



DEPARTMENT OF THE NAVY
UNITED STATES FLEET FORCES COMMAND
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5830
Ser N01L/099
25 Oct 22

FINAL ENDORSEMENT on (b)(6) ltr 5830 of 13 Jun 22

From: Commander, U.S. Fleet Forces Command
To: File

Subj: INVESTIGATION INTO PROXIMATE CAUSES OF, AND ANY CORRELATION
BETWEEN, THE DEATHS OF THREE USS GEORGE WASHINGTON (CVN 73)
SAILORS ON OR ABOUT APRIL 2022

1. I thoroughly reviewed the subject investigation and the endorsements. I approve the findings of fact, opinions, and recommendations as previously endorsed and as modified below.

2. Preliminary Statement:

a. I extend my deepest condolences to the shipmates, friends, and families of RS3 Mika'il Sharp, IC3 Natasha Huffman, and MASR Xavier Mitchell-Sandor. Every death by suicide is a tragedy that impacts our people, our military units, and our readiness. The tragic loss of our shipmates is keenly felt and they will not be forgotten.

b. This investigation was convened with the specific design to determine the proximate cause and the potential connection, if any, surrounding the deaths of three Sailors attached to USS GEORGE WASHINGTON (CVN 73) (GW) in April of 2022. Based on my review, I conclude these three suicides were independent events and that there was no direct correlation between these three deaths.

c. While I concur with the overall conclusions of the investigation, this specific investigation is insufficient in addressing the overarching Quality of Service (QoS = Quality of Life + Quality of Work) concerns associated with crews assigned to units conducting extended maintenance and construction periods in public and private shipyards. As such, I look forward to the findings and recommendations that result from Commander, Naval Air Forces Atlantic's (CNAL) broader investigation to assess the QoS challenges for the crews of aircraft carriers. Given the Refueling and Complex Overhaul (RCOH) process, while limited to nuclear-powered CVNs, is one of the most intense in duration and complexity of any maintenance process in the Fleet, I am confident that this broader QoS assessment will have general and scalable application across the Navy for crews assigned to any vessel undergoing prolonged, depot maintenance, or new construction availabilities.

d. I modify Commander, Naval Air Force's (CNAF) recommendation 34. I agree that the results of this investigation should be given to OPNAV N17 in order to use Get Real Get Better principles to better align Warrior Toughness and E-OSC programs; however, the alignment

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effort should be extended to also include all Culture of Excellence (COE) and Total Sailor Fitness (TSF) programs using the CNO's Navigation Plan Implementation Framework (NIF) process in order to streamline, reduce complexity, and eliminate redundancies. I also recommend this investigation and endorsements be turned over to the Learning to Action Board (L2AB) for its oversight function to ensure actions are tracked to closure. The potential lessons learned and corrective actions, specifically those associated with new Sailors being brought into the Fleet, apply broadly to all Navy commands.

3. Findings of Facts (FF):

- a. I concur with all FF, as modified by CNAF and CNAL, except as listed below.
- b. I do not concur with FF 243c. FF 243c is deleted.
- c. I do not concur with FF 243j. FF 243j is deleted.
- d. I do not concur with FF 243k. FF 243k is deleted.
- e. I do not concur with FF 243l. FF 243l is deleted.
- f. I do not concur with FF 243m. FF 243m is deleted.
- g. I do not concur with FF 243n. FF 243n is deleted.
- h. I do not concur with FF243o. FF 243o is deleted.
- i. FF 243r is added: "No one at the command knew, or had a reason to know, of MASR Mitchell-Sandor's previous suicidal ideations." [Encls (38), and (64)].

4. Opinions:

- a. Opinion 33 is modified and substituted with the following: "Had the Navy been aware of MASR Mitchell-Sandor's previous suicidal ideations, existing programs and procedures were in place that make it likely that he would have been placed in a "do not arm" status and received necessary care."

5. Recommendations:

- a. Recommendation 38 is added. "Recommend OPNAV N1, in conjunction with the action required in Recommendation 29, coordinate with the United States Marine Corps' High Risk Sailor Identification Initiative to develop a risk management tool for Commanding Officers to use in order to define, identify, manage, and oversee high risk Sailors more effectively and transparently within their command and during transfer processes (e.g., PCS, LIMDU, etc.)."

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b. I approve all recommendations as modified by CNAF and my endorsement. I further direct completion of all recommendations in accordance with the timeline established by CNAF. A copy of this report will be provided to Defense Health Agency (DHA), OPNAV N1 (for further delegation to OPNAV N17, CNPC, RTC, MEPC as required) and CNIC for their action on applicable Recommendations.

6. My point of contact is (b)(6), and he may be reached at (b)(6)
(b)(6), or (b)(6).



D. L. CAUDLE

Copy to:
ALL PREVIOUS ENDORSERS
DHA
OPNAV N1
CNIC
L2AB



CUI

DEPARTMENT OF THE NAVY
COMMANDER NAVAL AIR FORCE
UNITED STATES PACIFIC FLEET
BOX 357051
SAN DIEGO CALIFORNIA 92135-7051

5830
Ser N00/337
12 Sept 22

SECOND ENDORSEMENT on (b)(6) ltr 5830 of 13 Jun 22

From: Commander, Naval Air Force, U.S. Pacific Fleet
To: Commander, U. S. Fleet Forces Command

Subj: INVESTIGATION INTO PROXIMATE CAUSES OF, AND ANY CORRELATION
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Ref: (p) COMNAVAIRPAC/COMNAVAIRLANTINST 5103.1, Command Resilience Team Human
Factors Council
(q) COMNAVAIRPAC/COMNAVAIRLANTINST 3300.53A, Antiterrorism Program
(r) COMMAND RESILIENCE TEAM GUIDE, 26 June 2018

1. Forwarded, concurring with the findings, opinions, and recommendations of the investigating officer (IO) as modified by the First Endorsement, and as further modified below.

2. Preliminary Statement

a. I extend my deepest condolences to the families and loved ones of RS3 Mika'il Sharp, IC3 Natasha Huffman, and MASR Xavier Mitchell-Sandor. The entire Navy family shares in the grief of their loss.

b. I concur with Commander, Naval Air Force Atlantic's (CNAF) convening of a second, broader investigation to assess the quality of life challenges for our aircraft carriers undergoing extensive maintenance or construction in the shipyard.

c. The Sailor care programs, and policies discussed throughout this GW investigation apply to all Naval Aviation commands. I direct command triads to read this investigation and the endorsements and critically self-assess their own command resiliency using their Command Resiliency Teams and Human Factors Councils (CRT-HFCs). CNAF, in turn, will review Culture of Excellence (CoE) training writ large across the Naval Aviation leadership training continuum, from accession sailor through Major Commander, to better understand the efficacy in our CoE content, timing, and delivery method. CNAF will forward the results of this review to OPNAV N17 to form a combined working group using Get Real Get Better principles to simplify and align all CoE training. We cannot assume these issues are isolated to a single ship, or to shipyards alone. Rather, these three tragic losses brought to light the ultimate need to remain laser-focused on providing care and guidance to our Sailors.

3. Discussion Section

a. I concur with the discussion paragraphs as modified by the first endorsement, and the report's overall conclusions that the three deaths were caused by self-inflicted injuries (i.e., suicide) and that there was no correlation between the three deaths.

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4. Findings of Fact (FF)

- a. I concur with all FF as modified by CNAL. No additional FFs are submitted.

5. Opinions

- a. I concur with all opinions as modified by CNAL, except as listed below.

b. Opinion 26 is modified and substituted with the following: "Departmental leadership failed to properly address and document disciplinary infractions committed by MASR Mitchell-Sandor, which would have provided reason and means for the chain of command to suspend MASR Mitchell-Sandor's authorization to carry a firearm per reference (q). Additionally, properly addressing and documenting disciplinary infractions would have provided leadership with the ability to identify that MASR Mitchell-Sandor was struggling to adapt to shipboard and shipyard life, and to determine what appropriate corrective actions were needed, what resources MASR Mitchell-Sandor might require, and review suitability for continued naval service."

c. Opinion 31 is modified by replacing the word "hindsight" with "command programs such as The Command Resilience Team Human Factors Council (CRT-HFC)" – i.e., "With the benefit of hindsight command programs such as The Command Resilience Team Human Factors Council (CRT-HFC) multiple command members knew or should have known that MASR Mitchell-Sandor was experiencing displeasure with Navy life and could have intervened to help him better cope or seek out available support services."

6. Recommendations

- a. Recommendation 1 is concurred with as written.

Action Update: As of 12 September 2022, CNAF directed all CVNs and Naval Aviation Units to have a minimum of one safeTALK trained member onboard, recommend 2 to 3 safeTALK trained personnel in each division, reporting completion to their administrative ISIC no later than 31 December 2022.

- b. Recommendation 2 is concurred with as modified by CNAL.

Action Update: GW reported completion of this action item. As of 12 September 2022, CNAF directed all CVNs and Naval Aviation Units to conduct an aggressive advertising strategy designed to promote mental health reporting, to include locations and contact information for resources in their local area, reporting completion to their administrative ISIC no later than 31 October 2022.

c. Recommendation 3 is concurred with as modified by CNAL, with additional modification deleting the last sentence and replacing with the following: RCOH ships should be properly staffed with ASIST-trained personnel in a ratio congruent with the size of the ships' departments and divisions prior to entering and throughout the duration of the shipyard environment with strong consideration of training all leading petty officers (LPOs), leading chief petty officer (LCPOs) and Division Officers. RCOH ships should also train additional Assistant Suicide Prevention Coordinators (SPC). The RCOH ship's SPC should report number of ASIST trained personal each month to the TYCOM Suicide Prevention Program Manager (SPPM).

Action Update: As of 12 September 2022, CNAF directed all CVNs and Naval Aviation Units to have at least one ASIST-trained person onboard, recommend 2 to 3 ASSIST trained personnel in each division, reporting completion to their administrative ISIC no later than 31 December 2022.

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d. Recommendation 4 is modified to add this concluding sentence: Recommend CNIC review and amend CNICINST 1754.3A to include a role for TYCOM oversight of DRC allocation to CVNs/LHDs/LHAs.”

e. Recommendation 5 is concurred with as modified by CNAL, with additional modification adding the following after the last sentence: “While location of the DRC on the ship provides more physical proximity, there should be consideration of the advantages to location of the DRC off-site (i.e. at the Bank Building) such as quieter and more comfortable office spaces away from the industrial shipyard environment stressors.”

f. Recommendation 6 is concurred with as modified by CNAL, with additional modification adding the following after the last sentence: “The DRC, Chaplain, and mental health provider are all required members of the Command Resilience Team (CRT) where they have the duty and opportunity to apprise command leaders of common trends, including increases in destructive behaviors.”

g. Recommendation 7 is concurred with as written.

Action Update: As of 12 September 2022, CNAF directed all CVNs and Naval Aviation Units to conduct a comprehensive review of their sponsorship program, reporting completion to their administrative ISIC no later than 31 December 2022.

h. Recommendation 8 is concurred with as written.

Action Update: As of 12 September 2022, CNAF directed all CVNs and Naval Aviation Units to conduct a comprehensive review of their mentorship program, reporting completion to their administrative ISIC no later than 31 December 2022.

i. Recommendation 9 is concurred with as written.

j. Recommendation 10 is modified and substituted with the following: “Command Resilience Teams (CRT) are required to meet quarterly as a minimum per reference (b). Recommend the GW Command Resilience Team (CRT) meet monthly until completion of RCOH. In accordance with reference (r), the CRT’s function is to provide the commander with information and insight into concerns of command personnel in order to implement positive measures to promote well-being and resilience. Recommend CRT team consist of various junior ranks, per reference (r) and consist of a cross-section of paygrades, sex, race, and departments.”

k. Recommendation 11 is concurred with as modified, replace “or” with “and” in the first sentence to read as follows: “Recommend the GW CRT maintain a Quarterly ~~or~~ and Semi-Annual Prevention Scorecard.”

l. Recommendation 12 is concurred with as written.

m. Recommendation 13 is concurred with as written.

n. Recommendation 14 is concurred with as written.

o. Recommendation 15 is concurred with as written.

p. Recommendation 16 is concurred with as written.

