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Some tactical mistakes have theater-strategic consequences. Few would disagree with this statement. In fact, many recent events help prove its validity. But, so what? Can anything be done about it? Yes! The Combatant Commander (COCOM) is in a unique position to address the challenges of tactical mistakes. COCOMs can take actions which may actually prevent tactical mistakes. Similarly, COCOMs often make the first critical evaluation of whether a tactical mistake warrants a response. Finally, COCOMs serve as a key interagency link in coordinating appropriate responses to the unique circumstances of any tactical mistake. An analysis of recent case studies reveals applicable guidelines.

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SOME TACTICAL MISTAKES HAVE THEATER-STRATEGIC CONSEQUENCES

by

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A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Joint Military Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

Signature: ______________________

06 November 2007

Abstract

Some tactical mistakes have theater-strategic consequences. Few would disagree with this statement. In fact, many recent events help prove its validity. But, so what? Can anything be done about it? Yes! The Combatant Commander (COCOM) is in a unique position to address the challenges of tactical mistakes. COCOMs can take actions which may actually prevent tactical mistakes. Similarly, COCOMs often make the first critical evaluation of whether a tactical mistake warrants a response. Finally, COCOMs serve as a key interagency link in coordinating appropriate responses to the unique circumstances of any tactical mistake. An analysis of recent case studies reveals applicable guidelines.

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HYPOTHETICAL SCENARIO

In the summer of 2008 (just weeks before the Summer Olympics), a U.S. submarine makes a port call in Hong Kong. International relations in the region are similar to those existing today. Since there is no specific threat to U.S. forces in Hong Kong, nominal force protection is provided by a Mobile Security Force team, supplemented by a contracted picket boat. The submarine is moored to a buoy in the Hong Kong harbor at a location non-adjacent to commercial traffic lanes. The picket boat periodically circles the submarine, and warns away any approaching vessels. Unfortunately, the submarine crew's long-anticipated four-day liberty port call is interrupted by an incident on their second night in port.

The night is extremely foggy. A vessel is detected on radar approaching the submarine. The picket boat is vectored to intercept. Attempts to hail the unknown vessel go unanswered. By the time the picket boat gets alongside the approaching vessel, it is already less than 600 yards from the submarine, and still moving at a moderate eight knots. An escalating series of actions are taken in attempt to get the vessel to turn or stop – but all fail. Finally, lethal force is used, causing the vessel to turn slightly and drift to a stop.

Local authorities subsequently discover that the vessel was an old 15-ton fishing boat operated by a local fisherman and his four sons. The father had been seriously injured at sea earlier in the day; so the oldest son was piloting back into port. However, he had never done this, and was unable to operate the boat's radio. He was also confused by the fog, and distraught over the urgent need to get medical care for his father. The vessel's approach toward the submarine was clearly an accident caused by a complete loss of situational awareness as the son attempted to return to their village dock. The lethal force employed against the fishing boat killed all aboard except for the youngest son.

Obviously in this (not far-fetched) scenario, a mistake occurred. It was an understandable mistake – not an act of gross negligence. The mistake occurred at the tactical level, but could possibly impact the theater-strategic environment. What actions should the Combatant Commander consider?

BACKGROUND

The U.S. Navy has an established system to ensure that significant incidents are reported quickly up the involved chain of command.[1] In fact, most significant incidents are likely to receive press coverage[2] - so notification of all concerned parties (not just military) is usually not a problem. The challenge is to determine what coordinated statements/actions (if any) are most appropriate in response to each unique situation. Some tactical mistakes are universally accepted as simply a cost-of-doing-business.[3] Although these tactical mistakes may expose the need for improvements to tactical-level training, they do not require real changes in theater-strategic planning. However, *some* tactical mistakes do generate remarkable repercussions in the theater-strategic environment which warrant some type of coordinated response. Despite extensive tactical-level training to avoid mistakes, and despite having an effective system for reporting mistakes, it seems that much less effort has been applied to exploring what coordination is needed to determine how to respond once a significant incident occurs.

