>Recommendation 3.2.1:</u> Commander Submarine Forces, in coordination with BUMED, align eMHP practice to present a unified plan among the chain of command, patient, and provider in accordance with the existing instruction. Use informed consent (waiver of confidentiality) with patients to improve care, and as necessary, disclose information through existing exceptions to DoD policy on confidentiality—specifically, the harm to mission, special personnel, or other special circumstances.</p> <p><u>Recommendation 3.2.2:</u> BUMED PHAB issue guidance to mental health providers concerning the proper use of informed consent outside of enumerated exceptions in DoDI 6490.08 to improve care, ensure that high-risk personnel are identified and appropriately monitored, and improve the relationship between commander and provider. Seek change to DoDI 6490.08 to expressly address informed consent to improve patient care.</p> <p><u>Recommendation 3.2.3:</u> BUMED, in coordination with Type Commanders, include manning levels in comprehensive review of eMHP. See Recommendation 3.1.2.</p>
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Chapter 4 – Arms, Ammunition, & Explosives Program (AA&E): Suitability to Stand Armed Watch

Findings	Opinions	Recommendations
<p><u>Finding 4.1 (Potential Contributing/Noncompliance/Deficiency):</u> Romero completed required AA&E screening in September 2018 and qualified to stand the Topside Rover Patrol watch in December 2018. He completed required annual rescreening in September 2019, but OPNAV Instruction 5510.13C also requires rescreening “when circumstances indicate a review would be prudent.” He was not rescreened on that basis despite risk factors known to the Navy including his mental health; his (b) (6) health issues; two single motor vehicle accidents (motorcycle and car) within a year; general isolation from his shipmates; delinquent qualifications; repeated counseling; a disciplinary review board (DRB); a failure to advance to E-4; and an executive officer inquiry (XOI) the day before the shooting. OPNAV Instruction 5530.13C and training do not provide amplifying guidance on when circumstances require rescreening.</p>	<p><u>Opinion 4.1.1:</u> The circumstances before Romero assumed the watch on December 4, 2019, indicated an arms rescreening would have been prudent. The chain of command could not have known about Romero’s under-diagnosed mental disorder. However, the risk factors still should have raised questions about Romero’s maturity, stability, and dependability. The chain of command should have communicated with the weapons officer and made a decision to rescreen and consider removing Romero from armed watch based on the combination of Romero’s personal and work-related problems.</p> <p><u>Opinion 4.1.2:</u> Romero was qualified, screened, and rescreened annually to stand the Topside Rover Patrol watch. However, the weapons officer did not comply with requirements to conduct an independent personnel records review during annual rescreening and to maintain the initial OPNAV Form 5530/1. Romero’s OMPF would not have included the counseling chits or the DRB and XOI records. If the weapons officer had reviewed the OMPF, it would not have changed his annual rescreening determination.</p> <p><u>Opinion 4.1.3:</u> The AA&E screening policy, procedures, and training should clarify vague screening and rescreening standards, and incorporate prevention principles, human factors assessments, and decision points (tripwires) to help commanding officers make more informed decisions about whether personnel should have access to service weapons. Mental health treatment without a diagnosis should not be a tripwire by itself, but should be considered a tripwire for rescreening if present with other factors such as continuing poor performance, disciplinary actions, or family issues that raise concerns about maturity, stability, or dependability.</p> <p><u>Opinion 4.1.4:</u> Weapons officers should receive formal training on AA&E policy and procedures before assuming responsibility for implementing small arms programs.</p>	<p><u>Recommendation 4.1.1:</u> OPNAV N4 revise AA&E policy, procedures, and training requirements on screening and rescreening to clarify vague standards and incorporate prevention principles, human factor assessments, and tripwires for rescreening. Mental health treatment without a diagnosis should not be a tripwire by itself, but should be considered a tripwire for rescreening if present with other factors such as continuing poor performance, disciplinary actions, or family issues.</p> <p><u>Recommendation 4.1.2:</u> COMSUBPAC issue clarifying guidance on record retention requirements for OPNAV Form 5530/1.</p>

<p><u>Finding 4.2 (Potential Contributing/Noncompliance):</u> Romero assumed security duties as the Topside Roving Patrol without getting the required safety brief.</p>	<p><u>Opinions 4.2.1:</u> The missed security and safety briefs demonstrate a lack of procedural compliance and were a missed opportunity for duty section leadership to assess Romero's suitability for watch before he was issued a firearm.</p>	<p><u>Recommendation 4.2.1:</u> USS COLUMBIA revise duty section procedures to ensure armed watchstanders complete safety and security brief requirements before watch.</p> <p><u>Recommendation 4.2.2:</u> Fleet Commanders direct all submarine units to ensure duty section procedures require armed watchstanders complete safety and security brief requirements before watch.</p>
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Chapter 5 – USS COLUMBIA’s Command Climate: Leadership Challenges in the Shipyard Environment

Findings	Opinions	Recommendations
<p><u>Finding 5.1 (Potential Contributing/Noncompliance/Deficiency):</u> Command climate assessments and external assessments show USS COLUMBIA’s command climate was generally below average when compared to other submarines.</p>	<p><u>Opinion 5.1.1:</u> The organizational culture tolerated a below-average command climate because USS COLUMBIA was in an industrial environment. This cultural tolerance was reflected in the crew’s comments, a separate category in “People Centered Metrics” for submarines in the shipyard, and the ISIC’s reaction to the USS COLUMBIA’s below-average DEOCS results.</p> <p><u>Opinion 5.1.2:</u> More intrusive leadership, teamwork, and communication is required in more difficult environments such as extended maintenance periods in shipyards. Leaders should foster a culture of excellence where Sailors feel included, respected, and empowered regardless of location or operational status.</p>	<p><u>Recommendation 5.1.1:</u> USS COLUMBIA, in coordination with CSS-7, develop a more comprehensive command climate POA&M, and bring sponsorship and mentorship programs into compliance. Consider use of the Fleet Chief Petty Officer Training Team to improve chief petty officer and first class petty officer leadership.</p> <p><u>Recommendation 5.1.2:</u> Commander Submarine Forces identify methods to improve crew morale, and command climate for units in an industrial environment.</p>
<p><u>Finding 5.2 (Potential Contributing/Noncompliance/Deficiency):</u> USS COLUMBIA’s chain of command and medical department representative (MDR) did not share information effectively regarding Romero’s disciplinary issues, medical/mental condition, and family situation.</p>	<p><u>Opinion 5.2.1:</u> With information sharing and collaboration on Romero’s long-developing problems, the chain of command may have taken more intrusive actions to direct additional mental health evaluation or remove Romero from armed watchstanding.</p> <p><u>Opinion 5.2.2:</u> The USS COLUMBIA MDR, as Romero’s primary care provider, did not provide forceful backup to the chain of command concerning Romero’s mental health treatment. At a minimum, the MDR should have known after Romero’s PHA/MHA on October 9, 2019, about his March 2019 emergency room visit and his initial September 2019 eMHP Clinic visit.</p>	<p><u>Recommendation 5.2.1:</u> In combination with aligning eMHP practice to increase information sharing with the chain of command, Commander Submarine Forces take action as appropriate to increase communication and collaboration across the submarine force concerning mental health.</p>

