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The Honorable Warren B. Rudman
Chairman
Presidential Special Oversight Board
for Department of Defense Investigations
of Gulf War Chemical and Biological Incidents

Subject: Gulf War Illnesses: Evaluation of DOD's Investigative Processes

Dear Mr. Chairman:

We are pleased to appear before your Board today to discuss our report dealing with the Department of Defense's Office of the Special Assistant for Gulf War Illnesses. Enclosed is a copy of my prepared statement. We will make copies available to others upon request.

If you, members of the Board, or your staff have questions concerning my statement, please contact me on (202) 512-5140. Major contributors to this statement were William Cawood and Steve Fox.

Sincerely yours,

Mark E. Gebicke

Mark E. Gebicke
Director, National Security Preparedness

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STATEMENT BEFORE THE PRESIDENTIAL SPECIAL OVERSIGHT BOARD FOR DEPARTMENT OF DEFENSE INVESTIGATIONS OF GULF WAR CHEMICAL AND BIOLOGICAL INCIDENTS

Mr. Chairman and Members of the Board:

We are pleased to be here to discuss our February 1999 report on the Department of Defense's (DOD) Office of the Special Assistant for Gulf War Illnesses (OSAGWI).[1] This report dealt with (1) DOD's progress in establishing an organization to address Gulf War illnesses issues and (2) the thoroughness of OSAGWI's investigations into and reporting on servicemembers' potential exposure to chemical or biological agents during the Persian Gulf War. The report was prepared at the request of the Ranking Minority Member of the House Committee on Veterans Affairs.

Today, I plan to first provide a brief summary and then provide some background information and more details about our specific findings.

SUMMARY

In the face of severe criticism by veterans and others on the handling of Gulf War illnesses issues, DOD established OSAGWI in November 1996. Since then, DOD has made progress in addressing issues related to Gulf War illnesses. It has (1) significantly increased the emphasis and resources committed to determining the cause(s) of Gulf War veterans' health problems, (2) improved communications with veterans, and (3) identified chemical and biological warfare force protection issues requiring attention.

In reviewing six of the eight case narratives that OSAGWI had published at the time of our review, we found that OSAGWI generally followed its established investigation methodology and used appropriate investigative procedures and techniques. However, we found significant weaknesses in the scope and quality of OSAGWI's investigations in three cases that were not evident in the other three. These weaknesses included failures to (1) follow up with appropriate individuals to confirm key evidence, (2) identify and ensure the validity of key physical evidence, (3) include important information in the case narratives, and (4) interview key witnesses.

Despite these weaknesses, the preponderance of evidence led us to agree with OSAGWI's conclusions about the likelihood of the presence of chemical warfare agents in five of the six cases reviewed. The one exception involved OSAGWI's conclusion that a potential exposure of U.S. Marine Corps personnel to a chemical agent during a mine breaching operation was "unlikely." We believe this conclusion needs reassessment because OSAGWI overlooked some important information it had regarding this case. OSAGWI also considered, but did not include, other relevant information in this case narrative.

[1]Gulf War Illnesses: Procedural and Reporting Improvements Are Needed In DOD's Investigative Processes (GAO/NSIAD-99-59, Feb. 26, 1999).

In all six cases OSAGWI missed an opportunity to perform more complete investigations because it did not use potentially valuable sources of relevant information in DOD and Department of Veterans Affairs (VA) clinical databases. We noted that the lack of effective quality assurance policies and practices in OSAGWI's investigating and reporting processes contributed to the weaknesses we found.

With that overview, let me set the stage on OSAGWI's origin and mission and how we did our review.

BACKGROUND

Of the more than 100,000 Gulf War veterans who have participated in DOD or VA health examination programs, many have reported a wide array of health complaints and disabling conditions. Some veterans suspect that their health problems may be linked to chemical or biological agents, but a variety of other causes have also been suggested. Following the war, DOD claimed that chemical weapons were not present in the Gulf War theater. However, it later acknowledged that some U.S. troops might have been exposed to chemical agents. Veterans cited other incidents of potential exposure.

DOD established OSAGWI in 1996 to restore public confidence in its efforts to deal with Gulf War illnesses issues. Its primary missions are to (1) establish effective communications with veterans and veterans groups, (2) investigate and report on incidents of possible chemical or biological exposures, and (3) apply lessons learned from the Gulf War experience to better protect U.S. servicemembers on a contaminated battlefield.

Each OSAGWI investigation into possible exposures to chemical or biological warfare agents results in a summation document called a case narrative. This document is expected to contain all important investigative facts as well as OSAGWI's assessment of the likelihood that servicemembers were exposed. The standard OSAGWI uses for its assessments is whether all available facts would lead a reasonable person to conclude that a chemical or biological warfare agent was or was not present.