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[1] Chief of Naval Operations, "Special Incident Reporting," OPNAVINST 3100.6H (Washington, DC: Department of the Navy, CNO, 03 February 2006).

[2] Katie Collett, "Fire on Navy Cruiser in Shipyard Send Five to Hospital," *Norfolk Daily News*, 16 September 2007, http://www.ebird.afis.mil/ (accessed 17 September 2007). [I cite this as evidence that even relatively minor incidents are now reported widely – to back up my assertion in the text.]

[3] Author's personal opinion. However, this doesn't imply that tactical mistakes are accepted as unavoidable. [This opinion cannot be authoritatively supported by any one reference; however, it is a generally accepted principle. This footnote is included to avoid implying that such a policy exists.]

THESIS

No instruction manual exists on "what to do in case of significant incident" – at least not one that coordinates all diplomatic, informational, military, and economic efforts. Producing such a manual would prove a daunting task, since the range of "significant incidents" is incredibly vast. However, I assert **it is possible to develop guidelines to assist the Combatant Commander in coordinating appropriate actions in response to significant tactical mistakes**.

ROAD-MAP

Specifically, three key questions will be addressed:

- *Can preventive actions be taken to help avoid tactical mistakes which result in theater-strategic repercussions?*

- *Do common factors exist which can help determine whether a tactical mistake warrants a theater-strategic response?*

- *What are some considerations involved in determining the appropriate theater-strategic response?*

Selected case studies of relatively recent tactical mistakes will be examined. The impact of each on the theater-strategic environment, as well as evidence of response effectiveness, will be analyzed to support answers to the questions listed above. These answers will be developed from the case study material. Additionally, recommendations will be offered that outline some considerations for tactical mistakes.

WHAT CONSTITUTES A "TACTICAL MISTAKE"?

Some military actions are thought of as mistakes, but do not meet this paper's definition of "tactical mistake." For example, the invasion of Iraq in 2003 is commonly termed a mistake – since the presumption of Iraqi possession of weapons of mass destruction (a key factor in the decision to invade) turned out to be false.[4] This represented a theater-strategic mistake – not a tactical one. Similarly, the Japanese decision to attack Midway in 1942 was not a tactical mistake, even though the outcome was a failure. Tactical mistakes may have been made in the battle, but the decision was made at the operational level – and was based on a presumed probability of success.[5] In each of these two examples, planners at the theater-strategic or operational level made decisions under some degree of uncertainty. If conducted today, the planning would likely have involved "branch planning" to explore alternate options in the event that certain assumptions proved incorrect.[6] This paper will analyze tactical mistakes – those representing actions or decisions totally entrusted to the tactical level, for which no branch plan was deemed necessary.

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[4] USA Today, "Clinton Calls Iraq 'Big Mistake'," 16 November 2005, http://usatoday.com/ (accessed 24 October 2007).
[5] The Japanese Story of the Battle of Midway, (translation published by the Office of Naval Intelligence, July 1947), 1-3, http://www.history.navy.mil/library/ (accessed 02 November 2007).
[6] Chairman of the Joint Chiefs of Staff, *Joint Operation Planning*, JP-5.0 (Washington, DC: CJCS, 17 September 2006).

CASE STUDIES APPROACH

Four case studies will be reviewed - each involving key actions or decisions which had been delegated to the tactical level. Three case studies reflect tactical mistakes; lessons can also be drawn from the fourth, in which a tactical mistake was narrowly averted.[7] Although it would require several pages to fully explore each case study, this paper will simply sketch the pertinent facts. Rather than explain the details leading to each mistake (or near-miss), each case study will focus on how the incident and its higher-level response influenced the theater-strategic consequences.