<p><u>Finding 5.3</u> <u>(Noncontributing/Compliance/Deficiency):</u> USS COLUMBIA’s CRT conducted command climate assessments in accordance with OPNAV Instruction 5354.1G. However, unit-level CRTs with additional guidance and training can do more to promote healthy command climates and Sailor well-being.</p>	<p><u>Opinion 5.3.1:</u> The E-OSC should be expedited, and training resources should be augmented to incorporate primary prevention principles and human factors into CRTs.</p> <p><u>Opinion 5.3.2:</u> The CRT instruction, guide, and training should be updated to incorporate primary prevention principles and human factors, and training should be developed for command leadership and Sailor development schools that is tailorable to communities and their respective operational environments, platforms, and command compositions.</p>	<p><u>Recommendation 5.3.1:</u> OPNAV N17, in coordination with Echelon 2 Commanders, revise the E-OSC training plan to incorporate leadership resources in addition to CCSs and CMEO Managers.</p> <p><u>Recommendation 5.3.2:</u> OPNAV N17 update the CRT instruction and CRT guide to incorporate guidance on primary prevention principles and human factors.</p> <p><u>Recommendation 5.3.3:</u> OPNAV N17 develop CRT training for command leadership and Sailor development schools that is tailorable to platforms and across command environments.</p>
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Chapter 6 – Personal Security Program (PSP) and Insider Threat Program (ITP)

Findings	Opinions	Recommendations
<p><u>Finding 6.1 (Noncontributing/Compliance):</u> Security officials complied with PSP policies during Romero’s recruitment, training, and initial adjudication of his clearance.</p>	<p><u>Opinion 6.1.1:</u> In the context of PSP policies and guidelines, nothing screened Romero from joining the Navy, obtaining a clearance, and qualifying for submarine duty.</p> <p><u>Opinion 6.1.2:</u> Although no potential threat indicators were apparent when Romero joined the Navy, adjudicative guidelines and the security clearance process should be continuously improved based on reviews of previous insider threat incidents.</p>	<p><u>Recommendation 6.1.1:</u> DoD CAF audit the initial clearance adjudication of Romero to determine whether adjudicative guidelines and clearance processes should be revised.</p> <p><u>Recommendation 6.1.2:</u> Naval Education and Training Command (NETC), in coordination with BUMED, review this report to identify potential improvements to mental health screening procedures at RTC and accession training.</p>
<p><u>Finding 6.2 (Noncontributing/Compliance/Deficiency):</u> Security managers complied with PSP policies related to the continuous evaluation program (CEP) during Romero’s time on USS COLUMBIA. The CEP thresholds for questionable judgment, untrustworthiness, and unreliability, as established by SECNAV M-5510.30, generally did not create a decision point absent other reportable behavior.</p>	<p><u>Opinion 6.2.1:</u> The chain of command and security managers with responsibility for Romero did not have a requirement under reporting thresholds established in SECNAV M-5510.30 to initiate a JPAS incident report, remove his access to classified information, or suspend his security clearance.</p> <p><u>Opinion 6.2.2:</u> The thresholds for questionable judgment, untrustworthiness, and unreliability, as established by SECNAV M-5510.30, were too vague to result in JPAS incident reports of questionable or unfavorable information in most situations absent other reportable behavior.</p> <p><u>Opinion 6.2.3:</u> Romero likely would not have prompted a JPAS report under the more detailed CEP reporting requirements in DoDM 5200.02. Further clarifying definitions on general catch-all categories concerning judgment, reliability, trustworthiness, and maturity as well as amplifying guidance through training would aid unit-level decision-making in the CEP.</p> <p><u>Opinion 6.2.4:</u> Romero’s potential risk indicators did not meet reporting thresholds in the CEP, but reporting guidelines should be continuously improved based on review and lessons learned from insider threat incidents.</p>	<p><u>Recommendation 6.2.1:</u> DoD CAF use this incident as a case study to evaluate CEP reporting thresholds. Further define catch-all categories or provide illustrative examples through amplifying guidance and training to aid unit-level decision-making.</p>

