

Inspector General

United States
Department of Defense



Review of Electrocution Deaths in Iraq:
Part II - Seventeen Incidents Apart from
Staff Sergeant Ryan D. Maseth, U.S. Army

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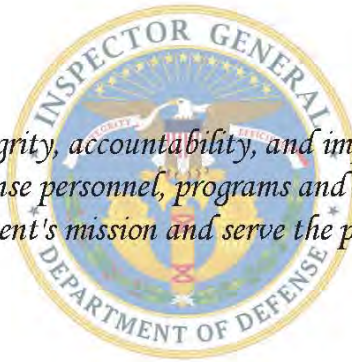
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INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
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JUL 24 2009

MEMORANDUM FOR DEPUTY UNDER SECRETARY OF DEFENSE FOR
ACQUISITION AND TECHNOLOGY
COMMANDER, U.S. CENTRAL COMMAND
COMMANDER, MULTI-NATIONAL FORCES – IRAQ
COMMANDER, ARMY SUSTAINMENT COMMAND
DIRECTOR, DEFENSE CONTRACT MANAGEMENT AGENCY
ARMY ASSISTANT CHIEF OF STAFF FOR INSTALLATION
MANAGEMENT

SUBJECT: Review of Electrocution Deaths in Iraq: Part II – Seventeen Incidents Apart
From Staff Sergeant Ryan D. Maseth, U.S. Army (Report No. IPO2009E001)


We are providing this final report for information and use.

We requested and received management comments from the Commander, U.S. Central Command; Commander, Multi National Forces – Iraq; Commander, Multi National Corps – Iraq; Director, Joint Staff; U.S. Army Assistant Chief of Staff for Installation Management; and the Director, Defense Contract Management Agency. We also received management comments from the Commander, Army Materiel Command and the Commander, U.S. Army Criminal Investigation Command. All comments conformed to the requirements of DoD Directive 7650.3, "Follow-up on General Accounting Office (GAO), DoD Inspector General (DoD IG), and Internal Audit Reports," June 3, 2004.

Management comments discussed observations and recommendations made in Part I. Management made no comments to the draft of this part of our report.

As stated in the enclosed report, the Army and Navy reopened their investigations in four electrocution cases as a result of our work. The Naval Criminal Investigative Service completed its investigation into the death of Hospital Corpsman Third Class David A. Cedergren, and we are reviewing the final investigative results in that case. The Army Criminal Investigation Command's investigations in the remaining three cases continue at this date. We will supplement this report as needed after reviewing the final investigations in all four cases.

We appreciate the courtesies extended to our staff. Please direct questions to me at (703) 602-1017 (DSN 664-1017).


Charles W. Beardall
Deputy Inspector General
for Policy and Oversight

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**Review of Electrocution Deaths in Iraq:
Part II – Seventeen Incidents Apart from
Staff Sergeant Ryan D. Maseth, U.S. Army
(Report No. IPO2009E001)**

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Review of Electrocution Deaths in Iraq: Part II – Seventeen Incidents Apart from Staff Sergeant Ryan D. Maseth, U.S. Army

I. Introduction and Summary

This is Part II of our “Review of Electrocutions in Iraq.”¹ Based on preliminary work conducted in support of Part I, and growing congressional interest, we sought information on all electrocutions that occurred in Iraq since Operation Iraqi Freedom began in March 2003. We identified 17 other electrocutions involving U.S. military or contractor personnel, as listed in Appendix A.

Nine of the 17 electrocutions involved accidental deaths that resulted from the victims touching or coming into contact with live electrical power lines. Whether equipment maintenance complied with proper electrical standards or grounding requirements were not issues in these nine electrocutions, and the investigations conducted in the cases sufficiently established responsibility for the deaths. The circumstances surrounding these deaths were straightforward, and the respective investigations laid out the relevant facts surrounding these incidents and established responsibility for the deaths.

The remaining eight electrocutions involved equipment malfunctions that could have related to whether equipment maintenance complied with proper electrical standards or whether the respective chain of command acted responsibly in protecting Service members. This report presents our results after reviewing the eight electrocutions involving equipment which occurred prior to Staff Sergeant Ryan D. Maseth’s death in January 2008. In each case, prior to our review, either the United States Army Criminal Investigation Command (USACIDC), or the Naval Criminal Investigative Service (NCIS) completed an investigation.² In addition, in most cases, other investigations were conducted, including accident/safety investigations, command directed investigations, and autopsies.

Our review focused on (1) whether USACIDC and NCIS adequately addressed the cause and manner of death in each case, and (2) if they thoroughly examined whether personnel in each victim’s chain-of-command were aware of electrical safety problems

¹ See our report, “Review of Electrocutions in Iraq: Part I - Electrocution of Staff Sergeant Ryan D. Maseth, U. S. Army” (Project No. D2008-DIPOE2-0196)

² Under DoD policy, the cognizant Military Criminal Investigative Organization is required to investigate each unattended military death, and investigate the case as a homicide until evidence establishes differently. The Military Criminal Investigative Organizations are the USACIDC, the NCIS, and the Air Force Office of Special Investigations.

and, by inaction, negligently placed the victim at risk. In addition to reviewing investigations conducted by a Military Criminal Investigative Organization (MCIO), we reviewed command-directed investigations, safety/accident investigations, autopsies, and any other investigation regarding the deaths. We also visited the sites in Iraq where the deaths occurred and interviewed current command personnel about the electrocutions. We conducted our work between August 2008, and March 2009.

Review Results

Our examination of the eight cases at issue determined that further investigation was warranted in four cases.