USS VINCENNES. Iran and Iraq were at war in 1988, often attacking each other's oil tankers with mines, small boats, or aircraft.[8] USS *Vincennes*, one of the U.S. Navy's new Aegis cruisers, was accelerated into a Persian Gulf deployment in order to protect neutral shipping. Once on station, the ship gained the nickname Robo-Cruiser, due to its automated combat system and the aggressive reputation of its Commanding Officer, Captain Will Rogers.[9] Unfortunately, on 03 July 1988, USS *Vincennes* shot down commercial airliner Iran Air

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[7] Chief of Naval Operations, "Navy Occupational Safety," OPNAVINST 5100.19E (Washington, DC: Department of the Navy, CNO, 30 May 2007). This instruction stresses the concept of learning from near-misses as well as from accidents.

[8] George H. W. Bush, Vice Presidential Address to UN Security Council on 14 July 1988, *Department of State Bulletin*, September 1988.

[9] John Berry and Roger Charles, "Sea of Lies," *Newsweek*, 13 July 1992, 30.

flight #655 (IR655) – believing it was an Iranian F-14 flying an attack profile. All 290 passengers and crew were killed.[10] *Newsweek* later reported one of the more-negative assessments:

> The destruction of IR655 was an appalling human tragedy. It damaged America's world standing. It almost surely caused Iran to delay the release of the American hostages in Lebanon. It may have given the mullahs a motive for revenge and provoked Tehran into playing a role in the December 1988 bombing of Pan Am 103. For the Navy, it was a professional disgrace. The Navy's most expensive surface warship, designed to track and shoot down as many as 200 incoming missiles at once, had blown apart an innocent civilian airliner in its first time in combat. What's more, *Newsweek* has learned the *Vincennes* was inside Iranian territorial waters at the time of the shoot-down – in clear violation of international law. The top Pentagon brass understood from the beginning that if the whole truth about the *Vincennes* came out, it would mean months of humiliating headlines. So the U.S. Navy did what all navies do after terrible blunders at sea: it told lies and handed out medals.[11]

Indeed, there were several inconsistencies in the U.S. Navy's first series of reports.[12] The lack of transparency harmed public trust in the government and eroded trust within the interagency. The Vice President's Chief of Staff reportedly commented that he did not trust the Pentagon to provide certifiable facts for inclusion in the Vice President's UN statement concerning the incident.[13]

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[10] VADM Fogarty, "Formal Investigation into the Downing of a Commercial Airliner by the USS VINCENNES," Unclassified letter to U.S. CENTCOM, 28 July 1988, 3-5.
[11] Barry and Charles, "Sea of Lies," 29.
[12] Nancy Roberts, "Reconstructing Combat Decisions: Reflections on the Shootdown of Flight 655" (Technical Report, Monterey, CA: Naval Postgraduate School, 1992), 11.
[13] Barry and Charles, "Sea of Lies," 38.

ABU GHRAIB. Instead of representing one specific tactical mistake, the abuses at Abu Ghraib were a series of actions conducting over a period of several months. The Schlesinger Report provides a good overview of what happened:

> The events of October through December 2003 on the night shift of Tier 1 at Abu Ghraib prison were acts of brutality and purposeless sadism. We now know these abuses occurred at the hands of both military police and military intelligence personnel. The pictured abuses, unacceptable even in wartime, were not part of authorized interrogations nor were they even directed at intelligence targets. They represent deviant behavior and a failure of military leadership and discipline.[14]

Although much has been published on the details of what happened (and why), this review is more concerned with the consequences and how the response was handled. The abuses at Abu Ghraib have caused tremendous damage to the reputation of the U.S. military, and even to the reputation of the American people – particularly in the eyes of the Islamic audience. The photos (widely distributed on the Internet) provide motivators for various radical groups to violently attack U.S. interests.[15]

Despite the dire consequences which are now apparent, the seriousness of the situation was not recognized initially. "The officials who saw the photos on 14 January 2004, not

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[14] James Schlesinger, "Final Report of the Independent Panel to Review DOD Detention Operations," (Report to Secretary of Defense, 24 August 2004), 5.
[15] Mark Danner, *Torture and Truth* (New York, NY: New York Review Books, 2004), 26-29.

realizing their likely significance, did not recommend the photos be shown to more senior officials."[16] Thus many senior government officials were surprised as Abu Ghraib abuses were first publicly announced on *60 Minutes*.[17] Similar to the previous case study, shortcomings in the preparation of a response only served to aggravate the situation.