<p><u>Finding 6.3 (Potential Contributing/Noncompliance/Deficiency):</u> Romero constituted an insider threat. Romero demonstrated potential risk indicators to shipmates that were not significant enough to prompt reports through any established insider threat reporting procedures or to law enforcement, but they should have been reported to supervisors.</p>	<p><u>Opinion 6.3.1:</u> No one could not have reasonably predicted Romero’s violent behavior on December 4, 2019, but he did demonstrate potential risk indicators that should have been reported to supervisors.</p> <p><u>Opinion 6.3.2:</u> This incident should be incorporated into DON insider threat awareness and reporting training to increase content on reporting workplace violence. The shipmates’ encounters with Romero are examples of the key principle of threat management, which is “see something, say something.”</p> <p><u>Opinion 6.3.3:</u> Prevention (e.g., PAR-like capabilities) should augment predictive tools to help prevent workplace violence. Command Resilience Teams (CRTs) may offer existing PAR-like capabilities at the unit level especially after the Expanded Operational Stress Control (E-OSC) program incorporates prevention principles and human factors.</p> <p><u>Opinion 6.3.4:</u> If shipmates would have reported potential risk indicators to supervisors, the chain of command may have aggregated them with other known risk factors to recognize that circumstances warranted his rescreening for armed watchstanding.</p>	<p><u>Recommendation 6.3.1:</u> Director, Navy Staff (DNS) and Echelon 2 Commanders, in coordination with DON Insider Threat Hub, use this incident as a case study when developing fleet reporting procedures to the DON Insider Threat Hub as it works toward full operational capability.</p> <p><u>Recommendation 6.3.2:</u> The Naval Criminal Investigative Service (NCIS) incorporate this incident, including the indicators into DON Insider Threat Training.</p> <p><u>Recommendation 6.3.3:</u> DNS, in coordination with DON Insider Threat Hub, consider use of the E-OSC program and CRTs when implementing PAR-like capabilities at the installation and organization-level. See Finding 5.3.</p>
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Chapter 7 – Force Protection		
Findings	Opinions	Recommendations
<p><u>Finding 7.1 (Noncontributing/Noncompliance):</u> The PHNSY AT plan does not include required Active Shooter Pre-Planned Response (PPR).</p>	<p><u>Opinion 7.1.1:</u> Active shooter PPR and security de-confliction procedures for the CIA would help responding security forces identify and reduce the risk of conflicting responses to security incidents in the CIA’s complex industrial environment.</p> <p><u>Opinion 7.1.2:</u> PHNSY, JBPHH NSF, and afloat units in the CIA should conduct routine coordinated training on active-shooter and security de-confliction procedures.</p>	<p><u>Recommendation 7.1.1:</u> PHNSY, in coordination with Type Commanders and JBPHH NSF, develop active shooter PPRs and security de-confliction procedures for the CIA.</p> <p><u>Recommendation 7.1.2:</u> PHNSY, in coordination with Type Commanders and JBPHH NSF, conduct routine coordinated training within the CIA that includes active shooter responses and security de-confliction procedures.</p> <p><u>Recommendation 7.1.3:</u> Echelon 2 Commanders ensure that all subordinate commands have active shooter PPRs and security de-confliction procedures in AT Plans.</p>
<p><u>Finding 7.2 (Noncontributing/Noncompliance):</u> PHNSY, JBPHH NSF, and afloat units in the CIA do not conduct required coordinated training.</p>	<p><u>Opinion 7.2.1:</u> PHNSY and USS COLUMBIA are not in compliance with training requirements. Routine coordinated training among PHNSY, JBPHH NSF, and afloat units in the shipyard would improve response capabilities.</p> <p><u>Opinion: 7.2.2:</u> The Standard Work Practices represent “the basics” of successful depot periods and should not be disregarded. Standard Work Practices are intended to set expectations in maintenance overhauls between organizations that do not typically work together (e.g., shipyard and specific submarines). Without Type Commander guidance, such as COMSUBPACINST 4790.2B, there should be some instruction that delineates coordinated security responsibilities.</p>	<p><u>Recommendation 7.2.1:</u> PHNSY, JBPHH NSF, and afloat units in shipyard conduct routine coordinated training and participate in local FP exercises.</p> <p><u>Recommendation 7.2.2:</u> COMNAVSEASYSCOM, in coordination with Type Commanders, assess the completion of coordinated training with afloat units in shipyards.</p> <p><u>Recommendation 7.2.3:</u> PHNSY and Puget Sound Naval Shipyard, in coordination with COMSUBPAC, review 21 enclosures of canceled COMSUBPACINST 4790.2B and issue necessary local guidance on Standard Work Practice requirements.</p> <p><u>Recommendation 7.2.4:</u> Echelon 2 Commanders renew the Naval Shipyard Installation MOA and consider adding a section that delineates training responsibilities.</p>

<p><u>Finding 7.3 (Noncontributing/Noncompliance):</u> PHNSY does not conduct required Antiterrorism Working Group (ATWG), Threat Working Group (TWG), or Antiterrorism Executive Council (ATEC) meetings.</p>	<p><u>Opinion: 7.3.1:</u> PHNSY is not in compliance with the COMPACFLT requirement for all commands to conduct ATWGs, TWGs, and ATECs. PHNSY ATWGs, TWGs, and ATEC meetings would facilitate internal and external information sharing, planning, and coordination among all stakeholders on force protection issues such as access controls, threat and vulnerability assessments, PPRs, training, and armed watchstanding requirements within the CIA and shipyard.</p>	<p><u>Recommendation: 7.3.1:</u> PHNSY conduct ATWGs, TWGs, and ATECs.</p> <p><u>Recommendation: 7.3.2:</u> COMNAVSEASYSCOM verify all shipyards are conducting ATWGs, TWGs, and ATECs as required by the Fleet Commander and/or OPNAV Instruction F3300.53C.</p>
<p><u>Finding 7.4 (Noncontributing/Noncompliance):</u> PHNSY did not conduct required Random Antiterrorism Measure (RAM) inspections.</p>	<p><u>Opinion 7.4.1:</u> Failure to comply with this requirement diminishes the overall security posture of PHNSY and JBPHH.</p>	<p><u>Recommendation 7.4.1:</u> PHNSY, in coordination with JBPHH NSF, develop and implement a RAM inspection program that includes JBPHH NSF support within the CIA.</p> <p><u>Recommendation 7.4.2:</u> COMNAVSEASYSCOM verify other shipyards have RAM inspection programs that include NSF support within the CIA.</p>
<p><u>Finding 7.5 (Noncontributing/Noncompliance/Deficiency):</u> USS COLUMBIA's Topside Roving Patrol does not execute AT duties and responsibilities consistent with the Submarine Organization and Regulations Manual (SORM), CSLCSPINST 5400.49.</p>	<p><u>Opinion 7.5.1:</u> Fleet and Type Commanders should evaluate the requirement for an armed Topside Roving Patrol in the CIA.</p> <p><u>Opinion 7.5.2:</u> USS COLUMBIA's Topside Rover Patrol security patrol is beyond the physical scope of Top Side Rover responsibility as delineated in the Type Commander's instruction, CSLCSPINST 5400.49 (SORM).</p>	<p><u>Recommendation 7.5.1:</u> Commander Submarine Forces, in coordination with COMPACFLT; Commander, U.S. Fleet Forces Command (CUSFF); Commander, Naval Installations Command (CNIC); and COMNAVSEASYSCOM, assess whether armed watchstanding requirements in the CIA can be modified in some Force Protection conditions.</p> <p><u>Recommendation 7.5.2:</u> If the armed watchstanding requirements are validated, Commander Submarine Forces, clarify AT duties and responsibilities of the armed watches in the CIA to include the pier and dry dock areas.</p>