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q. Recommendation 17 is modified and substituted with the following: "Per reference (p), the CRT-Human Factors Council (CRT-HFC) is required to meet quarterly, or more frequently as needed. Recommend GW execute monthly CRT/HFCs until completion of RCOH to review at risk sailors that have been forwarded by their respective Engaged Deckplate Leaders (EDLs). In addition to reference (p) requirements, recommend EDLs conduct monthly individual Sailor reviews for all personnel assigned to the security department and all personnel that have direct access to or handle weapons, regardless of the Sailor's previous month risk assessment, to recommend an additional Arms, Ammunition and Explosives (AA&E) screening if the Sailor's circumstances suggest that a review would be prudent, per reference (q)."

r. Recommendation 18 is concurred with as modified by CNAL, with additional modification to replace "Commander, Naval Air Force Atlantic (CNAL)" with "Commander, Naval Air Forces (CNAF)".

Action Update: As of 12 September 2022, CNAF directed all CVNs and Naval Aviation Units to review and ensure compliance with PACFLT (PACADMIN 232239Z FEB 16) and USFFC (ALFLTFORCM GENADMIN 171401Z JUN 21) that mandates use of the SITREP Data Tool (SDT) for drafting all personnel incident OPREP-3 UNIT SITREPs and OPREP-3 NAVY BLUE reports to enable accurate accounting and tracking by PACFLT and USFFC.

s. Recommendation 19 is concurred with as written.

t. Recommendation 20 is concurred with as written.

u. Recommendation 21 is concurred with as written, and concur with CNAL comments.

v. Recommendation 22 is substituted with the following: "Recommend BUMED (Naval Medical Forces Pacific, and Naval Medical Forces Atlantic) review the policies, instructions, and procedures required for sailors to transfer their primary care provider and specialty consultation care from CNAF to shore side MTF and/or civilian care. Emphasis of the review should include identifying common mistakes, challenges and barriers sailors encounter when transferring their care, with the intent of BUMED to provide Type Commanders and Commanding Officers a standardized and easy to follow set of instructions that can be provided to sailors and overseen by the individual's command."

w. Recommendation 23 is concurred with as written.

x. Recommendation 24 is concurred with as written.

y. Recommendation 25 is concurred with as written.

z. Recommendation 26 is concurred with as written.

aa. Recommendation 27 is concurred with and modified to add: "Recommend all CVN COs request at least one MFLC to provide additional non-medical counseling support to augment shipboard mental health services. The MFLC contract is centrally managed by the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy."

bb. Recommendation 28 is concurred with as modified by CNAL.

cc. Recommendation 29 is concurred with as written.

dd. Recommendation 30 is concurred with as written.

ee. Recommendation 31 is concurred with as written.

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ff. Recommendation 32 is concurred with as written.

gg. Recommendation 33 is concurred with as written.

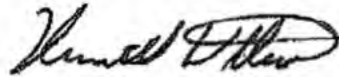
hh. Recommendation 34 is added: (b)(5)

ii. Recommendation 35 is added: "Recommend DHA create a process for ensuring treatment records of Active Duty Sailors seen in the Tricare network are entered into the Service member's electronic medical record (i.e., AHLTA, MHS GENESIS) to facilitate continuity of care as well as ensure the provision of safe and quality care by Navy Medicine providers."

jj. Recommendation 36 is added: "Recommend senior leaders receive training on generational differences in communication and thinking styles to acquire generational intelligence to connect and engage with younger Sailors (e.g., embed training module within curriculum at Navy Leadership and Ethics Command)."

kk. Recommendation 37 is added: "Recommend CNAF Culture of Excellence (CoE) team develop a checklist of all the various CoE programs and Sailor support programs, to include sponsorship and mentorship programs, and schedule CNAF Assist Visit Team annual inspections of all CVN and Naval Aviation Units to ensure program compliance and enable learning through dissemination of best practices."

7. My point of contact is (b)(6), and he may be reached at (b)(6),
or (b)(6).



K. R. WHITESELL

Copy to:
CNIC
COMNAV ARLANT



CUI

DEPARTMENT OF THE NAVY
COMMANDER NAVAL AIR FORCE ATLANTIC
1562 MITSCHER AVENUE SUITE 300
NORFOLK VA 23551-2427

5830
Ser N01L/230
25 Jul 22

FIRST ENDORSEMENT on (b)(6) ltr of 13 Jun 22

From: Commander, Naval Air Force Atlantic
To: Commander, U.S. Fleet Forces Command
Via: Commander, Naval Air Forces

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Ref: (h) DoDM 5200.02, Procedures for DoD Personnel Security Program
(i) SECNAVINST 1730.9A, Privileged and Confidential Communications to Chaplains
(j) OPNAVINST 1720.4B, Suicide Prevention Program
(k) DoD Annual Suicide Report for Calendar Year 2020
(l) CNICINST 1754.3A, Deployed Resiliency Counselor Program
(m) BUMEDINST 6010.33, Organizational Incident Operational Nexus
(n) OPNAVINST 5350.4E, Navy Alcohol and Drug Misuse Prevention and Control
(o) DoDI 1332.14, Enlisted Administrative Separations

Encl: (56) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6)
(b)(6) (hereinafter "Friend #1")
(57) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6)
(b)(6) (hereinafter "Friend #2")
(58) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6)
(b)(6) (hereinafter "Friend #3")
(59) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of GW
Command Chaplain
(60) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of
MASR Mitchell-Sandor's High School Class Counselor
(61) CNAF Force Special Security Officer email of 23 Jun 22
(62) CNAF Force Psychologist email of 12 Jul 22
(63) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of
MASR Mitchell-Sandor's step-brother
(64) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of
MASR Mitchell-Sandor's Aunt and Uncle #2
(65) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6)
(b)(6) (hereinafter "girlfriend")

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(66) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6) (b)(6) (hereinafter "Friend #4")

(67) USS George Washington (CVN-73) Command DAPA e-mail of 19 Jul 22

1. Forwarded, concurring with the findings, opinions, and recommendations of the investigating officer (IO), as modified below. Enclosure (56) through (67) were received following completion of the investigation and are enclosed herein.

2. Preliminary Statement

a. On May 4, 2022, I convened a second and broader investigation to assess the various quality of life issues and other systemic issues for our aircraft carriers currently undergoing extensive maintenance or construction in the shipyard in Newport News, VA. This includes a review of the crew move aboard decision, availability of outside lodging/berthing facilities, and other circumstances unique to shipyard life (e.g., noise, personal security, parking, access to shopping and dining services, onboard messing and berthing, cell phone and internet connectivity, laundry services, showers, heads, etc.). That investigation is currently in progress, and I cannot presuppose the outcome, but it is safe to say that generations of Navy leaders had become accustomed to the reduced quality of life in the shipyard, and accepted the status quo as par for the course for shipyard life. Although two of the three deaths appear unrelated to life onboard the ship, it appears that MASR Mitchell-Sandor's quality of life was negatively impacted by the material condition of the ship and lack of shipboard amenities. I agree with the IO that the general stress of the shipyard environment was not the root cause of these deaths, but it was certainly a contributing factor in MASR Mitchell-Sandor's case. The report from this follow-on investigation will help to bring to light these systemic issues with an eye towards making lasting change.

b. The current investigation is limited to the facts and circumstances to the extent information was available to the Navy. Currently, the Naval Criminal Investigative Service (NCIS) and local police departments are still investigating the causes of death for these service members. Therefore, if the law enforcement investigations develop new information relevant to the scope of this investigation, it will need to be reviewed and incorporated into the final endorsement, as necessary.

c. Enclosure (41) is NCIS's interim report of investigation, which NCIS agreed to share with the IO. This enclosure contains graphic photographs. Additionally, the added enclosures (56) through (60) and enclosures (63) through (66) were also provided by NCIS. Until NCIS completes their investigation and authorizes release, the enclosures are Controlled Unclassified Information, are law enforcement sensitive, and are exempt from disclosure under the Freedom of Information Act (FOIA). Pursuant to FOIA, the remainder of the investigation is publically releasable after appropriate redactions are made to protect privacy sensitive and other FOIA-exempt information.

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3. Discussion Section

a. I concur with the first two discussion paragraphs and the report's overall conclusions that the three deaths were caused by self-inflicted injuries (i.e., suicide) and that there was no correlation between the three deaths.

Discussion Pertaining to RS3 Sharp

b. RS3 Sharp. I concur with the discussion section relating to RS3 Sharp, as modified below.

(1) The second sentence of discussion paragraph 3 is modified to change the word "in" to "on" — i.e., "He enlisted in the Navy on 10 June 2020."

(2) The last sentence of discussion paragraph 8 is modified to add the word "likely" before the word "pushed" — i.e., "likely pushed him to the decision that suicide was his only way out."

Discussion Pertaining to IC3 Huffman

c. IC3 Huffman. I concur with the discussion section relating to IC3 Huffman.

Discussion Pertaining to MASR Mitchell-Sandor

d. MASR Mitchell-Sandor. I concur with the discussion section relating to MASR Mitchell-Sandor, as modified below.

(1) The second sentence of discussion paragraph 16 is modified to change the word "in" to "on" — i.e., "He enlisted in the Navy on 24 Aug 2021."

(2) The first sentence of discussion paragraph 18 is modified to change the word "and" to "but" — i.e., "MASR Mitchell-Sandor had multiple opportunities to change or improve his living situation, ~~and~~ but chose not to.

(3) Discussion paragraph 18, though apparently true, places too much emphasis on MASR Mitchell-Sandor's personal decisions to not improve his own living conditions, and therefore places too much of the burden on him for his situation onboard the ship. The below discussion paragraphs are added to provide context to this very junior Sailor's position onboard his first ship. As senior Sailors, it is easy to forget our Navy life in the beginning. As officers with no enlisted experience, it is easy to lose sight of how powerless one might feel as the most junior member of a crew. Even as midshipmen on our summer enlisted cruises, we had the relative safety and companionship of the other midshipmen who were with us. It appears MASR felt truly alone, and at least onboard the ship, was living all alone.

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(i) Discussion Paragraph 18a is added: MASR Mitchell-Sandor was onboard only three months prior to taking his life. At 18 years of age, he was placed into the austere and industrial shipboard environment that is typical of all Navy ships. As every sea-going Sailor has experienced, those first days and months onboard ship are a difficult transition period. To live and work in this environment is challenging even when a ship is at its highest levels of material readiness. The USS George Washington (hereinafter “GW”) was not in a high level of material readiness. The environment onboard an aircraft carrier can be even more daunting due to the sheer size of the ship. Experienced Sailors can find simply navigating the ship difficult. The shipyard environment only compounds the challenges for a young new Sailor like MASR Mitchell-Sandor to assimilate and see the ship as a new home. With limited places to sit and relax, and without television services, there is little for Sailors to do onboard other than work. [FF 18a, 18b, 258, 259, 260, 261, 266, 268-270, 288, 351, and 352]

(ii) Discussion Paragraph 18b is added: Though MASR Mitchell-Sandor was offered the opportunity to change berthings to improve his living conditions, he declined. Often Sailors will choose to avoid the hassle of moving their belongings around the ship; however, for a brand new 18-year-old Sailor, more senior Sailors, sponsors, or mentors should have helped him to understand his options and encouraged him to relocate. From a safety standpoint alone, allowing a brand new Sailor to choose to be alone in a berthing lacking basic amenities is unsatisfactory. Senior enlisted leadership knew that MASR Mitchell-Sandor was sleeping in his car and counseled him, but there is no evidence of any follow through to understand the root cause for his decision making. More senior Sailors or an assigned mentor should have been there to support him and help him make decisions that were in his best interests. This was a time for intrusive leadership. [FF 258, 259, 260, 261, 266, 268-270, 288, 288a, 288b, 351, and 352]

(4) Discussion paragraph 25 is modified to change the word “would” to “may” — i.e., “This ~~would~~ may have provided the chain of command an opportunity to identify that MASR Mitchell-Sandor was struggling to adapt to military life . . .”