USS *LA MOURE COUNTY* GROUNDING. Whereas the first two case studies were highly publicized, this one is less well-known. U.S. Southern Command sponsors an annual fleet training exercise involving the circumnavigation of South America by a multi-national collection of warships.[18] USS *La Moure County* was a participant in the 2000 exercise. While conducting an amphibious training event in the pre-dawn hours of 12 September 2000, USS *La Moure County* ran aground in a remote area of Chile. No one was killed, but the ship was a total loss (at an estimated cost of ~$250 million).[19] It was sunk as a target hulk during the following year's exercise.[20]

While clearly an embarrassment to the U.S. Navy, this tactical mistake did not result in detrimental theater-

[16] Ibid., 349-350.
[17] "Resign, Rumsfeld," *The Economist*, 08 May 2004.
[18] "Exercise: UNITAS," Just the Facts Web site, http://www.ciponline.org/ (accessed 02 November 2007).
[19] *Navy Times*, "La Moure County totaled," 27 September 2000. [A series of *Navy Times* articles followed in subsequent weeks.]
[20] "Grounding and Aftermath," Wikipedia Web site, http://www.en.wikipedia.org (accessed 27 October 2007).

strategic consequences. No nations decided to end their participation in the annual exercise due to this accident.[21] Environmental groups showed the most interest – expressing concern over the potential ecological damage to that isolated region.[22] Naval Sea Systems Command proactively posted Internet photos of the damaged ship, always prominently featuring actions to contain and clean up the resulting contamination.[23] These pictures were far more effective than any written statements in showing the U.S. Navy's response.

FALKLANDS WAR TRANSIT. This "near-miss" case study is also less well-known – primarily because an incorrect action was averted at the last minute. The British battle group almost shot down a Brazilian commercial airliner in the early days of the 1982 Falklands War. During the battle group's transit south, an Argentine Air Force 707, converted to perform reconnaissance, was detected on several occasions. Fearing that this aircraft (termed the Burglar) could be providing targeting data to other Argentine forces, Admiral Woodward (the Battle Group Commander) sought, and surprisingly

[21] UNITAS Web site, http://www.southcom.mil (accessed 27 October 2007). [comparison of 2000 attendance to subsequent years revealed no drop in participation – nor did web site indicate foreign concern/impact by the grounding of *La Moure County*.]
[22] Sierra Club Bulletin, *Sierra* (January-February 2001): 55.
[23] USS *La Moure County* Grounding Web site, http://www.dcfp.navy.mil/ (accessed 27 October 2007).

received, advance authority to shoot down the aircraft.[24] Following two later approaches, neither of which resulted in opportunities to engage, the *presumed* Burglar was again detected on a profile to overfly the Battle Group. With only 20 seconds remaining until missile launch, Admiral Woodward ordered "Weapons Tight" as he realized the aircraft was flying on a direct line from Durban, South Africa to Rio de Janeiro, Brazil.[25] His reflection on the potential cost of his near-mistake is insightful.

> If we had shot that airliner down, it would probably have left the Americans with no choice but to withdraw their support; the Task Force would have had to be recalled; the Falklands would be the Malvinas; and I would have been court-martialed. These would have been the consequences of the international community's rightful horror at the news of a battle group shooting down several hundred civilians by mistake.[26]

ANALYSIS

Evidence will be drawn from the four case studies in order to answer this paper's three key questions.

- Can preventive actions be taken to help avoid tactical mistakes which result in theater-strategic repercussions?