Chapter 8 – Incident Response & Emergency Management

Findings	Opinions	Recommendations
<p><u>Finding 8.1</u> <u>(Noncontributing/Compliance/Deficiency):</u> JBPHH NSF responded within the required 15 minutes but did not promptly establish radio communications with other law enforcement agencies. The Naval Criminal Investigative Service (NCIS) and the Honolulu Police Department (HPD) responded without a report or request for support.</p>	<p><u>Opinion 8.1.1:</u> The JBPHH NSF response to the shooting incident was immediate. The proactive actions of other law enforcement agencies, specifically NCIS and HPD, would have saved lives if a more robust response was required.</p> <p><u>Opinion 8.1.2:</u> The lack of JBPHH NSF communication with other responding law enforcement agencies, and the absence of standing communication and coordination procedures with HPD, made command and control at the ICP difficult and complicated response efforts after the shooter was found dead. This difficulty impacted coordination in other areas, including base access, staging areas, building clearance, and accountability of outside agencies on base. JBPHH NSF monitored integrated radio channels, but communications can improve with more coordination and training.</p>	<p><u>Recommendation 8.1.1:</u> CNRH review current mutual aid agreements with HPD and develop training scenarios to test interagency communication plans. Conclude a mutual aid agreement with HPD that addresses specific communication, coordination, and training procedures for general law enforcement response to incidents of mutual concern. Once this mutual aid agreement is established, incorporate it into a training plan.</p> <p><u>Recommendation 8.1.2:</u> Commander, Naval Installations Command (CNIC), assess adequacy of mutual aid agreements including the adequacy of communication plans with local law enforcement at other installations. Fort Hood and Washington Navy Yard investigations noted similar coordination issues.</p>
<p><u>Finding 8.2</u> <u>(Noncontributing/Noncompliance/Deficiency):</u> Navy tactics, techniques, and procedures (NTTPs) and local JBPHH pre-planned responses (PPRs) do not specifically address physical restraints, personnel evacuation, or building clearance procedures in the context of an active shooter incident. Two JBPHH NSF personnel initially used flex cuffs and duct tape to temporarily control personnel during building clearance. JBPHH NSF and supporting law enforcement agencies also conducted building clearance procedures differently.</p>	<p><u>Opinion 8.2.1:</u> JBPHH NSF’s use of flex cuffs and duct tape was not in compliance with NTTPs or JBPHH PPRs. JBPHH NSF require training on building clearance, physical restraint, and evacuation procedures for active shooter incidents. If the expectation is for JBPHH NSF Guard Officers (0085) to be able to clear a building during an active shooter event, they should receive the proper training to be able to perform such a task.</p>	<p><u>Recommendation 8.2.1:</u> JBPHH NSF conduct local training on building clearance, physical restraint, and evacuation procedures for active shooter incidents.</p> <p><u>Recommendation 8.2.2:</u> OPNAV N4, in coordination with Commander, U.S. Fleet Forces Command (CUSFF) and Naval Warfare Development Command (NWDC), improve NTTPs consistent with partner law enforcement TTPs in the context of active shooter incidents.</p> <p><u>Recommendation 8.2.3:</u> CNIC direct regions and installations to train on building clearance, physical restraint, and evacuation procedures for active shooter incidents.</p>

<p><u>Finding 8.3 (Noncontributing/Deficiency):</u> JBPHH NSF and supporting law enforcement agencies could not access all locked spaces to clear buildings and secure the shooting scene.</p>	<p><u>Opinions 8.3.1:</u> Physical security plans should include access procedures for first responders to be able to enter locked buildings, including restricted areas.</p>	<p><u>Recommendation 8.3.1:</u> PHNSY, in coordination with JBPHH NSF, revise access procedures in their physical security plan for first responders to have access to locked buildings and restricted areas in active shooter and other emergency situations. This plan should include guidance for debriefing any first responders who enter restricted areas.</p> <p><u>Recommendation 8.3.2:</u> Echelon 2 Commanders ensure subordinate commands' physical security plans include access procedures for first responders to be able to enter locked buildings, including restricted areas, in active shooter and other emergency situations.</p>
<p><u>Finding 8.4 (Noncontributing/Compliance/Deficiency):</u> FFD Basic Life Saving (BLS) unit responded within required 7 minutes upon receiving the report of an active shooter.</p>	<p><u>Opinion 8.4.1:</u> FFD responded quickly to the scene and provided appropriate medical care to the victims. However, response procedures can be improved based on lessons learned from the incident including designation of entry and egress gates.</p>	<p><u>Recommendation 8.4.1:</u> CNIC and JBPHH incorporate FFD lessons learned from this incident, including specifying entry and egress gates for off-base emergency response, into coordinated training with local law enforcement and emergency medical providers.</p>
<p><u>Finding 8.5 (Noncontributing/Compliance/Deficiency):</u> USS COLUMBIA's Petty Officer of the Deck responded as trained to the active shooter incident. He made immediate notifications on the ship's announcing system (IMC), the ship's force protection radio, and the Command Early Warning Net (CEWN). However, the standard casualty procedure did not account for an active shooter on the pier with ship's force responding from the berthing barge.</p>	<p><u>Opinion 8.5.1:</u> The Petty Officer of the Deck responded as he was trained when he identified Romero as a threat to the ship and crew. Although not in the Ship's System Manual (SSM), a more appropriate code word announcement would have been "Active shooter at the head of Dry Dock 2." The lack of an appropriate code word such as "Active Shooter" could have led to additional casualties if Romero had not immediately shot himself.</p>	<p><u>Recommendation 8.5.1:</u> Type Commanders, in coordination with CNIC, add guidance to address an active shooter to casualty response procedures.</p>