NCIS reopened its investigation into one of those cases -- the 2004 death of Petty Officer David A. Cedergren -- after Armed Forces Institute of Pathology revised its initial autopsy findings to state the cause of death was “electrocution with concurrent myocarditis [inflammation of the heart] and the manner of death was accidental [rather than natural].”

With respect to the remaining seven cases, we found that investigations conducted by the Military Criminal Investigative Organizations were adequate for the cause and manner of death determinations, which was the primary purpose of those investigations. However, in three cases, we concluded the evidence should have led to additional investigative work to resolve accountability issues, and we requested USACIDC reopen its investigations. Those three cases involved an electric power washer used to clean vehicles and equipment, a hot water heater and water pump connected to a shower facility, and a water pump for a swimming pool. In each case, we questioned whether the victim’s chain of command acted responsibly to protect the victim and other personnel.

Upon completion, we will again review the NCIS and USACIDC investigations which required additional work.

II. Scope

This review examined 17 of the 18 U.S. military or contractor personnel who had been electrocuted in Iraq since Operation Iraqi Freedom began in March 2003.³ In nine of the 17 electrocutions, accidental deaths resulted from the victims touching or coming into contact with live electrical power lines. Evidence regarding the circumstances surrounding these deaths was uncontroverted; therefore, these cases did not present a basis for further review. The remaining eight electrocutions, however, involved equipment malfunctions that could have related to whether a contractor complied with proper electrical standards, or whether the victims' chains of command acted responsibly to protect their troops. These electrocutions are listed in the table below.

Table 1. Electrocutions in Iraq (Cases Involving Equipment)

No.	Rank, Name and Service	Incident Date	Incident / Incident Location
1	Specialist Marvin A. Campo-Siles (Army)	04/17/04	Electrocuted while attempting generator repair, Pad 9, Forward Operating Base Brassfield-Mora, Samarra, Iraq
2	Specialist Chase R. Whitham (Army)	05/08/04	Electrocuted while swimming in outdoor pool, Forward Operating Base Patriot, Mosul, Iraq
3	Private First Class/E-2 Brian K. Cutter (Marine Corps)	05/13/04	Electrocuted while attempting air conditioner repair, Al-Asad Airbase, Camp Fallujah, Iraq
4	Specialist Marcus O. Nolasco (Army)	05/18/04	Electrocuted while taking a shower, Forward Operating Base Summerall, Bayji, Iraq
5	Hospital Corpsman Third Class David A. Cedergren (Navy)	09/11/04	Electrocuted while taking a shower, Outdoor Shower, Camp Iskandariyah, Iraq
6	Sohan Singh (Civilian Contractor)	07/19/05	Electrocuted while attempting to enter his room, Fallujah Surgical, Camp Fallujah, Iraq.
7	Sergeant Christopher L. Everett (Army)	09/07/05	Electrocuted while using a power washer, Camp Taqaddum, Iraq
8	Sergeant Michael J. Montpetit (Army)	06/22/07	Electrocuted while attempting generator repair, Forward Operating Base Prosperity, Iraq

In conducting our review, we collected and reviewed the set of investigative files (i.e., MCIO investigation, accident/safety investigation, command-directed investigation, and the autopsy report) completed in each of these electrocutions.⁴ We looked for any factual inconsistency within the investigative file set that might indicate a deficiency in the investigation. To aid in the assessment of accountability, we attempted to identify the

³ As indicated above, the electrocution of SSG Maseth is addressed in a separate report.

⁴ Our review in the Hospital Corpsman Cedergren case was limited because NCIS reopened its investigation, and we did not want to interfere with the ongoing investigative activities. We will review the investigation again after completion.

victim's chain of command and to establish what equipment was involved and what entity was responsible for its installation and maintenance.

Our work included a field trip during September and October 2008 to the sites in Iraq where the deaths occurred, and interviews with extant command personnel. The scenes bore little resemblance to those depicted in photographs at the time of the electrocutions. At some sites, the U.S. has returned control over the territory involved to the Iraqis, and no longer has ongoing operations.

III. Case Reviews

Specialist Marvin A. Campo-Siles, United States Army

Specialist Marvin A. Campo-Siles was electrocuted while attempting a generator repair at Pad 9, Forward Operating Base Brassfield-Mora, Samarra, Iraq, on April 17, 2004. The generator and exterior of the housing unit involved in the incident are shown in the figure below.



**Figure 1. Generator and Housing Area
Involved in the Specialist Campo-Siles Electrocution
(From Army Photographs)**

Investigations

Investigations were completed in the case, as follows:

Table 2. Investigations Conducted in Campo-Siles Case

Type	Report No.	Report Date
Armed Forces Institute of Pathology	A04-22	6/15/2004
Accident		7/13/2004
USACIDC	0075-04-CID469-79652-5H8	8/10/2004

Observations

Specialist Campo-Siles was a trained and experienced generator repairman. On April 17, 2004, he and two other soldiers were performing maintenance on a generator supplying electrical power to two warehouse-like structures that housed U.S. soldiers on Forward Operating Base Brassfield -Mora. The generator was functioning, but the housing units were not receiving electrical power. The team checked voltage at the breaker box and concluded that electricity was not flowing through the breaker box. While Specialist Campo-Siles remained at the breaker box, the two other soldiers began following the wires to determine where the electrical “drop off” was occurring. The wiring from the generator (located outside the housing unit) and the interior of the housing area are shown in the figure below.