I believe the answer is yes. The most beneficial action is to ensure key tactical decision-makers understand the theater-strategic objectives and issues involved. In the

[24] Woodward, Sandy, *One Hundred Days – The Memoirs of the Falklands Battle Group Commander* (Annapolis, MD: Naval Institute Press, 1992), 101-102.
[25] Ibid., 102.
[26] Ibid., 103-104.

Falklands War Transit case study, it is clear that Admiral Woodward fully appreciated the theater-strategic cost in making his decision to break off a tactical engagement. Without that higher-level perspective, tactical concerns probably would have driven him to shoot.

Conversely, Captain Rogers did not demonstrate any interest in theater-strategic issues.[27] Even if he had possessed a higher-level perspective, he has adamantly stated he made the correct tactical decision, and would do the same again.[28] However, it is certainly possible that a better awareness of the theater-strategic costs would have caused him not to place *Vincennes* in such a high-risk position.

Likewise, the Abu Ghraib guards showed no knowledge or concern for how their actions could affect the theater-strategic environment. Admittedly, it may be unrealistic to expect junior enlisted personnel to *thoroughly* understand theater-strategic issues. However, even at Abu Ghraib, the leadership should (and could) have communicated the importance of "winning the hearts and minds" of the Iraqi people.

- Do common factors exist which can help determine whether a tactical mistake warrants a theater-strategic response?

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[27] Fogarty, "Formal Investigation to CENTCOM," 16.
[28] Will and Sharon Rogers, Storm Center (Annapolis, MD: Naval Institute Press, 1992), 41.

While it is difficult to support a definitive "no" answer, I believe it would be unwise to assume any reported tactical mistake "is not serious enough" to warrant at least the preparation of a response. Incidents appearing minor to the Combatant Commander could prove of great interest to other audiences.[29] Universal criteria to judge the potential impact of incidents has not yet been discovered. Using some measure of "press interest" as a threshold is tempting – until one realizes how many issues with absolutely no theater-strategic impact get disproportionate news coverage. A dollar cost threshold would also be misleading – since it would have predicted high impact for the complete loss of USS *La Moure County*, and low impact for the Abu Ghraib situation. Each tactical mistake needs to be evaluated based on criteria that seem to vary on a case-by-case basis. Even Secretary Rumsfeld admitted the difficulties of judging the impact of the Abu Ghraib abuses:

> I failed to identify the catastrophic damage that the allegations of abuse could do to our operations in the theater, to the safety of our troops in the field, to the cause to which we are committed. When these allegations first surfaced, I failed to recognize how important it was to elevate a matter of such gravity to the highest levels, including the leaders in Congress.[30]

[29] Chairman of the Joint Chiefs of Staff, *Interagency, Intergovernmental Organization, and Nongovernmental Organization Coordination during Joint Operations*, JP 3-08 (Washington, DC: CJCS, 17 September 2006).
[30] Donald Rumsfeld, "Testimony," Joint session of Senate and House Armed Services Committees, 108th Cong., 2nd sess., 2004, http://www.defenselink.mil/ (accessed 02 November 2007).

- What are some considerations involved in determining the appropriate theater-strategic response?

The Combatant Commander is in perhaps the most critical position to influence preparation of responses to tactical mistakes. The Combatant Commander staff will naturally serve as "the middleman" in relaying information from the tactical level to other government agencies. Translating or explaining military terminology and procedures to civilian officials is a particularly important function.

Describing how *La Moure County* could run aground presented an illustrative challenge. Simple answers are usually desired but seldom available. In this case, one would expect an investigation to reveal (a) a flawed chart; (b) malfunctioning navigation equipment; or (c) an incompetent or negligent navigation team. Neither option completely explained the grounding. In fact, the chart was accurate and the Global Positioning System was working properly. However, these two navigation tools used different reference points – and it was unlikely the navigation team would have been aware of this "disconnect."[31] Communicating complicated answers requires informed staff members with good communication skills.