<p><u>Finding 8.6</u> <u>(Noncontributing/Noncompliance/Deficiency):</u> CNRH RDC and JBPHH EOC did not send the initial mass notification lockdown messages within 2 minutes of incident notification and verification as required by DoD Instruction 6055.17 and did not reach required percentages of the protected population.</p>	<p><u>Opinion 8.6.1:</u> The CNRH RDC and JBPHH EOC did not meet timelines for mass warning notifications, and the AtHoc and GV systems did not reach 100 percent of the protected population.</p> <p><u>Opinion 8.6.2:</u> The DEMO failed to execute his duties as directed by the JBC. This resulted in the failure to meet mass warning notification timelines and 100 percent of the protected population. A contributing factor was the inability for a user to identify originators of telephonic AtHoc messages.</p> <p><u>Opinion 8.6.3:</u> Additional effective means of mass notifications are necessary where personnel do not have computer or cell phone access.</p> <p><u>Opinion 8.6.4:</u> GV messages that announce emergency lockdown procedures would be more effective if they included distinctive tone-based signals in conjunction with human voice announcements. GV lockdown messages did not provide effective warnings because they were difficult to understand and are subject to weather, interference, and background noise.</p>	<p><u>Recommendation 8.6.1:</u> CNRH RDC and JBPHH EOC conduct a review of the incident response and mass warning notifications. Add routine training on mass warning notifications to the continuing training program for bases and the region.</p> <p><u>Recommendation 8.6.2:</u> CNIC, in coordination with Naval Information Warfare Center (NIWC), improve technical capabilities in MWN systems and SOPs to reduce the risk of human error.</p> <p><u>Recommendation 8.6.3:</u> COMNAVSEASYSKOM, in coordination with CNIC, develop and implement visual and voice mass notification systems for shipyard environments.</p> <p><u>Recommendation 8.6.4:</u> CNIC develop distinctive tone-based signal or other means to alert personnel of lockdown procedures more effectively.</p>
<p><u>Finding 8.7</u> <u>(Noncontributing/Noncompliance/Deficiency):</u> The Navy and Air Force AtHoc systems are not interoperable.</p>	<p><u>Opinion 8.7.1:</u> The lack of interoperable systems is not in compliance with DoD policy to pursue a single enterprise-wide MWN system.</p>	<p><u>Recommendation 8.7.1:</u> NIWC complete the AtHoc Connect upgrade to enable Navy and Air Force interoperability. Ensure the system performs as required during installation exercises where AtHoc messages are sent installation-wide.</p> <p><u>Recommendation 8.7.2:</u> OPNAV N2/N6 share the results of this investigation report related to interoperability of Navy and Air Force systems with the appropriate Air Force staff code.</p>

<p><u>Finding 8.8 (Noncontributing/Deficiency):</u> The lockdown prevented the JBPHH EOC from being staffed with required personnel during the emergency.</p>	<p><u>Opinion 8.8.1:</u> JBPHH EOC activation procedures should account for base lockdown procedures.</p>	<p><u>Recommendation 8.8.1:</u> JBPHH revise EOC activation procedures to account for base lockdowns. Once procedures are revised, conduct an unannounced drill to validate the EOC can man within time requirements during a base lockdown.</p> <p><u>Recommendation 8.8.2:</u> CNIC direct all region and installation commanders to review and revise ROC and EOC standard operating procedures (SOP) to account for how base lockdowns may affect EOC activation.</p>
<p><u>Finding 8.9 (Noncontributing/Deficiency):</u> Active shooter training helped personnel take immediate action in response to the active shooter incident. However, the industrial shipyard environment presented circumstances that are not addressed in COMNAVSEASYSCOM and CNIC active shooter training, and some personnel did not respond as they were trained.</p>	<p><u>Opinion 8.9.1:</u> Active shooter training should include guidance on outdoor scenarios when employees must find cover or remain in place. The training should also address employee responses to casualties.</p> <p><u>Opinion 8.9.2:</u> Table-top discussions and exercises should be tailored to address unique work conditions in lockdown procedures.</p>	<p><u>Recommendation 8.9.1:</u> COMNAVSEASYSCOM, in coordination with CNIC, direct naval shipyards conduct annual active shooter exercises and table-top exercises that cover outdoor active shooter scenarios under local work conditions and lockdown procedures.</p> <p><u>Recommendation 8.9.2:</u> CNIC and COMNAVSEASYSCOM revise active shooter training to include additional scenarios and lessons learned identified in this incident.</p>

Chapter 9 – Post-Incident Response		
Findings	Opinions	Recommendations
<p><u>Finding 9.1 (Noncontributing/Compliance/Deficiency):</u> Casualty support to families was timely and effective, but coordination issues between Civilian Benefits Center (CBC) personnel and Casualty Assistance Calls Officers (CACOs) caused confusion and delay.</p>	<p><u>Opinion 9.1.1:</u> The CBC generally delivered timely and effective support to the families of the two deceased civilian employees.</p> <p><u>Opinion 9.1.2:</u> CBC and CACO policies are not well coordinated, leading to unclear guidance regarding support to civilian families after the death of a family member. CBC and CACO policies should be revised to incorporate coordination procedures between CBC personnel and CACOs when CACOs provide casualty support to NOK and other designated persons after civilian deaths.</p>	<p><u>Recommendation 9.1.1:</u> DON OCHR, in coordination with OPNAV N1, revise CBC policy to incorporate coordination procedures between CACOs and CBC personnel when CACOs provide casualty support after civilian deaths.</p>
<p><u>Finding 9.2 (Noncontributing/Deficiency):</u> NOK information was not available in the official civilian personnel records system and contributed to delay in casualty support.</p>	<p><u>Opinion 9.2.1:</u> The lack of NOK information caused delay in casualty support including notification to victims’ families. This increased the risk that a family member would not get proper notification.</p>	<p><u>Recommendation 9.2.1:</u> DON OCHR develop and implement policy to require civilians to provide NOK information for official personnel records and verify annually.</p> <p><u>Recommendation 9.2.2:</u> DON OCHR coordinate with DoD and the Office of Personnel Management (OPM) to evaluate the multiple personnel tracking systems such as DCPDS or TWMS, and NFAAS. Consider consolidation of these systems into a single system or system of systems that shares data using modern applications.</p>
<p><u>Finding 9.3 (Noncontributing/Compliance):</u> Navy provided timely and effective support to victims, families, and other civilian employees regarding death and injury compensation claims in accordance with SECNAV Instruction 12810.2A.</p>	<p><u>Opinion 9.3.1:</u> HRO Hawaii provided comprehensive support to employees and the victims’ families. HRO Hawaii provided supervisors and employees with injury compensation and recovery Fact Sheets based on templates developed in response to the Washington Navy Yard (WNY) shooting in 2013 and shared by the Naval Sea Systems Command DCHR Office.</p>	<p><u>Recommendation 9.3.1:</u> DON OCHR gather lessons learned and materials prepared in response to this and similar incidents and distribute them in a handbook to be shared with the DON human resources community.</p>