(5) Discussion paragraph 31 is modified by adding reference to enclosure (62) and findings of fact FF 332a and 332b.

(6) The last sentence of discussion paragraph 34 is modified and substituted with the following: This, coupled with the detrimental effects of chronic sleep deprivation and fatigue, may have led MASR Mitchell-Sandor to his belief that suicide was the only option. His ready access to a firearm provided the means for him to follow through with his suicidal intent. [FF 239, 262, 319-331, 342-344, 362-365, and 369-373]

(7) In light of the new evidence provided in the added enclosures, discussion paragraph 35 is modified and substituted with the following: MASR Mitchell-Sandor’s suicide was contemplated and planned in advance. Both in basic training and during his time at master-at-arms “A” school, he asked his then-girlfriend if she would attend his funeral. On a separate occasion, he told his then-girlfriend that he saw his step-brother’s firearm in the dresser drawer at home and contemplated using it to end his life. The step-brother corroborates this with his own

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account of finding his room torn apart and MASR Mitchell-Sandor holding his step-brother's firearm. His step-brother grabbed him and took the gun from his hand. Mitchell-Sandor was crying and stated that he did not want to go back to the ship. The step-brother told his parents of the incident with the gun and they told him that they would take care of it — the incident was never spoken about again. This event occurred on or about 14 February 2022 — approximately two months prior to his death. The day prior to his death, MASR Mitchell-Sandor took two of his home-town friends out to breakfast and lunch, and paid for each of their meals. One friend described this as being out of the ordinary for him. MASR Mitchell-Sandor also told them that he felt “trapped” in the Navy, and that if he left the Navy, the Federal Bureau of Investigation (FBI) would come after him. His parents also confirmed that this trip home was off-schedule, unexpected, and out of the ordinary. On his way back to the ship for the final time, he sent a text message to his girlfriend stating that he was having a mental breakdown, was very upset, and wanted out of the Navy. His final communications with friends and family was a text to his parents. His final text message is long, thought-out, well-written, and contains specific instructions as to where he wants to be buried. While it is possible this may have been composed in the hour or so prior to MASR Mitchell-Sandor taking his life after he last spoke to his father on the phone, it is more likely he had composed this message days in advance, given its clarity and how much detail and effort he put into it. On the night he intended to take his life, MASR Mitchell-Sandor armed up for watch, and spoke with MA2 (#2) one last time to get advice regarding his concerns, but ultimately decided to continue with his plan. He removed himself from others by entering the male head (bathroom), where he would have some privacy and where his female roving partner could not follow. Between 2000 hours and 2100 hours he called his father on the phone and sent a video message to Friend #3. In both instances he was believed to have been crying. He sent his final text message, and used his Navy-issue firearm to shoot himself in his left temple, which ultimately ended his life. [FF 243e-243i, 243k, 243k, 244d, 244e, 333a-333d, 340a, 348-383, 360-362]

4. Findings of Fact (FF)

General Facts

a. FF 14 is modified to replace the word “normal” with “common” — i.e., “Noises such as the sounds of needle gunning, bells going off, frequent announcements on the ship’s main circuit public announcement system (1MC), grinding, etc., are ~~normal~~ common.”

b. FF 18a is added: Morale, Welfare, and Recreation services, such as television, were not available onboard. [Encl (35)]

c. FF 18b is added: For crew residing onboard, there were limited places to sit and relax. [Encl (35)]

d. FF 52 is modified to replace the word “component” with “competent” — i.e., “While an “appropriate ~~component~~ competent authority” is to decide whether behavior qualifies as suicide-related behavior . . .”

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e. FF 66 is modified by replacing it with the following: Due to restrictions related to the COVID-19 pandemic, MWR events had previously been shut down and, at the time of this investigation, were only beginning to bring these types of events back online.

Facts Pertaining to RS3 Sharp

f. I concur with the findings of fact related to RS3 Sharp, as modified below. FF 84a is added: The GW Drug and Alcohol Program Advisor (DAPA) had no records regarding alcohol abuse by RS3 Sharp. [Encl (67)]

Facts Pertaining to IC3 Huffman

g. I concur with the findings of fact related to IC3 Huffman, as modified below.

(1) FF 130 is modified by adding enclosure (61) and replacing the last sentence with the following: This suicide attempt was not reported in the Defense Information Service System (DISS). Pursuant to reference (h), reporting of information that suggests an individual may have an emotional, mental, or personality condition that impairs judgment, reliability, or trustworthiness are required to be reported in DISS. [Encls (8), (10), (48), and (61)]

(2) FF 177 is modified by replacing “who” with “whom” —i.e., “~~who~~ whom he allegedly tried to choke.”

Facts Pertaining to MASR Mitchell-Sandor


h. I concur with the facts pertaining to MASR Mitchell-Sandor, as modified below.

(1) FF 241a is added: Uncle #2 stated that MASR Mitchell-Sandor was unhappy during “A” school due to the restrictions of the training schedule. [Encl (64)]

(2) FF 243a is added: During basic training, MASR Mitchell-Sandor was engaged in a long-distance romantic relationship with Friend #1. [Encl (56)]

(3) FF 243b is added: MASR Mitchell-Sandor’s relationship with Friend #1 ended less than a month prior to his death (sometime in March 2022). [Encl (56)]

(4) FF 243c is added: (b)(5)

A large rectangular area of the document is redacted with a solid grey fill, covering several lines of text.

(5) FF 243d is added: Friend #1 stated that when she was dating MASR Mitchell-Sandor, that both in basic training in his “A” School, he would ask her if she would attend his funeral. [Encl (56)]

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(6) FF 243e is added: Friend #1 recalled a phone call with MASR Mitchell-Sandor where he told her that while his step-brother was in the shower, he located his step-brother's firearm in the dresser drawer, and stated to her that he "saw the pistol and wanted to just end it then." She could not recall the exact date. [Encl (56)]

(7) FF 243f is added: Approximately one and half to two months prior to MASR Mitchell-Sandor's death (on or about 14 February 2022), MASR Mitchell-Sandor's step-brother found that his room had been "ripped apart." [Encl (63)]

(8) FF 243g is added: Step-brother reported that he found MASR Mitchell-Sandor on the bed holding the step-brother's unloaded pistol that he kept in his dresser drawer. [Encl (63)]

(9) FF 243h is added: Step-brother immediately grabbed MASR Mitchell-Sandor and took control of the weapon. [Encl (63)]

(10) FF 243i is added: Mitchell-Sandor was crying and stated that he did not want to go back to the ship. [Encl (63)]

(11) FF 243j is added: (b)(5)

(12) FF 243k is added: (b)(5)

(13) FF 243l is added: (b)(5)

(14) FF 243m is added: (b)(5)

(15) FF 243n is added: (b)(5)

(16) FF 243o is added: (b)(5)

(17) FF 243p is added: Friend #2 stated that a mutual and close personal friend died in July 2021, and that the loss of their friend weighed heavily on the group of friends. The friends would spend time together at the grave, and MASR Mitchell-Sandor would discuss this with his family and friends. In MASR Mitchell-Sandor's final text message to his family, he asked to be buried next to his deceased friend. [Encls (38), (57), (65)]

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(18) FF 244q is added: MASR Mitchell-Sandor's friend died just before he left for basic training and the loss continued to weigh on him. [Encls (64) and (65)]

(19) FF 253a is added: MASR Mitchell-Sandor confided to a shipmate that he was unhappy with life onboard the ship and was told by that shipmate that maybe he shouldn't go home so often. [Encl (64)]

(20) FF 281 is modified replacing it with the following: According to MA3, the command climate was worse under the previous commanding officer, but it is better now. [Encl (24)]

(21) FF 288a is added: MASR Mitchell-Sandor kept a sleeping bag in his car. [Encls (35) and (38)]

(22) FF 288b is added: MAC knew MASR Mitchell-Sandor slept in his car. [Encl (35)]

(23) FF 288c is added: MASR Mitchell-Sandor told multiple friends and family members that he would sleep in his car due to the noise onboard the ship. [Encls (63), (64), (65), (66)]

(24) FF 288d is added: MASR Mitchell-Sandor complained frequently to friends and family regarding the living conditions onboard the GW. [Encls (63), (64), (66)]

(25) FF 293 is modified by adding reference to enclosure (65).

(26) FF 293a is added: According to his girlfriend, he made two trips to South Carolina — the first on or about February/March and the second on or about March/April — and was planning to make a third at the end of April or beginning of May. [Encl (65)]

(27) FF 315a is added: MASR Mitchell-Sandor was having problems with the chain of command for his lack of military bearing, his failure to address people professionally, his lack of motivation, and delays in getting his qualifications. [Encl 41]

(28) FF 315b is added: Two Petty Officer Third Classes in security department stated that the chain of command's interactions with MASR Mitchell-Sandor did not amount to bullying, but were appropriate corrections to motivate him to be a better Sailor. The interactions were described as "professional." [Encl (41)]

(29) FF 332a is added: MASR Mitchell-Sandor was never diagnosed with or treated for depression. [Encl (62)]

(30) FF 332b: According to the CNAF Force Phycologist, MASR Mitchell-Sandor exhibited several behaviors, which are indicative of someone battling with depression (e.g., socially isolating himself; recurrent thoughts of suicide (with plan); unhappiness, sadness, feelings of being alone, and feeling stuck in his job). [Encl 62)]

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(31) FF 333a is added: The day before his death, on 14 April 2022, MASR Mitchell-Sandor invited Friend #3 and another friend out to breakfast and lunch, and paid for both meals. [Encl (58)]

(32) FF 333b is added: Friend #3 stated that although MASR Mitchell-Sandor was generous, it was out of the ordinary that he would buy both of their meals. [Encl (58)]

(33) FF 333c is added: Friend #3 stated that during breakfast MASR Mitchell-Sandor talked about a shortened two year service obligation because he felt “trapped.” [Encl (58)]

(34) FF 333d is added: When Friend #3 asked MASR Mitchell-Sandor what would happen if he did not go back, he responded that the “FBI would be after me.” [Encl (58)]

(35) FF 340a is added: MASR Mitchell-Sandor also texted his girlfriend on his drive back to Virginia saying that he was having a mental breakdown, that he was very upset, and that he wanted out of the Navy. [Encl (65)]

(36) FF 340b is added: His girlfriend tried to reassure him via Snapchat that everything would be ok, and that she would see him in a few weeks. Her final Snapchat message was sent around 1900 hours and was never opened. She also texted him numerous time, but he did not respond. [Encl (65)]

(37) FF 361a is added: On 15 April 2022, at approximately 2030 hours, Friend #3 received a Snapchat video message (i.e., instant messages accessible for only a short time) where she recalled that MASR Mitchell-Sandor was crying. [Encl (58)]

(38) FF 384 is added: The GW Command Chaplain recalls meeting with MASR Mitchell-Sandor as part of his required check-in process. [Encl (59)]

(39) FF 385 is added: Consistent with references (i) and (j), the Command Chaplain could not discuss the specifics of their encounter. [Encl (59)]

(40) FF 386 is added: The GW Command Chaplain stated that MASR Mitchell-Sandor declined the chaplain’s offer to sit down with him. [Encl (59)]

(41) FF 387 is added: The GW Command Chaplain did provide MASR Mitchell-Sandor with a card that contained the Chaplain’s office numbers, in case he ever needed to contact a duty chaplain. [Encl (59)]

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5. Opinions

General Opinions

a. Opinion 1 is modified by adding reference to finding of facts 68, 71, 75, 79-88, 94-97, 102-105, 112, 119, 124-132, 136-139, 143-155, 159-188, 201-219, 229, 238, 240, 242, 243a-243q, 253, 255-258, 261, 257-265, 285-288, 291-293, 302-309, 320-333, 340-340b, 342-344, 349-357, and 360-365.

b. Opinion 3 is modified by replacing the last sentence with the following: One Sailor noted a desire to keep mental health related issues out of his medical record.