It is also vital to clearly describe limitations in obtaining data. After learning of the *Vincennes* incident,

[31] "USS *La Moure County* Grounding," Navy Mishap Report, (Technical Report to Commander, Naval Surface Forces Atlantic), 15 October 2000.

government officials were expecting immediate radar data to prove what had happened. The military industry (and the Navy) had advertised the ability of Aegis ships to precisely record the exact locations of any aircraft tracked by the SPY-1A radar. What had not been explained was the inability of the ships to process the data tapes. Government officials were surprised to learn the tapes had to be delivered to Dahlgren, Virginia in order to display any useful information.[32] If data is not available, it is important to be able to explain why – and to give an accurate estimate of when to expect it.

RECOMMENDATIONS

Based upon the analysis, I offer three recommendations.

RECOMMENDATION 1. The Combatant Commander can serve as a key link between tactical forces and interagency partners. This role creates the opportunity to take actions which may actually avoid tactical mistakes.

(1) Educate tactical decision-makers on the geo-political environment in which they operate – and empower/encourage them to direct questions via the Combatant Commander to applicable organizations outside of the military.

. . . and a corollary:

Do not unduly restrain the actions of tactical decision-makers by implementing restrictive rules of engagement.

[32] Fogarty, "Formal Investigation to CENTCOM," 18.

A natural response to concerns of lower-level mistakes is to consolidate (vice delegate) control.[33] Yet the Falklands transit case study showed an example of a correct tactical decision being made in a critical situation – a decision more completely thought-out, according to Admiral Woodward, because he knew he was entrusted with that responsibility.[34] Failure to delegate authority to the tactical decision-makers could result in a less-careful on-scene assessment, based on human tendencies to exert less attention on areas not directly under their control.[35]

Additionally, tactical decision-makers are often in the best position to evaluate risks. If educated more on the potential geo-political costs, these "smart warriors" may be more wary of putting forces into situations with high potential for theater-strategic consequences to tactical mistakes. A more-informed tactical decision-maker could certainly recommend courses of action that may not have been considered at higher levels. The *Vincennes* case study reveals that Combatant Commander staff efforts to account for civilian air traffic did not adequately consider what information was

[33] Karel Montor, ed., Naval Leadership, (Annapolis, MD: Naval Institute Press, 1987), 274.
[34] Woodward, *One Hundred Days – The Memoirs of the Falklands Battle Group Commander*, 103-104.
[35] Montor, Naval Leadership, 274-276. [I recognize I am taking a principle intended for naval personnel – and broadly applying to all in the military service. This is a safe assumption, but perhaps more than the author intended.]

most needed by the ships' crews.[36] Conversely, little thought seems to have been given to determining what information provided by the ships would have been of most benefit to the airliners.[37] Facilitating some direct exchange between tactical watchstanders and civil aviation officials could have resulted in procedures that clarified the confusion leading to the accidental shooting of IR655.[38] In conclusion, Combatant Commander staffs can educate and expand the perspective of tactical forces by fostering closer ties with interagency organizations having an interest in regional operations.

RECOMMENDATION 2. The first recommendation dealt with how to avoid tactical mistakes that may cause theater-strategic consequences. This one addresses how to identify whether a reported incident warrants a higher-level response.

> **(2) Assume that any reported tactical mistake has the potential to impact the theater-strategic environment – and (at a minimum) prepare public statements coordinated between the pertinent government agencies. Keep all parties updated as further details emerge.**

Since it is not always clear whether a tactical mistake may cause higher-level repercussions, the Combatant Commander should begin response efforts in every case. Notification of other potentially-concerned agencies may reveal other issues

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[36] Fogarty, "Formal Investigation to CENTCOM," 24.
[37] Ibid., 25.
[38] House, *The July 3, 1988 Attack by the VINCENNES on an Iranian Aircraft: Hearing before the Committee of Armed Services*, 102nd Cong., 2nd sess., 1992, 1004.

that were not apparent from a military perspective.[39] These "other issues" could become elevated in importance if it appears they are being ignored.