Figure 2. Generator Cable and Housing Unit Involved in Specialist Campo-Siles Electrocution (From Army Photographs)

Shortly after leaving Specialist Campo-Siles, the two other soldiers heard a scream and, upon checking, discovered Specialist Campo-Siles lying on the ground. He apparently had disconnected wires from the breaker box and was holding live electrical wires in his hands. A yellow screwdriver apparently used for the disconnections was found near the electric meter. The incident site is shown in the figure below.



**Figure 3. Site Where Specialist Campo-Siles
was Electrocuted (From Army Photographs)**

After safely dislodging the wires, one soldier used a vehicle to go for help. The other remained with Specialist Campo-Siles. The soldier who went for help returned with another soldier, and the three loaded Specialist Campo-Siles into the vehicle. One administered cardiopulmonary resuscitation during transport to the Medical Aid Station. Specialist Campo-Siles never regained consciousness. A doctor at the Medical Aid Station subsequently pronounced him dead.

The USACIDC investigation included:

- examining the death scene appropriately—sketches were made and pictures were taken;
- conducting pertinent interviews and obtaining statements from the individuals; and
- ensuring autopsy results were collected and used appropriately—the cause of death was listed as “electrical injury,” and the manner of death was listed as “accident.”

The investigation was adequate for the circumstances.

Site Visit

We visited the site on October 5-6, 2008. The facility is now used as a warehouse for equipment, not for housing troops, and the generator is no longer located outside the warehouse.

Government Contractor Involvement

The Accident/Safety Investigative Report identified a U.S. contractor as having provided the “commercial generator,” but did not indicate the contractor owned the

generator or was responsible for its maintenance. The investigative reports also did not identify the company or individual responsible for installing the generator, or breaker box.

Conclusion

Further investigation is not warranted.

Specialist Chase R. Whitham, United States Army

Specialist Chase R. Whitham was electrocuted while swimming in an outdoor pool at Forward Operating Base Patriot, Mosul, Iraq, on May 8, 2004. The site is shown in the figure below.



Figure 4. Pool Where Specialist Whitham was Electrocuted (From Navy Photographs)

Investigations

Investigations were completed in the case as follows:

Table 8. Investigations Conducted in Whitham Case

Type	Report No.	Report Date
Accident	2004-05-08-001	5/28/2004
Armed Forces Institute of Pathology	ME 04-346	6/7/2004
USACIDC	0061-04-CID389-80658-5H8	8/4/2004 (Reopened)

The Incident

In April 2004, a junior officer decided to fix an outdoor swimming pool in advance of the summer's heat. He used in-house Iraqi employees to restore the appearance of the pool and fix the water pumping system. The battalion commander was asked to open the pool, but denied the request and directed the installation of force protection barriers. A senior noncommissioned officer informed all other noncommissioned officers the pool was not to be used. Several soldiers said they used the pool in early May. On May 8, while several soldiers, including Specialist Whitham, were swimming, Specialist Whitham touched a metal pipe circulating pool water and was electrocuted. Another swimmer received an electrical burn on his stomach. Electricians

subsequently determined the pool's water pump shorted and was not properly grounded or bonded.

Observations

The investigators conducted minimum investigative steps to confirm cause and manner of death. Interviews were minimum in number and scope, and potentially important leads were not pursued. Physical evidence was not collected. A negligent homicide investigation was not considered even though (1) the command did not apply quality controls to ensure compliance with any electrical code or safety requirement when “in-house Iraqi workers” installed the water pump 2-3 weeks before the electrocution, and (2) the command did not post signs or otherwise take action to prevent soldiers from using the pool after it was placed off limits. The investigations did not resolve those matters. Additionally, members of the mayor's cell, who allegedly inspected the in-house laborers' work, were not identified and interviewed.

Equipment

- **Water Pump:** The pump was located above ground, adjacent to a fuse box, and connected a water supply pipe, which continued to the pool, to a second above ground pipe, which also continued to the pool. The pipes were both 3-inch diameter metal pipes that extended about 20 feet through a hedge to the North swimming pool West side. Report of investigation photographs indicate boxes made of wood/lumber covered the pump and fuse box, as shown in the figure below.



**Figure 5. Covers for Pump and Fuse Box
in Area Where Specialist Whitham was Electrocuted
(From Navy Photographs)**

- From photographs, the water pump nomenclature read “BU...RKS.” A model or serial number was not identified. Photographs at the scene were inadequate to help with nomenclature identification.

(NOTE: The water pump was not grounded or bonded, and the over-current protection was a standard 10A breaker, not a ground fault breaker.)

- North Swimming Pool: The sides/edges were straight on the north, south, and east sides, and the west side was semi-circular. The two silver metal pipes extending from the west side to the water pump were above ground/visible. Specialist Whitham was observed touching one of these metal pipes before he was electrocuted. Two other pools at the site were not in use/not filled with water.

Site Visit

We did not visit the site. The former Forward Operating Base Patriot has been returned to Iraqi control.

Government Contractor Involvement

It is unknown whether repairs to the swimming pool complex would have been covered, or should have been pursued through one or more U.S. contractors operating in Iraq. However, the command used local in-house Iraqis for the repairs.

Conclusion

We concluded further investigation was warranted and on December 5, 2008, referred the case to the Army for further examination. Based on our referral, USACIDC reopened its investigation. Conclusions concerning accountability and responsibility await completion of the investigation.

Private First Class Brian K. Cutter, United States Marine Corps

Private First Class Brian K. Cutter was electrocuted while attempting repair on an air conditioner unit at Al-Asad Airbase, Iraq, on May 13, 2004. The site is depicted in the figure below.