<p><u>Finding 9.4 (Noncontributing/Deficiency):</u> Counseling support programs provided effective counseling support to civilians, active duty personnel, and families. However, some counseling support programs had to increase services to offset a lack of Civilian Employee Assistance Program (CEAP) resources, and a lack of coordination and communication negatively impacted delivery of counseling support.</p>	<p><u>Opinion 9.4.1:</u> CEAP did not have sufficient counseling support immediately after the shooting. Four hours of onsite counseling per day, as provided in the Magellan Health contract, was inadequate to support the needs of a large workforce following a traumatic event. DON OCHR and Magellan Health should have responded more quickly to requests for support.</p> <p><u>Opinion 9.4.2:</u> CEAP, EFAC, SPRINT, local medical providers, and religious support personnel who augmented these counseling support programs, combined to provide effective counseling support to civilian employees, active duty personnel, and families at JBPHH after the shooting incident.</p> <p><u>Opinion 9.4.3:</u> HROs and JBPHH did not release timely and accurate information about available counseling support services because of a lack of coordination. One official should have the responsibility and authority to lead coordination of counseling support services in Navy regions after major incidents. MFSC EFAC should complete prior coordination, training, staffing, and recall procedures before major incidents.</p>	<p><u>Recommendation 9.4.1:</u> DON OCHR review CEAP contracts to ensure adequate counseling support, including crisis management and the ability to surge additional support following major incidents (e.g., active shooter or mass casualties).</p> <p><u>Recommendation 9.4.2:</u> CNIC develop policy that designates an official (e.g., Region Director, Total Force Manpower Management (N1)) to take lead on coordinating counseling support services throughout Navy regions following major incidents.</p> <p><u>Recommendation 9.4.3:</u> JBPHH EFAC Director, in coordination with JBPHH PAO, establish a memorandum of understanding (MOU) on training, staffing and recall procedures in accordance with established guidance.</p>
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<p><u>Finding 9.7 (Noncontributing/Noncompliance):</u> NFAAS was not activated to account for personnel after the December 4, 2019 shooting incident.</p>	<p><u>Opinion 9.7.1:</u> NFAAS should be used to account for personnel throughout an affected area after an active shooter incident because the incident may impact personnel from several commands. As this incident and the WNY incident demonstrate, location alone does not define the affiliation of all affected personnel. All personnel within the area should be accounted for regardless of the command to which they are assigned.</p>	<p><u>Recommendation 9.7.1:</u> CNIC review procedures and conduct training on recall and post-incident accountability for personnel and families through NFAAS.</p>
<p><u>Finding 9.8 (Noncontributing/Compliance):</u> Public Affairs (PA) external communications were in accordance with Navy instructions.</p>	<p><u>Opinion 9.8.1:</u> CNRH PA external communication efforts immediately following the incident were timely, accurate, and appropriate, but procedures can be improved.</p>	<p><u>Recommendation 9.8.1:</u> CHINFO, in coordination with CNIC, develop PA policy for active shooter and other major security incidents that incorporate shorter response timelines, best practices, and lessons learned from previous incidents. This should include periodic drills and/or tabletop exercises to test procedures and ensure individual understanding and proficiency.</p>

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Appendix B – Command Investigation Team

<u>Name</u>	<u>Role/Area of Expertise</u>	<u>Command</u>
RADM Jones, Scott	Commander	CNAFR
RDML Gaucher, Robert	Chief of Staff	COMPACFLT

Command Investigators

<u>Name</u>	<u>Role/Area of Expertise</u>	<u>Command</u>
CAPT (b)(6)	Post Submarine Commanding officer/Team Executive Officer	COMSUBPAC
CAPT (b)(6)	Lead Legal	RLSO HI
CAPT (b)(6)	Psychiatric Expert	NAVMEDCEN SAN CA
CIV (b)(6)	Human Resources Director	COMNAVSEASYSKOM DC
CIV (b)(6)	NAVSEA Shipyard Liaison	COMNAVSEASYSKOM DC
CDR (b)(6)	Public Affairs Specialist	COMPACFLT
CDR (b)(6)	Navy Emergency Management	JBPHH
LCDR (b)(6)	Legal	OJAG
LCDR (b)(6)	Navy Force Protection	COMNAVREG PEARL HI
LT (b)(6)	Submarine Officer/Lead Writer	COMSUBRON ONE
CIV (b)(6)	Human Resources Specialist	COMNAVSEASYSKOM DC
CIV (b)(6)	Casualty Assistance Specialist	COMNAVREG NW BGR, WA
LTJG (b)(6)	Legal	RLSO HI
CMDCM (b)(6)	Command Master Chief	COMNAVSURFGR MIDPAC
MACM (b)(6)	Navy Force Protection	COMNAVREG SW SAN CA
MTCS (b)(6)	Navy Antiterrorism	COMPACFLT
CSCS (b)(6)	Command Climate Specialist	COMPACFLT
HMC (b)(6)	Fleet SSIDC	COMPACFLT
LN1 (b)(6)	Legal	RLSO HI
LN2 (b)(6)	Legal	RLSO HI

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Appendix C – Timeline of Events