In reviewing the six case narratives, we (1) traced each statement in the case narratives to its underlying supporting documentation in OSAGWI files, (2) reviewed OSAGWI documentation associated with the incident to determine if all relevant information was included in the case narrative, (3) contacted key sources of information to verify the accuracy and completeness of the information these sources provided to OSAGWI, (4) independently sought other sources of information, and (5) contacted key participants not originally interviewed to determine if relevant information was available that might affect OSAGWI's assessment.

With that backdrop, let me get into our findings in more detail.

DOD HAS MADE PROGRESS IN ESTABLISHING AN ORGANIZATION TO ADDRESS GULF WAR ILLNESSES ISSUES

In the past few years, DOD has clearly exerted increased emphasis on determining the cause(s) of Gulf War veterans' health problems. Since OSAGWI was established, the staff assigned to deal with Gulf War illnesses issues has increased from 12 to about 200 in 1998. The operating budget also increased from $4.1 million to $29.4 million in the same time frame.

To improve communications with veterans, OSAGWI has cleared a large backlog of veterans' inquiries, used a toll-free hot line, established an internet web site, begun publishing a newsletter, and assisted veterans in obtaining medical examination and other services at DOD and VA facilities. Within its first year of operation, OSAGWI successfully cleared a backlog of 1,200 veterans' inquiries through personal telephone calls and received an additional 1,200 letters and 2,700 e-mail messages. By January 1, 1999, OSAGWI had received 2,850 letters and 4,906 e-mail messages. OSAGWI officials met with the public and veterans at 18 town hall meetings and appeared at 41 national veterans' conventions. Its internet site reportedly receives over 60,000 inquiries each week, and over 12,000 individuals receive OSAGWI's bimonthly newsletter. Moreover, after OSAGWI completes an investigation and publishes the corresponding case narrative, it sends to each directly affected veteran a letter that contains a synopsis of the investigation's results.

OSAGWI also identified several areas needing improvement on the basis of its experience in investigating and reporting on possible chemical, biological, or environmental exposures. OSAGWI is working with DOD and other executive branch agencies to implement these lessons learned. Specific examples of the lessons learned include the need for

- improving systems for tracking troop movements during a conflict so that accurate data is available to show where individuals or units were located on the battlefield at any point in time;
- improving wartime records development and post-war records management systems and addressing issues such as the lack of a uniform records management program for joint commands;
- improving chemical and biological warfare agent detection equipment to make it less prone to false alarms and requiring doctrinal changes to collect and retain detector-produced printouts of detections;
- implementing techniques to better safeguard the health of deployed troops, such as deploying forward field laboratories early and taking samples to determine whether contamination may have occurred subsequent to the use of depleted uranium ammunition; and
- improving and implementing depleted uranium training programs.

INVESTIGATIVE AND REPORTING PROCEDURES HAVE VARIOUS WEAKNESSES

We found procedural, investigative, or reporting problems in three of the six cases we reviewed that were not evident in the other three cases. Specifically, OSAGWI investigators sometimes failed to follow up with appropriate individuals to confirm key evidence, identify or ensure the validity of key evidence, include important information, and interview key witnesses. Despite these weaknesses, the preponderance of evidence led us to agree with the conclusions in OSAGWI case narratives concerning the presence of chemical warfare agents in all but one of the six cases reviewed.

This one exception involved a potential exposure of U.S. Marine Corps personnel during a minefield breaching operation. OSAGWI concluded that an exposure in this case was "unlikely." However, this case narrative did not include some key information contained in OSAGWI files. Specifically, we found the following.

- OSAGWI had information regarding the presence of artillery fire that contradicted one of its primary determinations—that no artillery fire or chemical mines were present and therefore no means of chemical warfare agent delivery existed.
- OSAGWI did not include information that chemical detection paper attached to a vehicle used in the operation changed color, indicating the potential presence of a chemical warfare agent.

After reviewing all relevant information OSAGWI had in its files, we concluded that OSAGWI needed to reassess this case, taking into consideration this added information.

The other two cases in which we found investigative or reporting weaknesses involved a possible exposure of (1) a servicemember to a mustard agent during an inspection of an Iraqi bunker complex and (2) servicemembers to chemical agents in Al Jubayl, Saudi Arabia.

In the mustard agent case, OSAGWI did not follow up adequately to confirm whether an in-theater urinalysis test was administered. We found insufficient evidence to support the existence of such a test. Moreover, OSAGWI did not establish whether clothing tested for chemical warfare agent in this case actually belonged to the individual allegedly exposed. Finally, OSAGWI reached its conclusion without interviewing some key witnesses. Despite these weaknesses, the evidence in this case supported OSAGWI's conclusion that exposure to a chemical warfare agent was "likely."