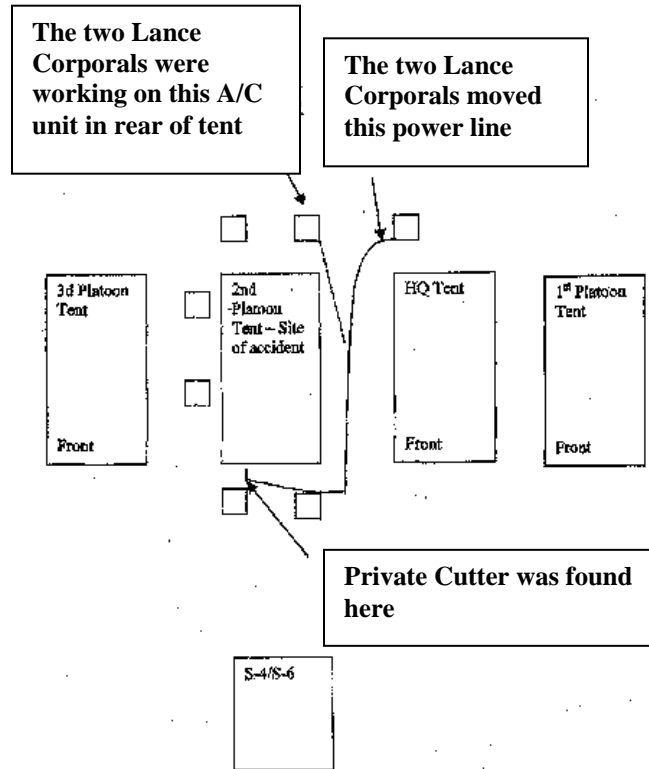


Figure 6. Drawing Depicting Area Where Private Cutter was Electrocuted (From Army Report of Investigation)

Investigations

Investigations were completed in the case as follows:

Table 9. Investigations completed in the Cutter case

Type	Report No.	Report Date
Command	5800 Legal	5/17/2004
Armed Forces Institute of Pathology -Preliminary	ME 04-363	5/18/2004
Armed Forces Institute of Pathology	ME 04-363	2/17/2005
NCIS	21MAY04MEBJ0191	11/3/2006

Observations

The Naval Construction Battalion (Seabees) ensured that two air conditioning units worked in each tent the 3rd Assault Battalion would occupy prior to their arrival at Al-Asad Airbase. However, some units stopped working by the time the battalion arrived. Due to high work demand at the camp, the Seabees did not get back to fix the air conditioning before three Marines started working on it themselves.

After 49 hours without air conditioning, the senior noncommissioned officer, a Gunnery Sergeant, asked Private First Class Cutter to see if he could fix the air conditioning. Private First Class Cutter attempted to rewire the electrical boxes and an air conditioner unit, but did not have the proper training, knowledge, or tools for the task. Two junior enlisted personnel who attempted to assist with the repair also did not have the proper training, knowledge, or tools.

Private First Class Cutter died from electrical shock while using a metal tool and attempting to rewire an air conditioning unit to the breaker box and subpanel/junction box. Resuscitation attempts were unsuccessful.

After considering the investigative results, on June 13, 2004, the Commanding Officer, Marine Corps Regimental Combat Team-7, held that:

1. Private First Class Cutter died while attempting to fix the air conditioning units feeding his platoon's tents. That attempt was made by three young Marines who, while not qualified to fix or work on electrical systems or air conditioners, had in the past demonstrated proficiency with utilities. The attempt was executed in an expeditionary camp in a combat zone where temperatures routinely approached 100d Fahrenheit by midmorning. The attempt was also made without proper supervision or the conduct of a hasty ORM [Operational Risk Management] prior to commencement of work. The tragic results should have been predicted and precluded. . . .

3. I do not fault . . . [the senior noncommissioned officer] for considering the use of his "fix-it" Marines to repair the air conditioners. In this environment, under these conditions, leaders are required to balance operational requirements with risk; there will be times when a decision is made to employ Marines outside of their MOS [Military Occupational Specialty] qualifications. However, risk identification and assessment, a requirement to supervise to ensure risk is mitigated, and the leaders enduring and immutable requirement to supervise is

inherent to that decision. [The senior noncommissioned officer]. . . assigned the task and then failed in these basic leadership tenets. He bears a measure of responsibility for the sequence of events leading to the tragic consequences. . . .

5. . . . [the senior noncommissioned officer], after tasking Private First Class Cutter, [and two junior enlisted personnel] to repair the air conditioners, failed to ensure that proper tools were provided, that proper safety procedures were in place, and that proper supervision was provided to the Private First Class and two LCpls [Lance Corporals].

6. . . . recommend that Commanding Officer, 3d AA Bn [3rd Assault Amphibian Battalion] reflect . . . [the senior noncommissioned officer's] leadership failure via administrative action to include a fitness report, NPLOC [Non-Punitive Letters of Caution], or page 11 entry.

Site Visit

We visited the site on October 7-8, 2008. However, the tent compound involved in the electrocution no longer existed. At the time of our visit, the location was an active construction site.

Government Contractor Involvement

The tents were not covered by a U.S. Government contractor. The Naval Construction Battalion (Seabees) and possibly local contractors performed electrical work at the tents.

Conclusions

Further action is not warranted. Corrective action was taken against the noncommissioned officer who requested Private First Class Cutter repair the air conditioning unit.

Specialist Marcus O. Nolasco, United States Army

Specialist Marcus O. Nolasco was electrocuted while showering at Forward Operating Base Summerall, Bayji, Iraq, on May 18, 2004. The shower is shown in the figure below.