 Performance counseling

 Medical encounter

17 November 2017	Enlists in the Navy (San Antonio, TX).
11 December 2017	Reports to Recruit Training Command in Great Lakes, Illinois.
24 January 2018	DoD Consolidated Adjudications Facility (DoD CAF) closes Romero’s initial adjudication and grants Secret (T3) security clearance.
3 February 2018	Graduates from recruit training and transfers to Naval Submarine School in Groton, Connecticut, to attend Machinist Mate Auxiliary “A” School.
12 June 2018	Graduates Machinist Mate Auxiliary “A” School.
28 June 2018	Reports to the USS COLUMBIA (SSN 771).
11 September 2018	Completes initial qualification to handle and carry M-9 pistol, M-4 rifle, and M5000 shotgun.
10 December 2018	Qualifies Ship’s Self Defense Force and Topside Roving Patrol.
 17 December 2018	Goes to Tripler Army Medical Center (TAMC) emergency room for injuries sustained during a motorcycle accident on 13 December 2018. He is diagnosed with acute traumatic pain in his left testicle and released without limitations the same day.
 4 March 2019	Goes to TAMC emergency room due to difficulty “concentrating, focusing, and staying engaged.” He reports he was at traffic court earlier that day for a speeding ticket and could not focus. TAMC staff note that he may have Attention Deficit Disorder, and enter a referral in his electronic medical record to the Naval Submarine Support Command (NSSC) Embedded Mental Health Program (eMHP) Clinic in Pearl Harbor before discharging him on his own recognizance. The eMHP Clinic cannot receive outpatient referrals through the electronic medical record system, and the TAMC staff did not inform the eMHP Clinic of the referral by other means. Romero does not make an eMHP Clinic appointment based on the referral.
 5 June 2019	Receives written counseling for purchasing a plane ticket without an approved leave chit.
6 June-25 June 2019	Takes leave to Texas.
26 June 2019	Performs requalification proficiency shootings for M-9 service pistol, M-4 service rifle.
 16 July 2019	Receives written counseling for being absent from qualification delinquent study.
 18 July 2019	Receives written counseling for being late to relieve his duty watch station.
 11 September 2019	Receives written counseling for sitting down during his required roving duties as Barge Security Watch. He is required to conduct a watch “upgrade,” which is a remedial process that includes reviewing watchstanding principles, conducting interviews, and completing a “Barge Security Watch” qualification card.

23 September 2019	Goes to NSSC eMHP Clinic for voluntary visit arranged by USS COLUMBIA's chief of the boat and auxiliary division chief petty officer after the health of Romero's (b) (6) declined and Romero stopped expressing himself to the division chief. Romero meets with the Force Psychologist for an initial assessment. The Force Psychologist gives a diagnostic impression for "Phase of Life Problems" and "Unspecified Problem Related to Unspecified Psychosocial Circumstances" and recommends continued individual therapy with the eMHP staff behavioral health technician, a non-licensed Navy enlisted (E-5) corpsman, to teach Romero coping skills to deal with issues related to his (b) (6), and his (b) (6) failing health.
26 September 2019	Completes annual AA&E rescreening
30 September 2019	Attends first therapy appointment with eMHP behavioral health technician.
8 October 2019	Attends second therapy appointment with eMHP behavioral technician.
11 October 2019	Receives two written counseling chits: (1) For showing up to work late on October 7, 2019, and (2) For relieving his duty watch station late and reporting to work late on October 9, 2019.
16 October 2019	Attends third therapy appointment with eMHP behavioral health technician. Receives Extra Military Instruction (EMI) for consistently being late to required duties.
22 October 2019	Attends fourth therapy appointment with eMHP behavioral health technician. The behavioral health technician and Romero agree that they should discontinue care because all goals have been met.
29 October 2019	Receives written counseling for being late to duty section turnover.
30 October 2019	Returns for a fifth therapy appointment with eMHP behavioral technician at NSSC despite the discussion on ending therapy. The behavioral health technician characterizes it as a miscommunication and agrees to schedule Romero for additional peer support sessions.
4-14 November 2019	Goes underway on the USS CHICAGO (SSN 721).
19 November 2019	Attends first peer support appointment with eMHP behavioral health technician.
20 November 2019	Receives written counseling for being late and missing the Physical Readiness Test (PRT).
21 November 2019	Receives written counseling for being late to his make-up PRT and work. USS COLUMBIA convenes a disciplinary review board (DRB) for Romero's continued tardiness at muster times, delinquent study muster times, watch relief times, and duty section muster times. DRB recommends executive officer inquiry (XOI).
26 November 2019	Romero attends second peer support appointment with eMHP behavioral health technician. Romero learns that he did not pass Naval Advancement Exam and would not advance to E-4.

<p>3 December 2019</p>	<p>Attends XOI for continued tardiness at muster times, delinquent study muster times, watch relief times, and duty section muster times. XO does not send Romero to commanding officer's nonjudicial punishment (CO's NJP) but decides to give Romero "Page 13" formal counseling. The Page 13 simply reads, "IF I AM LATE TO WORK AGAIN, I WILL BE HELD ACCOUNTABLE AT CO'S NJP." Romero declines to sign Page 13 when ship's administrative personnel present it to him because the XO had told him that he did not have to sign it until the end of the week. Romero never signs the Page 13.</p>
<p align="center">4 December, 2019</p>	
<p>0019</p>	<p>Enters his barracks room. Time based on key log system. The video surveillance system displays an 8 minute time difference (0011).</p>
<p>0313</p>	<p>Leaves his barracks room to pick up his girlfriend from work and spend time with her.</p>
<p>0738</p>	<p>Returns to his barracks room and leaves shortly after to attend small arms sustainment training on Ford Island.</p>
<p>0830-1100</p>	<p>Attends virtual Firearms Training Simulator (FATS) training on Ford Island.</p>
<p>0942</p>	<p>Texts girlfriend screenshot of prospective landlord contact information.</p>
<p>0951</p>	<p>Calls girlfriend. Leaves no impression anything is wrong.</p>
<p>1319</p>	<p>Returns to his barracks room and leaves shortly after to report for duty on USS COLUMBIA (SSN 771) in the Pearl Harbor Naval Shipyard (PHNSY) Controlled Industrial Area (CIA). Time is based on key log system. Video surveillance system displays a 7 minute time difference (1312).</p>
<p>1348</p>	<p>Enters PHNSY CIA turnstile to report for duty.</p>
<p>1404</p>	<p>Assumes Topside Roving Patrol watch. He assumes custody of (x1) M-4 rifle with three 30-round magazines (90 rounds) and (x1) M-9 pistol with three-15 round magazines (45 rounds).</p>
<p>1415-1425</p>	<p>At approximately 1415, Romero begins a roving patrol around Dry Dock 2, beginning at the Casualty Control (CASCON) shack on the port side and proceeding port to starboard. A few minutes into his patrol, he turns around on the starboard side of Dry Dock 2 before he had circulated the entire dry dock and approaches three civilian employees from behind. Romero chambers a round, raises his M-4 rifle, and begins firing at the civilians. The three civilians fall to the ground 15-20 feet in front of Romero at the head of Dry Dock 2. Romero uses the M-9 pistol to shoot himself. The shooting lasts a few seconds from beginning to end.</p> <p>While Romero was firing, the Petty Officer of the Deck in the CASCON shack makes radio calls while drawing his weapon. His first call is over the USS COLUMBIA's ship announcement circuit, the 1MC, "Repel Boarders." He then calls "shots fired, shots fired" over the force protection radio and announces on the Command Early Warning Net (CEWN), a base security radio network, that "there was an active shooter at the head of Dry Dock 2." The USS COLUMBIA Ship's Duty Officer (SDO) then calls on the ship's force protection radio to ask what is happening. The Petty Officer of the Deck replies, "Repel Boarders, shots fired, Romero is shooting shipyard workers."</p>