Opinions Pertaining to RS3 Sharp

c. Opinion 7 is disapproved. Although it is true that the GW DAPA had no records of alcohol abuse related to RS3 Sharp, co-workers were under no duty to report such abuse to the DAPA. Reference (n) delineates duties for the command, officers, chief petty officers, and supervisory enlisted personnel, but it does not impose a reporting requirement on other junior Sailors for cases of suspected alcohol abuse/misuse.

Opinions Pertaining to IC3 Huffman

d. Opinion 14 is modified and substituted with the following: IC3 Huffman had a history of mental health challenges, which included previous suicide attempts and a history of self-harm. These mental health challenges were exacerbated by the excessive use of alcohol mixed with her prescribed medications. This history, alcohol use, and relationship difficulties all contributed to her decision to take her own life. [FF 130, 136, 141-145, 173, 198, 201-207, 209, and 213-215]”

e. Opinion 18 is modified by adding reference to findings of fact 167-169, and by replacing the last sentence with the following: Although she continued to receive care during the transition, the transition and the conflicting diagnoses were added stressors.

Opinions Pertaining to MASR Mitchell-Sandor

f. Opinion 19 is modified by adding reference to findings of fact 241a, 243a-243i, 243p-243q, 288c-288d, 315a, 332b, 333c-333d, 340a.

g. Opinion 20 is modified by adding reference to findings of fact 241a, 243d-243k 332b, 333a-333d, and 340a, and further modified and substituted with the following: MASR Mitchell-Sandor’s death was not an impulsive decision, but was contemplated and planned prior to the incident. [FF 241a, 243d-243k 332b, 333a-333d, 340a, and 362-365]

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h. Opinion 21 is modified by adding reference to finding of fact 288c, and further modified and substituted with the following: Quality of life (QoL) concerns were major sources of stress for MASR Mitchell-Sandor, but these were not the sole cause of his suicide. [FF 255, 256, 258, and 288c]

i. Opinion 22 is modified by adding reference to finding of fact 288c, and further modified by replacing the word “habitability” with “QoL” — i.e., “While ~~habitability~~ QoL issues were not identified as the reason MASR Mitchell-Sandor committed suicide . . .”

j. Opinion 24 is modified by adding reference to findings of fact 332a and 332b, and further modified and substituted with the following: Other contributing factors included substantial life stressors, undiagnosed and untreated depression, as well as an inability to acclimate to the shipboard and shipyard environment. [FF 240, 242, 271, 288, 301, 320, and 332-332b]

k. Opinion 25 is modified by adding reference to finding of fact 288c.

l. Opinion 28 is modified by adding reference to findings of fact 384, and 386-387.

m. Opinion 29 is modified by adding reference to findings of fact 241a, 243d-243e, 243i, 332b-333d, and 340.

n. Opinion 30 is modified by adding reference to findings of fact 332a and 332b.

o. Opinion 31 is disapproved as the assignment and duties of Sailors is within the purview of the Commanding Officer, and if adequately managed should not impede, and may likely improve, obtaining needed qualifications since night shift watches are normally less demanding. Opinion 31 is replaced with the following: Pursuant to reference (k), junior enlisted (E-1 to E-4) are in the highest risk group for suicides. As a first-term Sailor onboard his first ship, increased attention and care should have been devoted to ensuring proper assimilation, mentorship, and sponsorship. With the benefit (b)(5), multiple command members knew or should have known that MASR Mitchell-Sandor was experiencing displeasure with Navy life and could have intervened to help him better cope or seek out available support services. Missing a scheduled meeting with the CMC, remaining alone in berthing, sleeping in his car, and violating the command’s leave and liberty policy were all “red flags” that indicated MASR Mitchell-Sandor was having problems. [FF 229-230, 234, 240, 253a, 256, 259, 260, 266, 288a-288b, 302, 304-305, 307, 312, 315a, and 332b].

p. Opinion 33 is added: (b)(5),(b)(6)
(b)(5),(b)(6)

[FF 243e-243o, 246-249, 340a]

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6. Recommendations

Immediate Recommendations

- a. Recommendation 1 is concurred with as written.

Action Update: On 10 June 2022, the GW conducted two suicide alertness training (safeTALK) courses with 35 Sailors receiving the training. As of 15 Jul 2022, 80 Sailors (E-4 to E-6) have been trained in Expanded Operational Stress Control (E-OSC) and 25 khaki leadership have been trained in Advanced E-OSC (a train the trainer program). E-OSC is a peer-to-peer program which is built from evidence-based practices to build and sustain toughness and resilience. On 21 June 2022, the CNAL Chaplain provided suicide prevention training during the GW's safety stand down. Lastly, the first of several Applied Suicide Intervention Skills Training (ASIST) programs is scheduled to be conducted on 25-26 Jul 2022.

- b. Recommendation 2 is concurred with as modified, replacing the last two sentences with the following: Advertising should include locations and contact information for the Command Chaplain, DRCs, Fleet and Family Service Centers, Naval Medical Center Portsmouth, Military OneSource, Tricare network, and virtual mental health (VMH) options. This advertising strategy shall promote and reinforce that all communications with chaplains will remain confidential pursuant to references (i) and (j).

- c. Recommendation 3 is modified by substituting the following: Recommend GW conduct a review of its suicide prevention program and bolster training beyond the yearly General Military Training (GMT) requirement on suicide prevention to include more in-depth, interactive training programs such as the LivingWorks curriculum, suicide alertness training (safeTALK) and Applied Suicide Intervention Skills Training (ASIST) program. RCOH ships should be properly staffed with ASIST-trained personnel in a ratio congruent with the size of the ships' departments and divisions prior to entering the shipyard environment, to include additional Assistant Suicide Prevention Coordinators (SPC).

Action Update: On 10 June 2022, the GW conducted two suicide alertness training (safeTALK) courses with 35 Sailors receiving the training. The first of several Applied Suicide Intervention Skills Training (ASIST) programs is scheduled to be conducted on 25-26 Jul 2022.

- d. Recommendation 4 is concurred with as written.

Action Update: On 9 May 2022, an additional DRC reported to the shipyard in Newport News, VA

- e. Recommendation 5 is modified by substituting the following: The Commanding Officer of the GW should evaluate the current locations of the assigned DRCs to ensure the locations are convenient for the crew. The locations should be conducive to providing counseling services

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and be in accordance with Commander, Navy Installations Command Instruction 1754.3A (reference (1)).

Action Update: As of 15 July 2022, the GW has two assigned DRCs. One is located onboard the GW, and the other is at an offsite location.

f. Recommendation 6 is modified by substituting the following: The DRC, GW Chaplain, and the GW Psych Boss should collaborate and report common trends and areas of concern to the TRIAD every two weeks, or as appropriate. Sailors must also be better-educated about this additional resource.

g. Recommendation 7 is concurred with as written.

h. Recommendation 8 is concurred with as written.

i. Recommendation 9 is concurred with as written.

j. Recommendation 10 is concurred with as written.

k. Recommendation 11 is concurred with as written.

l. Recommendation 12 is concurred with as written.

Action Update: The Commanding Officer of the GW activated the Organizational Incident Operational Nexus (ORION) program established by the Bureau of Medicine and Surgery Instruction 6010.33 (reference (m)). The intent of the ORION program is to proactively track Navy Sailors exposed to unit-level, non-combat trauma, and provide targeted outreach (i.e., “Caring Contacts” by ORION Outreach Coordinators) to those at elevated risk for psychological injury at specified intervals during the first year following the traumatic event. This tracking and targeted outreach is ongoing.

m. Recommendation 13 is concurred with as written.

n. Recommendation 14 is concurred with as written.

o. Recommendation 15 is concurred with as written.

p. Recommendation 16 is concurred with as written.

q. Recommendation 17 is modified to add this concluding sentence: (b)(5)

(b)(5)

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r. Recommendation 18 is modified to replace the words “Command Suicide Prevention Team” with “the Command Suicide Prevention Coordinator” — i.e., “It is important to ensure all suicide related behaviors are reported to the Command Suicide Prevention Team Coordinator.”

Action Update: On 5 July 2022, the Chief of Staff, Commander, Naval Air Force Atlantic promulgated the Commander’s Critical Information Requirements (CCIRs) and associated situational report (SITREP) guidance to subordinate commanders. This SITREP guidance included clarification that, pursuant to reference (e), the reporting of suicide related behavior (SRB) first requires a determination by an appropriate competent authority that the behavior qualifies as “suicide related.”

s. Recommendation 19 is concurred with as written.

Action Update: As of 15 July 2022, 370 of 422 Sailors that were living onboard GW (not including the duty section) have moved into off-ship accommodations. This allows for increased access to support services and MWR programs more readily available on our local installations. Of note: 25 Sailors have requested to remain onboard. Still awaiting a decision from the remaining 27 Sailors (mostly new check-ins)

t. Recommendation 20 is concurred with as written.

Action Update: Commander, Naval Air Force Atlantic intends to advertise and hire for this new civilian position in late summer of 2022.

u. Recommendation 21 is concurred with as written. The Surface Navy has done a tremendous job at incorporating sleep science into their watchbills and decision making. All hands should be educated on the benefits of obtaining the adequate amount of sleep and the risks associated with inadequate sleep. Discussing this with our most junior Sailors and giving them the tools they need to put the best sleep practices into action is worth the Navy’s investment.

Long-Term Recommendations

v. Recommendation 22 is disapproved. Although I agree that Sailors could benefit from training on how to successfully transition between primary care providers, this was not a causal factor in this case. IC3 Huffman did have trouble maintaining continuity of care when she was referred to an off-ship mental health provider for specialty care; however, this was not caused due to her transition from a “non-operational status,” as she was still attached to the ship and was performing temporary additional duties at the nearby Huntington Hall.

w. Recommendation 23 is concurred with as written.

Action Update: Due to the specific concern that demand for mental health treatment may be higher than what the Navy can provide, one of the specific areas for review includes the adequacy and accessibility of Sailor support services, including medical and mental health

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services. Commander, Naval Air Force Atlantic has surged support to the ship to mitigate any issues in Sailors accessing support services. In addition to its two billeted behavioral health personnel in the medical department (i.e., one psychologist and one behavioral health technician), the ship has three chaplains, and two deployment resiliency counselors. Since April 25, 2022, Navy Medicine has placed two additional mental health providers onboard the ship to increase Sailor access to mental health services. Informed by subject matter experts, the ongoing review will help us make a determination regarding the right number and skill-type combination of mental health personnel onboard the ship.

x. Recommendation 24 is concurred with as written.