Figure 7. Shower Where Specialist Nolasco was Electrocuted (From Army Photographs)

Investigations

Investigations were completed in the case as follows:

Table 10. Investigations Completed in the Nolasco Case

Type	Report No.	Report Date
Armed Forces Regional Medical Examiner - Preliminary	A04-56	05/21/2004
Accident	2004-05-08-001	7/13/2004
USACIDC	0099-04-CID469-79661-5H8	8/3/2004
USACIDC-Corrected	0099-04-CID469-79661-5H8	12/21/2004 (Reopened)

The Incident

On May 2, 2004, a local Iraqi contractor completed renovations on a bathroom/shower facility. The scope of work under the contract did not provide for removing and replacing all wiring in the shower facility as indicated in the purchase request.⁵ More importantly, it did not require the local contractor to (1) meet any

⁵ The file is unclear as to whether the statement of work was part of the final contract or part of the Request for Proposal. We were unable to locate the complete final contract.

minimum or standard electrical code or requirement, (2) use new or certified parts or equipment in the renovation, or (3) provide any warranty on the quality of work performed or materials supplied for the contract.

The scope of work required the local contractor to provide and install, among other things, an above ground water storage tank, two hot water heaters, and a pressurized water system that included an automatic water pump.

On May 10, 2005, the contract was certified completed without any quality assurance representative (electrician, plumber, or other) inspecting the work, either while in progress or after completion, and payment was authorized. That same day, electrical shock incidents and plumbing problems began. The next day the showers were closed and locked. Four days later (May 14, 2004) a new contract was let to a different local contractor to correct the problems in the bathroom/shower facility. Information on the closing was not formally disseminated or announced, and a second key to the showers remained in circulation among the soldiers. Some leaders were aware that shower use and incidents of shocks continued after the facility was closed. Specialist Nolasco was electrocuted in the shower on May 18, 2004.

Observations

The investigations were adequate for the cause and manner of death determination, but not to establish the extent to which negligence may have caused or contributed to the death. Also unresolved were whether a Government contractor performing maintenance at the base was required to inspect the local contractors' work on the bathroom/shower facility when asked to do so. Investigations did not fully explore whether the command negligently took appropriate action to protect soldiers during the time the shower facility was closed for repair. They also did not determine how and why soldiers had a second key to the shower facility and continued using the facility after it was closed for repair, or why leaders did not post signs showing the shower was closed. The file does not include information on the new contract, but does indicate the new local contractor replaced one hot water heater that the first local contractor had installed.

Equipment

- Water Heater: Unknown nomenclature. Probably foreign made. Installed during April 3 – May 2, 2004, contract work to renovate the shower facility.
- Water Pump: Unknown nomenclature. Probably foreign made. Installed during the April 3 – May 2, 2004, contracted shower facility renovation.

(Note: An automatic water pump did not maintain water in water heaters, causing a heating element to rupture, resulting in electricity traveling through the metal water lines into the shower.)

Site Visit

We visited the site on October 4-5, 2008. The area where the electrocution occurred is now a small-compound type area outside the current Forward Operating Base Summerall. U.S. Forces no longer inhabit or use the area. The specific shower stall where the electrocution reportedly happened could not be located. Nothing involved in the incident remained for examination.

Government Contractor Involvement

The command did not request the repair from a Government contractor and instead contracted with a local foreign national firm. However, the command then asked a Government contractor to inspect the local contractor's work, indicating the Government contractor might have had some responsibility for the shower facility. The investigations did not resolve the question.

Conclusions

We concluded that further investigation was warranted, and on December 5, 2008, we referred the case to the Army for further examination. Based on our referral, USACIDC reopened its investigation. Conclusions concerning accountability and responsibility await completion of the investigation.

Hospital Corpsman Third Class David A. Cedergren, United States Navy

Hospital Corpsman Third Class David A. Cedergren died in a shower facility at Camp Iskandiriyah, Iraq, on September 11, 2004. The shower facility is shown below.



Figure 8. Shower Area Where Hospital Corpsman Cedergren Was Electrocuted (From Navy Photographs)

Investigations

Investigations were completed in the case, as follows:

Table 14. Investigations Completed in the Cedergren Case

Type	Report No.	Report Date
Command	Command Investigation into the Circumstances Surrounding the Death of Hospital Corpsman Third Class David A. Cedergren 477 08 0071/8404 U.S. Navy, on 11 September 2004.	01/07/2005
Armed Forces Institute of Pathology	ME 04-679	11/8/2004
Armed Forces Institute of Pathology	ME 04-679 (Amended)	08/18/2008
NCIS	15SEP04-MEBJ-0401-7HNA	11/29/2005 (Reopened)

The Incident

In the early morning of September 11, 2004, a Marine Corps lance corporal entered the shower facility and saw Hospital Corpsman Third Class Cedergren unconscious on the floor in a shower stall. He went for help without touching Hospital Corpsman Cedergren because he was concerned the body might be electrified. Upon returning to the site with help, he and others used a plastic poncho to pull Hospital

Corpsman Cedergren from the shower stall. The lance corporal subsequently explained to investigators that he previously had heard about several Marines and an Iraqi receiving electrical shocks while using the shower. Hospital Corpsman Cedergren was taken to the aid station where he was later pronounced dead.