	Note: Video surveillance within the CIA rotates between cameras on a predetermined cycle. Video surveillance of the head of Dry Dock 2 shows Romero begin to raise the M-4 rifle and fire at the victims. The camera rotates away from the scene as he fires the M-4, and the victims and Romero are on the ground when the camera rotates back to the scene. Based on shell casings and weapon magazines recovered at the scene, Romero fired eight (8) rounds with his M-4 rifle and three (3) rounds with his M-9 pistol.
1426	Commander, Navy Region Hawaii (CNRH) Regional Dispatch Center (RDC) receives first 911 call concerning shooting incident and dispatches Joint Base Pearl Harbor-Hickam (JBPHH) Navy Security Forces (NSF) and Federal Fire Department (FFD).
1427	Civilian JBPHH NSF Guard Officer who is on patrol in CIA and conducting physical security checks arrives on scene at Dry Dock 2 immediately after the shooting and makes a radio call to CNRH RDC to report on situation and status of victims.
1430	JBPHH Chief Staff Officer orders JBPHH Emergency Operations Center (EOC) to be manned in response to the active shooter incident. The JBPHH EOC is manned with only 6 personnel instead of required 44 personnel due to a later lockdown directive. At the lowest level, "normal," the EOC is staffed with only an EOC manager. An active shooter incident is a level "three" (of five), which requires all EOC sections to be manned.
1431	Additional JBPHH NSF arrive at shooting scene.
1432	PHNSY Emergency Management Officer (EMO) directs the RDC to send out an Automatic Target Hand-Off Correlator (AtHoc) lockdown alert message to the PHNSY distribution list. The JBPHH Commander (JBC) directs the JBPHH Deputy Emergency Management Officer (DEMO) to send an AtHoc lockdown alert message to the surrounding area, but that never occurs because the DEMO mistakenly believes a message he had seen earlier was from JBPHH to the JBPHH distribution list. That AtHoc message was actually from the U.S. Air Force 15th Air Wing command post on the Hickam side of JBPHH. FFD arrives on scene and begins rendering aid to the three victims.
1433	CNRH Regional Operations Center (ROC) informs the CNRH Public Affairs office of the active shooter incident. CNRH Public Affairs starts to coordinate information for public release and for eventual media queries. This effort was later joined by the various military public affairs offices in Hawaii and Washington D.C.
1438	RDC sends AtHoc lockdown alert message to the PHNSY distribution list.
1440	JBPHH makes OPREP-3 voice report to CNRH.
1442	8 NCIS agents arrive on scene. NCIS later takes lead on law enforcement investigation.
1443	RDC directs EOC to make an active shooter lockdown announcement on the base's Giant Voice system.
1444	JBPHH EOC makes active shooter lockdown announcement on Giant Voice system. The Honolulu Police Department (HPD) arrives approximately 18 minutes after shooting according to HPD Captain.

1452	(b)(6) ██████████, the surviving victim, is transported to Queens Hospital by FFD ambulance.
1500	CNRH and JBPHH issue first public affairs external release (social media and press release).
1503	JBPHH transmits OPREP-3.
1504	Mr. Roldan Agustin is transported to Pali Momi Hospital by FFD ambulance. He succumbs to his injuries.
1510	Mr. Kapoi is transported to Tripler Army medical Center by city ambulance. He succumbs to his injuries.
1520	JBPHH external gates are secured.
1557	JBPHH external gates re-open.
1637	RDC logs all clear with the exception of PHNSY.
1730	The JBPHH Military and Family Support Center (MFSC) Emergency Family Assistance Center (EFAC) operates at two locations, the MFSC and PHNSY Building 2, and activates its call center. The MFSC EFAC and call center provide clinical counseling support through December 6 and December 9, 2019, respectively.
1732	CNRH conducts press availability.
1803	TAMC doctor pronounces Romero deceased at the scene.
2013	“All Clear” announced on Giant Voice System.
2125	NCIS assumes control of the scene. Building clearance complete in the CIA. After the scene is cleared and secured, with the lockdown no longer in effect, approximately 1000 civilian employees are allowed to exit through the CIA main exit gate.
4-6 December 2019	Crime scene processing from multiple entities to include NCIS Major Case Response Team (MCRT), FBI Evidence Recovery Team, and Air Force Office of Special Investigations (AFOSI) Forensic Consultants.
5-6 December 2019	Military CACOs make contact with the victims’ families and assist with benefits processing.
6 December 2019	Commander, Submarine Force Atlantic (COMSUBLANT) and Commander, Submarine Force, U.S. Pacific Fleet (COMSUBPAC) provide additional direction and guidance on screening of armed watchstanders to commanding officers. COMPACFLT Human Resources Office (HRO) Hawaii Director assumes lead for coordination of Civilian Employee Assistance Program (CEAP) counseling support. COMSUBPAC and PHNSY Commander conduct three all hands calls with the shipyard workforce.
8 December 2019	Special Psychiatric Rapid Intervention Team (SPRINT) arrives in Hawaii.
9-11 December 2019	SPRINT provides educational and consultative services to over 800 active duty and civilian personnel through small group and individual interventions. The SPRINT team members

	were augmented by personnel from Naval Health Clinic Hawaii, TAMC, Schofield Barracks, and the Chaplain Corps.
13 December 2019	SPRINT departs Hawaii.
16-20 December 2019	Two additional CEAP counselors are made available.
17 December 2019	CNO issues fleet-wide security stand-down in light of recent shootings to focus on command's security policies, AT plans, and Active Shooter Plans.

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Appendix D – Evidence in Support of Report

See enclosed CD-ROMs to view this Appendix

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