The *La Moure County* case study provides a good example of this situation. While the military focused initial efforts on resolving the navigation issue (especially important to the U.S. Navy), more press interest was given to the ecological impact.[40] Thus, the military adapted by making public news updates appropriately reporting on efforts to contain contamination in the grounding area. Updates also provided a good news "spin" – since the accidental grounding brought to light a common disconnect between coastal charts and GPS reference datum – publicly identifying a hazard to both military and commercial shipping before more accidents occurred.[41]

The Abu Ghraib case study shows the danger of assuming a tactical mistake is not serious enough to take the precaution of notifying interagency partners. Department of State and Department of Justice personnel should have had the advantage of knowing of the abuse allegations as early as January 2003 – vice being surprised by a 60 Minutes presentation that April.

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[39] Chairman of the Joint Chiefs of Staff, *Interagency, Intergovernmental Organization, and Nongovernmental Organization Coordination during Joint Operations*, JP 3-08 (Washington, DC: CJCS, 17 September 2006).
[40] Gregg Baumann and Michael Dean, "Salvaging of USS *La Moure County* (LST 1194) in Cinfuncho Bay, Chile," *Naval Engineers Journal* 113, no. 3 (Summer 2001): 163.
[41] *Navy Times*, "Navigation Lessons Learned from LST Grounding," 13 November 2000.

RECOMMENDATION 3. This recommendation may appear to be less helpful, but seems to be violated most frequently – and at the highest expense to theater-strategic interests.

> **(3) Be completely honest (and accurate) in all public statements made in response to tactical mistakes.**

While sounding so obvious, this may be uniquely challenging. Tactical mistakes have the potential to reveal an embarrassing error in judgment – or worse, an existing weakness which places other forces at risk. It can be very tempting to hide pertinent facts, citing security classification as reasonable justification. Yet with today's information-sharing, it is likely the truth will be discovered later or disclosed by some source. Perceptions of a "cover-up" can cause much harm in both the theater-strategic and the political environment. Admiral Crowe recognized this in his 1992 testimony to Congress about the inconsistencies concerning *Vincennes*:

> We should have declassified the ship's position and issued a press release pointing out *Vincennes*' location within Iranian waters. With the prescience of 20/20 hindsight, I wish we had done that.[42]

"Justifiable" misrepresentations and half-truths are not the only danger. Sometimes the facts just are not available. In these situations, "care must be taken to separate data from speculation and interpretation of those data."[43] Although most

[42] House, *The July 3, 1988 Attack by the VINCENNES on an Iranian Aircraft*, 997.
[43] Roberts, "Reconstructing Combat Decisions: Reflections on the Shootdown of Flight 655," 15.

people want to provide answers, innocent mistakes can destroy credibility when those answers are later proven wrong.

SUMMARY

The hypothetical scenario described on page 1 of this paper raises many questions. An analysis of selected case studies does yield some guidance that can benefit Combatant Commanders in dealing with tactical mistakes. Proactive actions can be taken to reduce the likelihood of tactical mistakes. However, each situation is unique; it is very challenging to determine the potential theater-strategic impact of such a wide array of possible tactical mistakes. Thus it is prudent for the Combatant Commander to contribute towards a coordinated interagency response to any reported tactical mistake – ensuring that all concerned organizations are informed. Public statements should be prepared quickly, and should be absolutely truthful.

Tactical mistakes will never be eliminated, so some effort at planning "how to respond" is certainly appropriate. The first step is for all to recognize the potential risks/costs. "Commanders at every level must be aware that in a world of constant and immediate communications, any single action may have consequences at all levels."[44]

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[44] Chairman of the Joint Chiefs of Staff, *Joint Operations*, JP 3-0 (Washington, DC: CJCS, 17 September 2006), II-1.

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