The camp commandant told investigators that he had heard about incidents of shocks over the preceding 3 weeks, and had requested an inspection. The commandant said the military engineer who conducted the inspection removed an electrical wire that was touching a water pipe. The investigations did not report whether removing the wire solved the problem, or whether additional electrical shocks occurred after the inspection and before Hospital Corpsman Cedergren's death. After Hospital Corpsman Cedergren's death, the commandant requested another inspection from a different Marine Corps unit. The second inspection disclosed the camp's electrical system was unsafe, and identified several electrical deficiencies in or near the showers, including wiring that was not grounded.

None of the investigations determined who was responsible for erecting, wiring, or maintaining the shower facility.

An Armed Forces Medical Examiner autopsy and consultation with a heart specialist determined Hospital Corpsman Cedergren died from heart disease. The November 8, 2004, autopsy report categorized the death as from natural causes.

In July 2008, a Member of Congress contacted the DoD Inspector General on behalf of Hospital Corpsman Cedergren's family and asked for a review of the death investigations. As part of our review, we asked the Armed Forces Medical Examiner to examine its autopsy findings. Based on additional investigative information not available when the initial autopsy was completed, the Armed Forces Medical Examiner amended the initial autopsy findings. In an amended autopsy report dated August 18, 2008, the Armed Forces Medical Examiner categorized the manner of death as an accident, but held the death could have been caused by lymphocytic myocarditis (heart disease) or electrocution. As a result of the amended autopsy findings, the Naval Criminal Investigative Service reopened its investigation into the death.

Equipment

- Outdoor wooden showers with wood slat floors covered in chicken wire mesh. Photographs in the investigative files depict signage at the shower facility warning of "Danger" and "Electric Shock Hazard;" however, the signage is not explained.

Site Visit

On October 9, 2008, we visited the site. The wooden shower facility no longer existed, and people currently assigned did not know where it was previously located.

Government Contractor Involvement

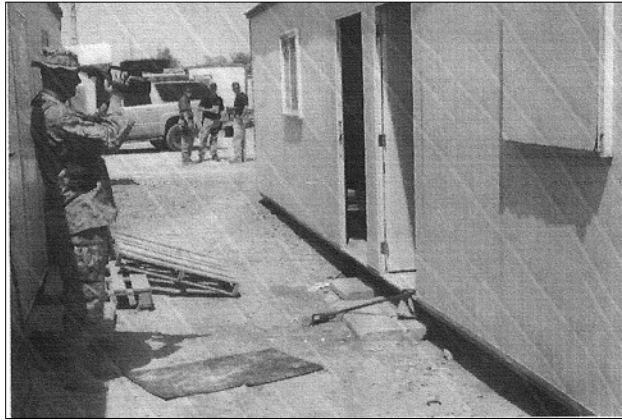
Original Government investigations did not establish responsibility for erecting, wiring, or maintaining the outdoor wooden shower facility.

Conclusions

NCIS reopened its investigation after we requested a review and the Armed Forces Medical Examiner revised its initial autopsy findings. The investigation was recently completed and is currently being reviewed by this Office.

Sohan Singh, Civilian Contractor Employee

Mr. Sohan Singh was electrocuted while attempting to enter his quarters at Fallujah Surgical, Camp Fallujah, Iraq, on July 19, 2005. The exterior of the quarters are shown in the figure below.



**Figure 9. Quarters Where Mr. Singh Was Electrocuted
(From Navy Photographs)**

Investigations

The following NCIS investigation was completed:

Table 12. Investigation Completed in the Singh Case

Type	Report No.	Report Date
NCIS	19JUL05MEBJ04607HMA/C	10/23/2005

Observations

Mr. Singh was a third country national (India) employed by a Kellogg, Brown, and Root (KBR) subcontractor Daoud & Partners.

The NCIS investigation determined that Mr. Singh or his roommate improperly installed an air conditioning unit sitting on the floor in Mr. Singh's living quarters. The electrical plug had been removed, and the wires "stripped and stuck" into an electrical receptacle connecting the neutral wire to a live feed, which caused the metal floor, walls and door to become electrified with 217.7 volts. Witness interviews revealed that Mr. Singh had been pouring water on his bare feet to rinse off dust immediately before attempting to open the door to his quarters, at which time he fell to the ground in a convulsion and became unresponsive. The investigation did not disclose any evidence of

foul- play. Mr. Singh's father requested return of the body to India without autopsy in compliance with custom and tradition. KBR complied with the request.

The investigation could have been significantly more thorough, but would not have altered the basic investigative finding that the electrocution was accidental. The accident resulted from human error.

Site Visit

We visited Camp Fallujah on October 8, 2008, but the area where the electrocution occurred bears little resemblance to the report of investigation photographs from July 2005.

Government Contractor Involvement

A DoD subcontractor employed Mr. Singh, but contracting issues were not involved in the electrocution.

Conclusions

Further investigation is unnecessary. Our review did not result in questions regarding the cause or manner of death determinations, or establish a basis for pursuing whether someone in the chain of command should be held accountable in Mr. Singh's death.

Sergeant Christopher L. Everett, United States Army

Sergeant Christopher L. Everett was electrocuted while using a power washer at Camp Taqaddum, Iraq, on September 7, 2005. The death scene is shown in the figure below.