In the case involving three reported incidents with potential exposure to chemical agents in Al Jubayl, Saudi Arabia, the available evidence generally supported OSAGWI's conclusions that two of the reported incidents did not occur and that the presence of chemical agents was "unlikely" in the other incident. However, OSAGWI did not include important information that would have made the case narrative more complete–that many of the individuals associated with this case had reported unusually high levels of health problems since their service during the Persian Gulf War. Without this information, a reader could conclude that there was little basis for concern about exposure to hazardous substances in this case. The case narrative also failed to mention that health problems affecting many individuals associated with this incident were among the first Gulf War illnesses-related incidents reported and the subject of several major DOD investigations and studies. Had

OSAGWI included this information, it would have avoided any appearance that it had not completely reported what was known from the investigation. Moreover, OSAGWI did not adequately identify and coordinate some information developed during this investigation with the Naval Health Research Center for inclusion in its Gulf War illnesses research on Navy personnel (Seabees) who were in that area.

For all six cases, we found that OSAGWI had not used DOD and VA clinical databases that contain information on the health of thousands of Gulf War veterans who may have symptoms of the types commonly associated with Gulf War illnesses. Use of these databases is identified in OSAGWI's methodology for conducting investigations, and they were used by OSAGWI in some other investigations. Their use might have provided leads regarding whether more investigative effort was needed in cases where exposure to chemical warfare agents or other environmental hazards might have occurred. During our review of the case narratives, we noted weaknesses in OSAGWI's internal quality assurance practices that contributed to some of the problems we found.

RECOMMENDATIONS

To ensure that OSAGWI's case narratives contain all the facts that have surfaced to date, we recommended that the Secretary of Defense direct the Special Assistant for Gulf War Illnesses to

- revise the marine minefield breaching, the mustard agent, and the Al Jubayl case narratives to reflect the new and/or unreported information we identified and
- examine whether OSAGWI's conclusion in the marine minefield breaching case should be changed in light of the additional information known about this case.

To enhance the thoroughness of OSAGWI's investigative and reporting practices, we recommended that the Secretary of Defense direct the Special Assistant for Gulf War Illnesses to

- use the DOD and VA Gulf War clinical databases to assist in designing the nature and scope of all OSAGWI investigations;
- include relevant medical information in its case narratives where it is needed to fully explain incidents of possible exposure to chemical agents or other potential causes of Gulf War illnesses; and
- ensure that OSAGWI's internal review procedures provide that (1) those reviewing an investigation and related report are independent of the team investigating the incident and (2) steps are in place that will lead the reviewers to thoroughly check that all relevant information obtained by the investigation teams has been included in the case narrative reports, all conclusions have been fully substantiated by the facts, and all logical leads have been pursued.

We further recommended that OSAGWI contact the Naval Health Research Center regarding the usefulness and desirability of comparing data between two units that served in the same area to determine whether veterans from the units were reporting the same types and numbers of symptoms.

AGENCY COMMENTS

DOD generally concurred with the report and agreed to revise OSAGWI's reports to include new or unreported data identified by our review and to use this information in reassessing case narrative findings. DOD stated that follow-up investigations were either planned or underway regarding the three cases where we noted weaknesses. While DOD agreed to update the marine minefield breaching case narrative, it also noted that there were still inconsistencies regarding the presence of artillery fire. DOD said that as part of its follow-up investigation, it would objectively consider all information and detail more completely the artillery issue and its relevance to whatever final assessment is made.

DOD and VA disagreed with our recommendation that OSAGWI incorporate the use of DOD and VA clinical databases into its evaluations. Their disagreement was based on concerns that these databases might be inappropriately used to establish a causal relationship between an event and the medical findings of the registries. However, DOD agreed that the databases need to be examined and analyzed for what they can contribute to understanding the illnesses of Gulf War veterans.

We agree that information from these databases should not be used to establish a causal association and did not intend that this information should be used for such purposes. However, we continue to believe that these databases could provide relevant information to investigators about whether individuals who were at or near a site under investigation are reporting health problems. This information could then be combined with other information to help guide the nature and scope of OSAGWI investigations.

DOD indicated that it would request the Naval Health Research Center to undertake the analytical comparison we had recommended. DOD also commented that independent reviewers are critical to a thorough and acceptable report on its investigations. DOD added that this was the reason it had established its current multilevel review process.

Mr. Chairman, that concludes my prepared remarks. I will be happy to answer any questions you may have about our report.

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