Action Update: As part of the investigation convened on May 4, 2022, Commander, Naval Air Force Atlantic directed a review of the Crew Move Aboard (CMA) strategy for ships undergoing Refueling and Complex Overhaul (RCOH), including the GW. This review is ongoing.

y. Recommendation 25 is concurred with as written.

Action Update: As part of the investigation convened on May 4, 2022, Commander, Naval Air Force Atlantic directed a review of available lodging and berthing for ships in RCOH. This includes a review of the availability, adequacy and quality of available lodging. This review also includes a review of statutory, DoD, and Navy authorities governing Basic Allowance for Housing (BAH) and their effect on Sailor quality of life.

z. Recommendation 26 is concurred with as written.

Action Update: These items are also included as areas for review in the investigation convened on May 4, 2022, Commander, Naval Air Force Atlantic. This investigation remains ongoing. Additionally, Commander, Naval Air Force Atlantic staff have been actively engaging with HII-NNS to develop plans for future improvements on the shipyard and in the local area. The GW has taken initial steps to improve quality of life for those still residing on the ship. The GW has added cell phone repeaters inside the skin of the ship, activated wireless internet hotspots, and are increasing MWR services for off-duty Sailors. Supervisor of Shipbuilding Conversion and Repair, Newport News (SSNN) is taking the initiative to lead a working group to consolidate these efforts, ensure all are aligned, and elevate barriers as early as possible. A Project Charter is in development to codify the membership of this working group, identify the group's purpose, and identify the deliverables required in support of this effort to "get real-get better" as it relates to quality of life for our Sailors. This will include identifying immediate action (e.g., review of available office space, parking, shuttle services, etc.) as well as long-term actions (e.g., construction of parking garages, funding additional berthing barges, etc.). The initial meeting of the team was held 17 June 2022 at SSNN. This was the first of many future recurrent meetings.

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The Navy enterprise has already **completed** a number of actions to influence these lines of effort. These actions are summarized below.

- Barracks (office space)
 - Program Objective Memorandum (POM)-24 issue paper to convert Steam Generator Chemical Cleaning Facility to a multipurpose facility: fitness center, coffee shop, laundry facility, Navy Exchange and Internet Café (PMS 312)
 - POM-24 issue paper to fund two additional barges in FY24/25 (PMS 312)
 - POM-24 issue paper to fund additional office space (PMS 378)
 - Huntington Hall restored the use of the kitchen area (SSNN)
- Parking
 - Added additional parking areas closer to the shipyard, and eliminated parking at the more distant Chesapeake Square Mall (SSNN/PMS 312)
 - Additional in-yard buses added to shuttle Sailors from the turnstile to their assigned ship (SSNN/PMS 312)
 - POM-24 issue paper for parking garage (PMS 312)
- Mental Health
 - Leased Additional medical facilities for health care providers (PMS 312)
 - Conducted a Military Health Outreach Fair with an emphasis on mental health, will conduct quarterly (SSNN)

aa. Recommendation 27 is concurred with as written.

bb. Recommendation 28 is modified by substituting the following: Recommend Navy request that the Defense Health Agency (DHA) conduct a review of mental health care capacity and access for both inpatient and outpatient services in the local area. This should include analysis of both the military treatment facilities as well as local area Tricare network resources.

cc. Recommendation 29 is concurred with as written.

dd. Recommendation 30 is concurred with as written.

Action Update: On 23 June 2022, the Acting Under Secretary of Defense for Personnel and Readiness issued reference (o), which redefined “entry-level status” for enlisted separations. The new instruction expands this entry-level status window from 180 days to 365 days, effective 23 December 2022. Further Navy implementing guidance should be forthcoming.

ee. Recommendation 31 is concurred with as written.

ff. Recommendation 32 is concurred with as written.

CUI

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gg. Recommendation 33 is concurred with as written.

Action Update: As of 15 Jul 2022, 80 Sailors (E-4 to E-6) have been trained in Expanded Operational Stress Control (E-OSC) and 25 khaki leadership have been trained in Advanced E-OSC (a train the trainer program).

7. My point of contact for this matter is (b)(6), who can be reached at commercial (b)(6), or via e-mail at (b)(6).


J. F. MEIER

5830
13 Jun 22

From: (b)(6)

To: Commander, Naval Air Force Atlantic

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Ref: (a) JAGINST 5800.7G, Manual of the Judge Advocate General
(b) OPNAVINST 5354.1H, Navy Harassment Prevention and Military Equal Opportunity Program
(c) DoDI 6130.03, Volume 1, Medical Standards for Military Service
(d) DoD Person Search, DMDC Website¹
(e) OPNAVINST 3100.6K, Special Incident Reporting Procedures
(f) Security Executive Agent Directive (SEAD) 4, National Security Adjudicative Guidelines
(g) RCOH-020 Ship Habitability and Crew Move Aboard Strategy
(h) DoDM 5200.02, Procedures for DoD Personnel Security Program
(i) SECNAVINST 1730.9A, Privileged and Confidential Communications to Chaplains
(j) OPNAVINST 1720.4B, Suicide Prevention Program
(k) DoD Annual Suicide Report for Calendar Year 2020
(l) CNICINST 1754.3A, Deployed Resiliency Counselor Program
(m) BUMEDINST 6010.33, Organizational Incident Operational Nexus
(n) OPNAVINST 5350.4E, Navy Alcohol and Drug Misuse Prevention and Control
(o) DoDI 1332.14, Enlisted Administrative Separations
(p) COMNAVAIRPAC/COMNAVAIRLANTINST 5103.1, Command Resilience Team Human Factors Council
(q) COMNAVAIRPAC/COMNAVAIRLANTINST 3300.53A, Antiterrorism Program
(r) COMMAND RESILIENCE TEAM GUIDE, 26 June 2018

Encl: (1) CNAL ltr 5830 Ser N01L/096 of 22 Apr 22 (Appointing Order)
(2) Summary of interview of (b)(6), USN
(3) Summary of interview of (b)(6), USN
(4) Summary of interview of (b)(6), USN and (b)(6), USN
(5) Summary of interview of (b)(6), USN
(6) Summary of interview of (b)(6), USN
(7) Summary of interview of (b)(6), USN
(8) Summary of interview of (b)(6), MD, USN (Senior Medical Officer)
(9) Summary of interview of (b)(6), USN
(10) Summary of interview of (b)(6), USN (hereinafter "EM1")
(11) Summary of interview of (b)(6), USN (hereinafter "EM2")
(12) Summary of interview of (b)(6), USN
(13) Summary of interview of (b)(6), USN

¹ URL: <https://pki.dmdc.osd.mil/appj/dps/index.html>

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- (14) Summary of interview of (b)(6), USN (hereinafter "Psych Tech")
- (15) Summary of interview of (b)(6), USN (hereinafter "IT3")
- (16) Summary of interview of (b)(6), Psy.D., USN (hereinafter "Psych Boss")
- (17) Summary of interview of (b)(6) USN
- (18) Summary of interview of (b)(6) USN
- (19) Summary of interview of (b)(6), USN
- (20) Summary of interview of (b)(6), USN
- (21) Summary of interview of (b)(6), USN (hereinafter "MA1")
- (22) Summary of interview of (b)(6), USN (hereinafter "MA2 (#1)")
- (23) Summary of interview of (b)(6), USN (hereinafter "MA2 (#2)")
- (24) Summary of interview of (b)(6), USN (hereinafter "MA3")
- (25) Summary of interview of (b)(6), USN (hereinafter "MACM")
- (26) Summary of interview of (b)(6) USN (hereinafter "MASN")
- (27) Summary of interview of (b)(6), USN
- (28) Summary of interview of (b)(6), USN (hereinafter "RS2")
- (29) Summary of interview of (b)(6), USN (hereinafter "RS3 (#1)")
- (30) Summary of interview of (b)(6), USN (hereinafter "RS3 (#2)")
- (31) Summary of interview of (b)(6), USN (hereinafter "YNSN")
- (32) Summary of follow up interview of MA2 (#2), USN
- (33) Summary of follow up interview of EM1
- (34) Summary of interview of (b)(6), USN (hereinafter "MA2 (#3)")
- (35) Summary of interview of (b)(6) USN (hereinafter "MAC")
- (36) Summary of interview of (b)(6), Mother of IC3 Huffman
- (37) Summary of interview of (b)(6), Wife of RS3 Sharp
- (38) Summary of interview of (b)(6) and (b)(6) Parents of MASR Mitchell-Sandor
- (39) USS GEORGE WASHINGTON (CVN 73) Instruction 1050.2A of 15 Jun 18
- (40) CVN 73 2021 Command Climate Assessment Executive Summary of 19 Jan 22
- (41) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS ROI 15APR22-NFYT-00037-7HNA (30-day Report)
- (42) Line of Duty Investigation ICO IC3 Huffman
- (43) Line of Duty Investigation ICO MASR Mitchell-Sandor
- (44) Email from (b)(6), dtd 23 May 22
- (45) Report to Congressional Armed Services Committees – Study on Effects of Sleep Deprivation on Readiness of Members of the Armed Forces March 2021
- (46) "Fatigue and its management in the workplace," Article by Caldwell, et al
- (47) Email from (b)(6), dtd 20 May 22
- (48) CNAF Force Psychologist Summary of IC3 Huffman's Military Medical Record
- (49) Text message to (b)(6) from (b)(6), sent 13 Apr 22 at 1824
- (50) Google Maps Printout of Trip from HII-NNS to Shelton, CT, searched 7 Jun 22
- (51) Google Maps Printout of Trip from HII-NNS to Charleston, SC, searched 7 Jun 22
- (52) Sleep Calculations and Tables ICO MASR Mitchell-Sandor
- (53) CVN 73 Approved Security Watchbill of 15 Apr 22

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- (54) CNAL ltr 5830 Ser N01L/134 of 6 May 22 (Extension to 6 Jun 22)
- (55) CNAL ltr 5830 Ser N01L/163 of 1 Jun 22 (Extension 13 Jun 22)
- (56) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6) (b)(6) (hereinafter "Friend #1")
- (57) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6) (b)(6) (hereinafter "Friend #2")
- (58) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6) (b)(6) (hereinafter "Friend #3")
- (59) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of GW Command Chaplain
- (60) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of MASR Mitchell-Sandor's High School Class Counselor
- (61) CNAL Force Special Security Officer email of 23 Jun 22
- (62) CNAF Force Psychologist email of 12 Jul 22
- (63) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of MASR Mitchell-Sandor's step-brother
- (64) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of MASR Mitchell-Sandor's Aunt and Uncle #2
- (65) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6) (b)(6) (hereinafter "girlfriend")
- (66) (CUI // LAW ENFORCEMENT SENSITIVE) NCIS Summary of Interview of (b)(6) (b)(6) (hereinafter "Friend #4")
- (67) USS George Washington (CVN-73) Command DAPA e-mail of 19 Jul 22

Preliminary Statement

1. Pursuant to enclosure (1) and in accordance with reference (a), a command investigation was conducted to determine the proximate cause and the potential connection, if any, surrounding the recent deaths of three Sailors attached to the USS GEORGE WASHINGTON (CVN 73) on or about April 2022. These Sailors were RS3 Mika'il Sharp, IC3 Natasha Huffman, and MASR Xaiver Mitchell-Sandor. Two extensions of time were granted to allow the investigation team additional time to complete this report (see enclosures (54) and (55)). Throughout this report, the USS GEORGE WASHINGTON (CVN 73) is referred to as either "CVN 73" or "GW."