Figure 10. Area Where Sergeant Everett Was Electrocuted (From Army Photographs)

Investigations

The Naval Criminal Investigative Service conducted the investigation until the U.S. Army Criminal Investigation Command arrived at the scene on September 11, 2005. NCIS continued logistical support until USACIDC completed the investigation and departed the area on September 28, 2005. Investigations were completed in the case as follows:

Table 15. Investigations Completed in the Everett Case

Type	Report #	Report Date
Command	Both an AR 15-6 Investigation and a Line of Duty Investigation were started, but combined into a single investigative report.	9/18/2005
Armed Forces Institute of Pathology	ME 05-0841	10/15/2005
USACIDC	SSI-0239-2005-CID259-36338-5H8	12/15/2005 (Reopened)
Accident	2005-09-07-002	5/10/2007

The Incident

In early August 2005, a contractor moved an electrical generator to replace an ineffective diesel generator. The new generator provided power for various nearby activities, including a power washer used to clean vehicles. Almost immediately, a military member without electrical or generator training connected the power washer to the new generator. Over the next 2 weeks, people who used the power washer received electrical shocks, including Sergeant Everett and a member of the base's generator repair team. A military maintenance supervisor told the same generator repair team member (who had no formal training in electricity or generator repair) to ground the generator. The team member inserted a grounding rod and connected it to the generator. The power washer continued to shock Service members, and they reported it. On September 7, 2005, Sergeant Everett was electrocuted using the power washer to clean a vehicle.

Observations

Our review of investigations into this matter disclosed significant unresolved testimonial conflicts between witnesses in the different investigations. Those conflicts included questions about how often and who connected or reconnected the power washer; the qualifications and training of the generator maintenance personnel; the efficacy of grounding techniques used; the protocol used in testing for ground; and the extent to which military leaders knew about the specific electrical hazard. Additionally, the investigations did not affirmatively establish responsibility for installing, maintaining, or connecting items to the generator.

Equipment

- Power Washer: Gerni brand, Model 482A, Serial Number: 030401000326 2003; Green, Black and Yellow in color, plastic and metal construction. Power washer had a black rubber hose and handheld washing wand attached.
- Generator:
 - Model and Serial Number: AX91375 and GAUJC027M, respectively. (Note: In some instances, the contractor's Power Generation Dept. Fault/Repair Sheets have the two numbers inverted, so we are unsure which is the model number and which is the serial number.)
 - KW = 400. KVA = 500.
 - Engine Model Number: 2806C-E16TA
 - Engine Serial Number: 2PXL15.8H16 or HGB061025U0 (Note: Some Power Generation Dept. Fault/Repair Sheets list the engine serial number as 2PXL15.8H16. Others list it as HGB061025U0. Also, some identify the engine as a "Perkins" brand name.)

Site Visit

On October 7-8, 2008, we visited the site. The maintenance area where the electrocution occurred no longer existed. Current personnel identified the area where the vehicle washing area had been located. The area is now a large empty lot used for parking vehicles.

Government Contractor Involvement

Questions remain as to whether a Government contractor was contractually responsible for maintaining the generator involved in the electrocution.

Conclusions

We concluded that further investigation was warranted and on December 5, 2008, referred the case to the Army for further examination and appropriate action. Based on our referral, USACIDC reopened its investigation. Conclusions concerning accountability and responsibility await completion of the investigation.

Sergeant Michael J. Montpetit, United States Army

Sergeant Michael J. Montpetit was electrocuted while attempting a generator repair at the Joint Security Station, Forward Operating Base Prosperity, Iraq, on June 22, 2007. The generator is shown in the figure below.



Figure 11. Generator on Which Sergeant Montpetit was Attempting Repair When Electrocuted (From Army Photographs)

Investigations

Investigations were completed in the case as follows:

Table 16. Investigations Completed in the Montpetit Case

Type	Report No.	Report Date
Accident	2007-06-22-001	07/04/2007
Armed Forces Institute of Pathology	ME 07-0797	08/05/2007
USACIDC	SSI-0149-2007-CID899-23061-5H8	09/13/2007

Observations

On June 22, 2007, Sergeant Montpetit and a co-worker arrived at the Joint Security Station, Forward Operating Base Prosperity, Iraq, to perform maintenance on a Caterpillar 800KW generator. The generator was backup power for the Joint Security Station. City electricity was the primary power. The previous night, the city feed wire sparked and caused a fire at the Joint Security Station. A Master Sergeant assigned to Headquarters and Headquarters Command, 2d Brigade Combat Team, 1st Calvary Division, turned the generator off and asked for maintenance assistance. According to

the safety report, Sergeant Montpetit and his co-worker were qualified generator repairmen, and had even repaired this particular generator before. With the generator running, Sergeant Montpetit was testing what are known as bus wires with an approved instrument. Sergeant Montpetit apparently came in contact with one of the live bus wires and collapsed. The Master Sergeant who requested the maintenance began cardiopulmonary resuscitation while Specialist Montpetit's co-worker went for medical assistance. Sergeant Montpetit never regained consciousness and was later pronounced dead. All three soldiers were in full battle gear, including individual body armor and ammo pouches.

The accident review board found that Sergeant Montpetit accidentally touched one or more hot bus bars and received an electrical shock through his body, which killed him.

- a) The generator was producing over 400 Volts and pushing about 230 volts to each bus bar.
- b) The burn marks on the back of his hands, indicate that Sergeant Montpetit touched one or more bus bars and was electrocuted as a result. . . .

The safety report noted:

. . . The battle gear worn at the time of the accident may have inadvertently made contact with the buss. The gear extends out from the body and the wearer can be unaware of the space that it occupies. If the gear and the wearer is moist with perspiration and the wearer is effectively grounded it can make unintentional but effective point of conduction. . . .

. . . [Sergeant]Montpetit perspired heavily. This made his skin and body an easier conductor of current and presented a low resistance for the voltage to go to ground. . . .