2. As will be clear in this report's recommendations, a comprehensive and exacting review of the various quality of life concerns and other systemic issues for aircraft carriers undergoing Refueling and Complex Overhaul (RCOH) at Huntington Ingalls Industries – Newport News Shipbuilding (HII-NNS), in Newport News, VA was outside the scope of this investigation. While this investigation may include references to command climate and culture, the scope of this investigation is narrow, and is focused on identifying the various causal factors that may have contributed to the deaths of these Sailors – i.e., contributing factors.

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3. In accordance with enclosure (1), I assembled a team to best address the two-pronged goals of this investigation, which consisted of the following individuals: (b)(6), PhD (hereinafter "Psychologist #1"), a clinical psychologist and Warrior Toughness instructor; (b)(6), PhD, American Board of Professional Psychology, the Commander, Naval Air Forces (CNAF) Force Psychologist (hereinafter "CNAF Force Psychologist"); (b)(6), CNAL Deputy Force Judge Advocate; (b)(6), CNAL Inspector General; (b)(6), CNAL Force Chaplain; (b)(6), CNAL Force Personnel Readiness; and (b)(6), CNAL Force Alcohol and Drug Control Officer and Command Managed Equal Opportunity (CMEQ) Program Manager.

4. All reasonably available evidence and information has been collected, and all requirements of reference (a) and enclosure (1) have been satisfied. The following difficulties collecting relevant evidence were encountered during the course of the investigation: 1) Hampton Police reports related to the deaths of IC3 Huffman and RS3 Sharp are not yet available, as the investigations are still ongoing; 2) the toxicology report in the case of IC3 Huffman is not yet available; 3) the final Report of Investigation (ROI) from NCIS in the case of MASR Mitchell-Sandor is not yet available, as the investigation is still ongoing; 4) the investigation team does not have access to MASR Mitchell-Sandor's phone or any of the information contained therein, as it is in the possession of NCIS pursuant to their investigation; and 5) the Line of Duty Investigation (LODI) for RS3 Sharp is not available, as it is not yet complete. Despite these information shortfalls, based on the amount of evidence obtained, the receipt of this additional information is unlikely to change the findings, opinions, and recommendations of this report.

5. (b)(6), served as legal advisor and was consulted in preparing this report.

6. To aid the reader, the report begins with an overall discussion section that summarizes the analysis and findings of the investigation. Following this discussion section are the more traditional listings with findings of fact, opinions, and recommendations.

Discussion

1. The investigation's focus was to determine the "proximate cause" and potential connection between the deaths of three Sailors onboard the GW. One definition of "proximate cause" is a cause that directly produces an event and without which the event would not have occurred. In the strictest application of this definition, each Sailor died from self-inflicted injuries – i.e., by suicide – and thus each was the ultimate proximate cause of their own deaths. Access to a readily available means to commit suicide, life stressors, and a decision to follow through, coupled with an impaired mental state led each of these Sailors to take their own lives. This investigation explores the facts and circumstances leading up to their deaths to help identify contributing factors that, if previously identified or mitigated, may have altered the ultimate outcome.

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2. While there were common stressors amongst the three GW Sailors who died on or about April 2022, such as the general stress associated with conditions in the shipyard environment, it is the opinion of the investigation team that the deaths of RS3 Sharp, IC3 Huffman, and MASR Mitchell-Sandor were not related or connected. Based on the available evidence collected, there were no indications that RS3 Sharp, IC3 Huffman, or MASR Mitchell-Sandor had any social or working relationships with one another. Each Sailor was experiencing unique and individualized life stressors, which were contributing factors leading to their deaths. [FF 1-6, 8, 12-16, 18, and 31-35]

Discussion relating to RS3 Sharp

3. On 9 April 2022, RS3 Sharp committed suicide while at a private residence using a personal firearm. He enlisted in the Navy on 10 June 2020, and was 23 years old at the time of his death. He was not living onboard GW, and was on temporary additional duty (TAD) orders to Joint Expeditionary base (JEB) Little Creek while attending barber school. There was no connection found between RS3 Sharp and either of the other two Sailors. RS3 Sharp was drinking heavily the night he died, which affected his decision-making ability. He was already dealing with multiple life stressors, and, on the night that he died, he likely believed that his behavior had irreparable consequences with his wife and her family. He also had ready access to a firearm that he kept in his wife's vehicle. These factors culminated in RS3 Sharp making an impulsive decision to end his life. [FF 2-5, 68-73, 75, 76, 79, and 81-89]

4. RS3 Sharp was known to many as a Sailor in good spirits that enjoyed cutting hair in the ship's barber shop. It is noted that some of the Sailors who were closest with RS3 Sharp stated that he had previously been bothered by a feeling of not being recognized for his work and that he felt "stagnant." However, RS3 Sharp had been promoted days before his death through the meritorious advancement program (MAP), and had been selected to attend a desired barber school at JEB Little Creek. While at barber school, RS3 Sharp appeared to be happy and continued his normal routine of playing video games online with friends, which provided him with regular social connectedness. [FF 68, 73, 75, 76, and 90]

5. RS3 Sharp suffered from emotional distress stemming from marital challenges with his wife, with whom he often argued. These arguments were amplified by long periods of separation due to the deployment of his wife,² separate living arrangements, and accusations of marital infidelity by both RS3 Sharp and his wife. The fact that RS3 Sharp and his wife resided at separate locations³ in order to save up to eventually buy a place of their own caused marital tension and hindered their ability to communicate with each other. [FF 69, 79-83, and 85]

² Mrs. Sharp had previously served as a Culinary Specialist (CS) on the USS PORTER, and was recently discharged.

³ RS3 Sharp resided with his mother at her residence, while his wife resided separately with her own mother at her residence.

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6. On the night of his death, RS3 Sharp and his wife were at a gender-reveal party for RS3 Sharp's sister-in-law. RS3 Sharp was known to binge drink, and could become "hostile" when he was drunk. Mrs. Sharp later stated he was drunk and a little "hostile" the night of his death. RS3 Sharp had been drinking throughout the night, and his wife was upset after finding pictures and messages on his phone between RS3 Sharp and other women. This led to an argument between RS3 Sharp and his wife, and they went into a bedroom with RS3 Sharp's "brother"⁴ to finish the argument away from the rest of the family members. [FF 84, 86, 92, and 94-96]

7. The argument between RS3 Sharp and his wife escalated into a physical altercation for the first time in their marriage. This altercation resulted in the Hampton Police Department being called to the scene. Mrs. Sharp left the party with one of her friends, but then returned prior to the arrival of police officers. Her family witnessed the argument and physical altercation, as well as RS3 Sharp's confrontation with law enforcement. When police officers asked Mrs. Sharp if anyone had "put hands on each other," she said "no." RS3 Sharp was not cooperating with the police, and though Mrs. Sharp attempted to calm him down, it wasn't working. Mrs. Sharp described the look in RS3 Sharp's eyes as that of being "already gone," and police officers directed her to leave. Law enforcement eventually departed the scene, and RS3 Sharp contacted his wife via video chat. He was visibly upset in his vehicle and, according to his wife, he was holding a firearm. Mrs. Sharp ended the video chat, and attempted to reach his mother, but was unable. The friend of Mrs. Sharp, who was driving, then received a phone call from someone at the party that RS3 Sharp had shot himself. [FF 97-111]

8. The events of 9 April 2022 built upon each other in such a way that RS3 Sharp likely felt his actions had irreconcilable negative consequences for his marriage, his life, and his career. These rapidly escalating events, combined with heavy intoxication and a readily-available firearm, inhibited RS3 Sharp's ability to develop a rational exit strategy from the situation, and likely pushed him to the decision that suicide was his only way out. [FF 75, 76, 84-86, and 94-111]

Discussion relating to IC3 Huffman

9. On or about 10 April 2022, IC3 Huffman committed suicide by hanging at her private residence. She enlisted in the Navy on 11 July 2018, and was 24 years old at the time of her death. Since November 2021, she had not been living onboard GW, and had been reassigned to Huntington Hall barracks on TAD, due to medication she was prescribed for her mental health diagnosis. There was no connection found between IC3 Huffman and either of the other two GW Sailors who died in April 2022. IC3 Huffman was dealing with multiple life stressors which continued to build over time. On the night she died, she had been drinking heavily and may have had an unknown amount and type of prescription medication in her system, affecting her decision-making ability. These factors culminated in IC3 Huffman making an impulsive decision to end her life. [FF 3-5, 112, 116, 124, 149-156, 158, 160, 166-168, 171, and 173]

⁴ This is a good friend RS3 Sharp grew up with, who he called "brother," and not actually a relative.

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10. IC3 Huffman experienced significant stress from several areas of her life. She was in the long process of a divorce stemming from an abusive marriage, which had not yet been finalized because her husband was continually moved between correctional facilities, making it problematic to have the final divorce papers signed. Her mother was diagnosed with cancer, and IC3 Huffman believed her mother was making questionable financial decisions, causing additional stress. IC3 Huffman experienced additional worry from her potential medical separation from the Navy as a result of her Bipolar Disorder diagnosis and prescribed medication. Though initially she did not want to be separated from the Navy, she later accepted this outcome and was making plans to attend a local college to pursue a degree in a technical field. However, after her diagnosis was changed by a new physician, she was informed that she might not be medically separated from the Navy, only to ultimately be re-diagnosed with Bipolar Disorder and then again be re-informed that she would, in fact, be medically separated. This back and forth caused anxiety about her future, and frustrated her ability to make adequate plans. [FF 158, 160, 166-168, and 171-181]

11. IC3 Huffman had an extensive history of dealing with mental health concerns. She had received mental health care dating back to the age of 14 that included both therapy and medication. While in the Navy, she had 34 confirmed prior mental health encounters, along with a previous suicide attempt in 2020. Of the 34 encounters, 9 occurred while IC3 Huffman was in her initial accession training. Further, it was stated that she sought help with a mental health provider on the Thursday before her death, though the investigation team was unable to find any record of this visit within the military medical health care system. [FF 124, 136-138, 141, and 190]

12. IC3 Huffman was referred to, and reported receiving care from, a civilian therapist since September 2021. Her Navy medical record indicates that she had a gap in psychiatric (medication) care after 28 February 2022, but continued receiving care from a civilian mental health therapist.⁵ However, IC3 Huffman reportedly was prescribed weekly Ketamine shots every Friday over a two-month period, which was corroborated by multiple sources. Ketamine is a controlled substance, and is generally not prescribed in the Navy to treat mental health conditions. Further, there is no record of IC3 Huffman having been prescribed Ketamine in her military health care record. IC3 Huffman also made comments indicating she had to pay for care out-of-pocket. This led the investigation team to believe that she was likely seeing a civilian physician in town, outside of the TRICARE network, which is why there is no record of these encounters in her military health care record. Therefore, she may have been taking additional medications other than what was annotated in her military health care record. [FF 124, 132-134, 168, 169, and 182-191]

13. IC3 Huffman was prescribed two refills of Seroquel by (b)(6) (hereinafter “Psychiatrist #1”) at NMCP, and last refilled her prescription on or about 28 March 2022. In addition to this medication, as indicated above, IC3 Huffman was believed to also be receiving regular Ketamine

⁵ Psychologists primarily provide psychotherapy (talk therapy), while psychiatrists primarily prescribe medications.

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treatments from an unknown civilian provider, and possibly may have been prescribed other medications as well. Based on discussions with the GW Senior Medical Officer (SMO), Psych Boss, and the investigation team's own mental health consultant, mixing any of these medications with alcohol would increase the effect of sedation, likely affecting IC3 Huffman's decision making ability. [FF 124, 182-191, 199, and 201-207]

14. On the night of 9 April 2022, IC3 Huffman had been drinking heavily and had an argument with her live-in boyfriend. She had consumed approximately half of a fifth (12.5 oz) of liquor during the night, and had an argument that stemmed from jealousy when her boyfriend showed a social media picture of his ex-girlfriend to a mutual friend. The argument escalated to the point where IC3 Huffman wanted to move out, and her boyfriend then removed himself from the situation by walking to a convenience store in order to cool down. When he returned, they tried to talk it through, but did not resolve the argument. In order to "get some space," her live-in boyfriend elected to sleep on the couch. When he awoke the next morning, he found IC3 Huffman hanging from the closet. [FF 199-227]

15. All evidence collected indicates that IC3 Huffman committed suicide by hanging. Though she had consumed heavy amounts of alcohol, and may have consumed an unknown amount and type of medication, these aren't believed to be the direct causes of her death, but likely affected her decision making process. There was no evidence that IC3 Huffman's cause of death was by any other means or injury. [FF 202-204, and 221-228]

Discussions Relating to MASR Mitchell-Sandor

16. On 15 April 2022, MASR Mitchell-Sandor committed suicide onboard GW using his Navy-issued pistol. He enlisted in the Navy on 24 August 2021, was living and working aboard GW, and was 19 years old at the time of his death. There was no connection found between MASR Mitchell-Sandor and either of the other two GW Sailors who died in April 2022. MASR Mitchell-Sandor was dealing with multiple life stressors which continued to build over several months. His decision-making process was degraded, and his risk of suicidal-related behavior increased, by significant sleep deprivation. Additionally, as a Master-at-Arms (MA), he had ready access to a firearm. When MASR Mitchell-Sandor came to the belief that he was trapped in his present situation with no way out, he made a plan to end his life, and ultimately acted on that plan. [FF 1-6, 229, 362-383]

17. MASR Mitchell-Sandor did not like living onboard GW. Habitability issues in berthing caused MASR Mitchell-Sandor significant stress. MASR Mitchell-Sandor traveled to his home in Connecticut often, and may have traveled as frequently as he did because of his concerns with living onboard GW. These issues included cold temperatures, constant noise, and periods without hot water or power. The existence of these issues was corroborated by multiple Sailors in the investigation who expressed similar concerns. MASR Mitchell-Sandor kept a sleeping bag in his vehicle, and is believed to have slept in his vehicle on several occasions. Additionally, MASR Mitchell-Sandor would spend much of his off-shift time in his personal vehicle in order

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to have adequate cell phone and internet reception in a location where he had privacy to speak with family and friends from home. [FF 14-20, 31, 36, 229, 256-261, 288, 291-297]

18. Despite his complaints regarding habitability onboard GW, MASR Mitchell-Sandor had multiple opportunities to change or improve his living situation, but chose not to. Once concerns regarding his berthing were brought up to leadership, MASR Mitchell-Sandor was offered an opportunity to move to a new berthing, but he declined. Additionally, on the night of his death, MASR Mitchell-Sandor had received an offer to stay with MA2 (#2) at his three-bedroom home in military housing. Also of note, MASR Mitchell-Sandor had a relative who lived nearby in Yorktown, VA, but he never stayed or asked to stay with that relative. [FF 258, 260, 266, 268-270, and 352]

18a. MASR Mitchell-Sandor was onboard only three months prior to taking his life. At 18 years of age, he was placed into the austere and industrial shipboard environment that is typical of all Navy ships. As every sea-going Sailor has experienced, those first days and months onboard ship are a difficult transition period. To live and work in this environment is challenging even when a ship is at its highest levels of material readiness. The USS George Washington (hereinafter "GW") was not in a high level of material readiness. The environment onboard an aircraft carrier can be even more daunting due to the sheer size of the ship. Experienced Sailors can find simply navigating the ship difficult. The shipyard environment only compounds the challenges for a young new Sailor like MASR Mitchell-Sandor to assimilate and see the ship as a new home. With limited places to sit and relax, and without television services, there is little for Sailors to do onboard other than work. [FF 18a, 18b, 258, 259, 260, 261, 266, 268-270, 288, 351, and 352]

18b. Though MASR Mitchell-Sandor was offered the opportunity to change berthings to improve his living conditions, he declined. Often Sailors will choose to avoid the hassle of moving their belongings around the ship; however, for a brand new 18-year-old Sailor, more senior Sailors, sponsors, or mentors should have helped him to understand his options and encouraged him to relocate. From a safety standpoint alone, allowing a brand new Sailor to choose to be alone in a berthing lacking basic amenities is unsatisfactory. Senior enlisted leadership knew that MASR Mitchell-Sandor was sleeping in his car and counseled him, but there is no evidence of any follow through to understand the root cause for his decision making. More senior Sailors or an assigned mentor should have been there to support him and help him make decisions that were in his best interests. This was a time for intrusive leadership. [FF 258, 259, 260, 261, 266, 268-270, 288, 288a, 288b, 351, and 352]

19. A phone call was made to the GW by MASR Mitchell-Sandor's relative regarding his concerns with the living conditions onboard, and there was speculation that the phone call may have led to MASR Mitchell-Sandor being teased. However, there was no evidence found to indicate that any of this rose to the level of the destructive behaviors described in Chapter 2 of reference (b), to include harassment, hazing, or bullying. When Sailors in the department were interviewed, none of those Sailors could provide any specifics as to what may have been said,

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and described it as “normal locker room banter.” MASR Mitchell-Sandor’s parents also did not believe their son had been either hazed or bullied. Additionally, none of the members interviewed witnessed MASR Mitchell-Sandor being directly teased or questioned about the call. [FF 258, and 271-282]

20. After the phone call incident, it is unclear how much MASR Mitchell-Sandor reported further issues to his chain of command. He communicated to his parents on multiple occasions that he believed his supervisors didn’t care about his concerns. His leadership at the E-9 level and above were largely unaware of his concerns with berthing. The only other known time MASR Mitchell-Sandor reported concerns with berthing up the chain of command is when he spoke to MA2 (#2) on the night of his death. MASR Mitchell-Sandor asked MA2 (#2) to run his concerns up the chain of command, to which MA2 (#2) stated he would. [FF 257, 259, 267, and 349]

21. Despite the fact that his parents described MASR Mitchell-Sandor as someone who had many friends back at home, he felt “alone” onboard GW. MASR Mitchell-Sandor derived strong support from his family and friends, but was unable to replicate the same social connectedness onboard the ship. It appears that MASR Mitchell-Sandor made the decision to self-isolate onboard GW. Whenever he was invited to off-ship social functions with his peers, MASR Mitchell-Sandor would decline to participate and instead choose to visit with family and friends in Connecticut or South Carolina. MASR Mitchell-Sandor’s frequent trips home and general focus on his former life rather than his current one deprived him of the opportunity to develop the necessary connections with his GW shipmates, who could have best helped him adapt to the shipboard and shipyard life. [FF 234, 253, 254, 266, 267, 351, and 355]

22. MASR Mitchell-Sandor was described by his parents as being “very proud” and rarely shared his concerns with others, to occasionally include his parents, who were his primary confidants. This mentality, aggravated by his self-isolation, was likely the reason MASR Mitchell-Sandor never sought help from any of the mental health resources onboard GW. Leadership in the Security Department discussed available mental health resources with the department as a whole, indicating that MASR Mitchell-Sandor likely knew about the resources available to him. However, there was no evidence that MASR Mitchell-Sandor ever sought out or utilized any of these resources prior to taking his life. [FF 242, 252, 258, 271-280, 353, 361, and 364]

23. MASR Mitchell-Sandor pursued opportunities to live off ship. He wanted to submit an application for Public Private Venture (PPV) off-base housing, but first needed to complete his initial shipboard qualifications. The fact that he had not yet achieved these qualifications was likely a source of stress for him. While he was not yet delinquent in his qualification process, his squad leader stated that MASR Mitchell-Sandor was on the verge of falling behind and feeling pressure to meet his qualifications. A review of his division officer (DIVO) record confirmed that he was not progressing well on his qualifications. MASR Mitchell-Sandor could not submit an application for PPV housing until he was qualified, and only then would he be added to the

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wait list for off-base housing. As an alternate option, MASR Mitchell-Sandor looked into moving into a place at his own expense that he found on Facebook. However, one of his supervisors recommended against doing so, as the residence was listed as “420 friendly,” meaning the owners likely were marijuana users/enthusiasts. In order to protect his Sailor from being placed in a potential compromising position, since any marijuana use would violate the Navy’s drug policy and lead to administrative separation processing, MASR Mitchell-Sandor’s supervisor informed him he shouldn’t stay there. [FF 261-266, and 268-270]

24. Another significant source of stress for MASR Mitchell-Sandor was the failing health of his grandmother, his “spiritual adviser” to whom he was very close. In fact, he was concerned enough with seeing his grandmother that he was willing to repeatedly violate the ship’s leave and liberty policy, even after he was verbally counseled not to do so by leadership on or about February 2022. [FF 291, 292, 297-299, 301-312, and 319]

25. MASR Mitchell-Sandor committed multiple infractions which departmental leadership did not document, to include: Unauthorized Absence (UA); leaving an assigned post prior to being properly relieved; violating COVID travel restrictions; and repeated violations of the command Leave and Liberty policy. The fault of these infractions is shared – while MASR Mitchell-Sandor shouldn’t have committed them, he was a very junior Sailor still trying to adjust to life in the Navy. Departmental leadership, on the other hand, may have not documented these instances out of a desire to help MASR Mitchell-Sandor and not negatively impact his career. However, if departmental leadership had made the required documentations in MASR Mitchell-Sandor’s record, then the red flags would have been more evident. This may have provided the chain of command an opportunity to identify that MASR Mitchell-Sandor was struggling to adapt to military life, and help him remediate areas where he was experiencing difficulties via extra military instruction (EMI), counseling, providing necessary resources, etc. Additionally, documenting these relevant data points would have established a pattern that would have helped the command determine whether MASR Mitchell-Sandor was compatible for continued Naval service. If ultimately he was found not to be compatible, the command could have helped identify ways in which MASR Mitchell-Sandor could depart the Navy. [FF 302-319]

26. Most of these infractions were directly related with MASR Mitchell-Sandor’s overwhelming desire to return home to Connecticut, or otherwise to South Carolina to see his girlfriend. When a scheduled meeting with the Command Master Chief (CMC) conflicted with his opportunity to drive home and MASR Mitchell-Sandor was informed that the meeting wouldn’t be moved to accommodate his trip, he purposefully missed the meeting and drove home, putting him in a UA status. In another instance, when he wasn’t relieved on time from watch, he chose to leave so he could drive home, rather than wait to be properly relieved by the oncoming watch. Every time he drove home to Connecticut or to South Carolina to visit family and friends, he violated the 350-mile radius established by the ship’s Leave and Liberty Policy, on which he had been counseled and was aware. MASR Mitchell-Sandor’s desire to return to his home, which he stated in his final text as the only thing that made him happy, was so strong that he was willing to go against policy in order to maximize his time there and away from the GW. It was clear that

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MASR Mitchell-Sandor was homesick, but the extent of his struggle was not evident to departmental leadership. [FF 302-319, and 364]

27. At the time of MASR Mitchell-Sandor's death, he was assigned to the Charlie Section watch team, which stood the watch from 1700-0500. Standing watch on the night shift while trying to get the adequate rest during the day in the RCOH environment is noted to be extremely difficult, not only by many of the Sailors interviewed, but also through the investigation team's direct observations while conducting interviews onboard GW. MASR Mitchell-Sandor experienced a difficult time getting the adequate rest required to stand a 12-hour watch, in part because of the constant noise associated with the shipyard environment. [FF 283-289]