The safety report, however, also noted:

. . . A week before the accident 15th BSB [Base Support Battalion] fixed an oil leak on the generator's engine. During the visit by the safety team, the electrical engineer noted that the generator was not properly grounded and the Iraqis had placed three feed wires to provide one-phase electricity to some of the buildings on the compound. . . .

. . . The generator can be accessed by Iraqis on the compound who have connected wires and possibly removed the grounding wire. . . .

As a result, the safety investigation concluded that improper grounding may have contributed to the severity of the injuries. The basic finding, however, is that a trained mechanic accidentally touched one or more bus wires carrying 230-400 volts each with the back of his right hand and was electrocuted while performing maintenance on a

powerful generator. Proper grounding would not have prevented the resulting death. The investigations establish that this electrocution was a tragic accident.

Equipment

Caterpillar 800 KW generator--Nomenclature unknown. Installation/maintenance--15th Base Support Battalion.

Site Visit

Forward Operating Base Prosperity no longer existed, and we did not visit the former JSS site.



Figure 12. Site Map Showing Area Where Sergeant Montpetit Was Electrocuted (From Army Report of Investigation)

Conclusions

Further action is not warranted. Our review did not result in questions regarding the cause or manner of death determinations, or establish a basis for pursuing whether someone in the chain of command should be held accountable for Sergeant Montpetit's death.

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Appendix A. U.S. Military or Contractor Personnel Electrocuted in Iraqi March 2003 through March 2009

No.	Rank	Date	Synopsis	Code
U.S. ARMY				
A1	CPT (O3)	18-Sep-03	Balad ~Soldier inadvertently grabbed power lines and was fatally injured when he tried to lift/move power lines while on top of Bradley vehicle.	PL
A2	SGT (E-5)	24-Dec-03	Kirkuk ~Electrocuted while running a communication cable in Kirkuk after he accidentally touched power line while trying to repair telephone wire.	PL
A3	PFC (E-3)	19-Mar-04	Babqubah ~ Electrocuted while running telephone wires. Metal ladder hit a power line.	PL
A4	SPC (E-4)	17-Apr-04	Samarra ~ Electrocuted while working on a generator at a Coalition base in Samarra, generator was not properly grounded.	G/E
A5	SPC (E-4)	8-May-04	Mosul ~ Died near Mosul in an electrical accident after he touched a metal pipe used to pump water into pool, and pump motor shorted out and was not properly grounded. No apparent KBR involvement. USACIDC investigation remains open.	G/E
A6	SPC (E-4)	18-May-04	Bayji ~ Died after an electrical accident while taking a shower. Water heater shorted out and was not grounded. KBR not involved. USACIDC investigation remains open.	G/E
A7	SGT (E-5)	7-Sep-05	Baghdad ~ Electrocuted while laying on aluminum pallets power washing the bottom of vehicles. Power washer was hooked directly to a generator with no circuit breakers or safety measures. Responsibility not clear. USACIDC investigation remains open.	G/E
A8	SPC (E-4)	12-Apr-07	Baghdad ~ Received an electrical shock while emplacing a concrete T-wall at COP Pathfinder and his crane hit a power line.	PL
A9	SGT (E-5)	22-Jun-07	Baghdad ~ Electrocuted while performing maintenance check on a generator and was hooking up equipment from power line to generator.	G/E
A10	SSG (E-6)	2-Jan-08	Baghdad ~ Electrocuted while in the shower as a result of an ungrounded water pump that shorted. USACIDC titled 2 KBR employees for criminal negligence. MNFI SJA determined insufficient for prosecution. USACIDC investigation remains open.	G/E
U.S. MARINE CORPS				
M1	LCPL (E-3)	2-Apr-03	An Nasiriyah ~ While manning a .50 caliber rifle on top of a 7-ton truck, he was electrocuted when the vehicle snagged low hanging power lines.	PL
M2	PFC (E-2)	13-May-04	Fallujah ~ Failed repair. Found on the ground clutching a box containing air conditioning power supply unit. No KBR involvement.	G/E
M3	SGT (E-5)	28-Jan-05	Camp A1 Taqaddum, Iraq ~ While assigned to a Route Recon Convoy that was conducting a search for unexploded ordnance, came in contact with a low hanging electrical wire and was electrocuted.	PL
M4	2LT (O-1)	4-Nov-06	Camp Rawah, Iraq ~ Assisting in improving a battle position on top of a roof structure when he fell approximately six feet from a cupola to the roof. Before or during his fall, he contacted power lines and was electrocuted.	PL
M5	LCPL (E-3)	16-Apr-07	Camp Al Asad, Iraq ~ While riding in the gun turret of a 7- Ton Truck, he was electrocuted after touching a low hanging electrical wire.	PL
U.S. NAVY				
N1	HM3 (E-4)	11-Sep-04	Camp Iskandariyah, Iraq ~ Found in an outdoor shower stall not breathing and without a pulse. A command inspection of the shower stalls deemed the showers dangerous for electrical shock. AFIP changed cause of death. NCIS investigation ongoing.	G/E
CONTRACTORS				
C1	Mr (Foreign National)	19-Jul-05	Baghdad ~ Individual was electrocuted when he grabbed the door knob to his room. The knob and door was electrified by an improperly installed window air conditioning unit installed by other occupants of his quarters.	G/E
C2	Mr (Foreign National)	24-Feb-08	Baghdad ~ While working at a construction site, swung a metal pipe that hit a power line and made him fall off a wall.	PL

LEGEND: PL = Individual killed by touching a power line G/E = Individual killed by improper grounding / faulty equipment

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