28. MASR Mitchell-Sandor would frequently travel to his parents' home in Connecticut (450 miles, 8 hours) and to visit a girlfriend in South Carolina (455 miles, 7 hours) following his 12-hour shifts. He would travel home to Connecticut every three day off-shift weekend (every other weekend), and to South Carolina during the week on his two day off-shift periods. These trips were both sources of stress and fatigue. Research indicates that it takes three to four days for initial accommodation to a circadian shift, and two weeks for a full acclimation. Therefore, the investigation team concluded that MASR Mitchell-Sandor was likely affected by physiological concerns connected with sleep deprivation and disrupted circadian rhythm associated with his shift work. [FF 289-310, and 321-333]

29. MASR Mitchell-Sandor departed the ship on 13 April 2022, two days prior to his death, in the early morning hours following a 12-hour watch, and then drove 8 hours to his parents' home in Connecticut for an unannounced visit. It was unusual for him to return home outside of weekends, and it was also unusual for him not to notify his parents that he was coming ahead of time. Once he arrived in Connecticut, he then reverted back to a normal day-time schedule, and slept during the night time hours. The quality of the sleep he received is unknown, especially because his circadian rhythm was aligned to the opposite schedule. The day of MASR Mitchell-Sandor's death, he departed Connecticut at or about 0500, and then drove over 8 hours so as to assume his 12-hour watch, which began at 1700. Research indicates "fatigue that degrades cognitive performance can result from long, monotonous tasks such as highway driving can be exacerbated by poor sleep hygiene and sleep environment." From waking up for his shift on 12 April 2022 until his death on 15 April 2022, (a period of 78 hours, or 3.25 days), it is estimated that MASR Mitchell-Sandor received a maximum of 14 hours of sleep of unknown quality, with at least one 30-hour period with no sleep. This may have been intensified by the fact that MASR Mitchell-Sandor continually switched from a night schedule to a day schedule over the past few months. [FF 321-383]

30. Based on the investigation team's calculations, MASR Mitchell-Sandor would experience three periods of 24 hours or more of total sleep deprivation per week, as a result of his frequent trips to Connecticut and South Carolina. He would accumulate an average of 13 hours of sleep debt per week, and in the 10-week period prior to his death, he had an approximate sleep debt of 130 hours. The sleep deprivation and fatigue that MASR Mitchell-Sandor experienced prior to

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his death likely affected his decision-making ability, decreased his emotional regulation, and decreased his desire for social interaction, causing him to further socially-isolate. [FF 320]

31. The report “Effects of Sleep Deprivation on Readiness of Members of the Armed Forces” states the following:

Several meta-analysis⁶ research studies demonstrate a clear association between sleep disruptions—resulting in chronic partial sleep deprivation—and suicidal behavior. This includes increased risk of suicidal ideation, suicide planning, suicide attempts, and death by suicide. The lowest risk of suicide is associated with eight hours of sleep per night, with an 11 percent increase in risk for each hour of sleep deprivation. Within diagnostic groups at risk of suicide (such as depression and [Post Traumatic Stress Disorder (PTSD)], sleep disruption and associated chronic partial sleep deprivation approximately double the risk of individuals to engage in suicidal behavior.

Therefore, MASR Mitchell-Sandor would have been at an increased risk for suicidal behavior, given the frequency of his sleep disruptions that resulted in chronic sleep deprivation. While MASR Mitchell-Sandor never was diagnosed with depression, likely because he never sought mental health treatment at ship’s medical, he exhibited several behaviors which indicated he may nonetheless have battled with depression. If this is indeed the case, his sleep disruption and chronic partial sleep deprivation may have doubled his risk of suicidal behavior. [Encl (45) and (62); FF 332a-332b]

32. The fact that the GW’s Leave and Liberty Policy was not adhered to was a concern. Had MASR Mitchell-Sandor been required to submit a request to take leave outside of the liberty radius when he drove to either Connecticut or South Carolina, it would have required completion of a Navy Travel Risk Planning System (TRiPS) individual travel safety assessment worksheet and approval from the chain of command. This process would have provided leadership with the opportunity to address the adverse effects a 7 or 8-hour drive would have immediately following a 12-hour night-shift, as well as address the reasons for the frequency of the trips. Additionally, this would have provided leadership a chance to counsel MASR Mitchell-Sandor on how to effectively use his off-duty time, rather than use all of it to travel to Connecticut or South Carolina. Adherence to the policy would also have decreased MASR Mitchell-Sandor’s trips home, and therefore limit his fatigue and sleep deprivation, simply because he did not have enough leave accrued to travel as frequently as he had been. [FF 291-318]

33. Once MASR Mitchell-Sandor was assigned to the GW, life became very challenging for him, especially in contrast to his life back at home in Connecticut. At home, he was very popular and beloved within his community, whereas onboard GW he was a very junior Sailor who hadn’t formed a strong support network. Further, he lived mostly by himself in the stressful and unaccommodating environment of a ship undergoing RCOH. This created a dichotomy for

⁶ A “meta-analysis” is defined as a statistical analysis that combines the results from multiple scientific studies.

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MASR Mitchell-Sandor, and he did all he could to “live” at home where he was most happy. This was evident from the fact that he was always talking and texting with family and friends from home during his moments of respite on the ship, and the fact that he would often sleep in his car, both to be able to better speak with friends and family, and to be away from the GW. However, this was most evident in his desire to drive to either Connecticut or South Carolina on his days off duty, despite the fact that such trips were depriving him of necessary sleep. While being home made him happiest, it also affected his ability to properly assimilate to, and become self-reliant in, the new and challenging shipboard environment. [FF 236, 237, 241, 290, 300, and 301]

34. MASR Mitchell-Sandor felt “trapped” in his job, on GW, and in the Navy, yet couldn’t find a way to improve his situation. He did not like living onboard the ship, but was frustrated in his attempts to find options to live off-ship. He wanted to get out of the Navy, but still had more than three years left in his enlistment contract. He told his parents that he wanted to go to school for sports medicine after he got out, so it appears he did not want to make a career out of the Navy. MASR Mitchell-Sandor hadn’t been in the Navy long enough to realize, nor was he likely ever told, that life in the Navy would continue to get better than the experience he was going through on the GW during RCOH. In his final text message to his parents, he describes not being able to live happily and was “looking for a way out,” possibly “never coming back and just trying to get a job and be with you guys.” This likely means MASR Mitchell-Sandor had contemplated desertion, leaving the GW prior to the end of his enlistment contract, and getting a job back home where he could continue to live with his family and near his high school friends. However, this ultimately wasn’t an option for MASR Mitchell-Sandor, as he felt he could not disappoint his family and friends. While he experienced a lot of support from his family, friends, and community, MASR Mitchell-Sandor may have felt a lot of pressure to perform and to live up to expectations. Thus, while MASR Mitchell-Sandor expressed a desire to quit the Navy, he could not go through with it for fear of letting down all those who supported him. This, coupled with the detrimental effects of chronic sleep deprivation and fatigue, may have led MASR Mitchell-Sandor to his belief that suicide was the only option. His ready access to a firearm provided the means for him to follow through with his suicidal intent. [FF 239, 262, 319-331, 342-344, 362-365, and 369-373]

35. MASR Mitchell-Sandor’s suicide was contemplated and planned in advance. Both in basic training and during his time at master-at-arms “A” school, he asked his then-girlfriend if she would attend his funeral. On a separate occasion, he told his then-girlfriend that he saw his step-brother’s firearm in the dresser drawer at home and contemplated using it to end his life. The step-brother corroborates this with his own account of finding his room torn apart and MASR Mitchell-Sandor holding his step-brother’s firearm. His step-brother grabbed him and took the gun from his hand. MASR Mitchell-Sandor was crying and stated that he did not want to go back to the ship. The step-brother told his parents of the incident with the gun and they told him that they would take care of it—the incident was never spoken about again. This event occurred on or about 14 February 2022—approximately two months prior to his death. The day prior to his death, MASR Mitchell-Sandor took two of his home-town friends out to breakfast and lunch,

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and paid for each of their meals. One friend described this as being out of the ordinary for him. MASR Mitchell-Sandor also told them that he felt “trapped” in the Navy, and that if he left the Navy, the Federal Bureau of Investigation (FBI) would come after him. His parents also confirmed that this trip home was off-schedule, unexpected, and out of the ordinary. On his way back to the ship for the final time, he sent a text message to his girlfriend stating that he was having a mental breakdown, was very upset, and wanted out of the Navy. His final communications with friends and family was a text to his parents. His final text message is long, thought-out, well-written, and contains specific instructions as to where he wants to be buried. While it is possible this may have been composed in the hour or so prior to MASR Mitchell-Sandor taking his life after he last spoke to his father on the phone, it is more likely he had composed this message days in advance, given its clarity and how much detail and effort he put into it. On the night he intended to take his life, MASR Mitchell-Sandor armed up for watch, and spoke with MA2 (#2) one last time to get advice regarding his concerns, but ultimately decided to continue with his plan. He removed himself from others by entering the male head (bathroom), where he would have some privacy and where his female roving partner could not follow. Between 2000 hours and 2100 hours he called his father on the phone and sent a video message to Friend #3. In both instances he was believed to have been crying. He sent his final text message, and used his Navy-issued firearm to shoot himself in his left temple, which ultimately ended his life. [FF 243e-243i, 243k, 244d, 244e, 333a-333d, 340a, 348-383, 360-362]

Discussion Conclusion

36. The following findings of fact and opinions support the information contained in the above discussion section. The focus of the above discussion was on the proximate cause and the connection of these suicides. It did not address the investigation team’s findings related to command climate, mental health care, and quality of life issues onboard the ship. Those areas are briefly addressed below to help provide context to the environment that each Sailor was living in. For IC3 Huffman and MASR Mitchell-Sandor, it is clear that Navy life added stress to their lives. There is no indication that the events leading to RS3 Sharp’s suicide were aggravated by the Navy, other than the hypothetical concern of Navy discipline due to his interactions with local police stemming from the incident of domestic violence. It is impossible to know definitively if any action by the Navy prior to these events would have changed the outcomes. Only IC3 Huffman had ever sought mental health care.

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Findings of Fact

General Facts

1. GW was and is in the midst of its mid-life RCOH period at HII-NNS during the time of the incidents. [Encl (17), Ref (b)]
2. MASR Mitchell-Sandor, IC3 Huffman, and RS3 Sharp were all first-term Sailors, assigned to their first ship, the GW. [Encls (9) and (17)]
3. RS3 Sharp, IC3 Huffman, and MASR Mitchell-Sandor all worked in different departments onboard GW. [Encls (2), (6), (17), (20), (25), and (27)]
4. None of the Sailors interviewed identified any social or work-related connections between RS3 Sharp, IC3 Huffman, or MASR Mitchell-Sandor. [Encls (2), (4), (6), (8), (9), (14), (16), (17), and (28)]
5. None of the Sailors interviewed believed that the deaths of RS3 Sharp, IC3 Huffman, or MASR Mitchell-Sandor were related in any way. [Encls (2), (4), (6), (8), (9), (14), (16), (17), and (28)]
6. From a medical treatment perspective, both the ship's Senior Medical Officer (SMO), a licensed psychiatrist, and the Ship's Psychologist (Psych Boss) did not know of any connection between the three Sailors who died on or about April 2022. [Encls (8) and (16)]
7. When asked what a "suicide contagion" was, SMO stated that it was the idea that suicide becomes a more viable option for a Sailor who has observed that another has done it, making it a possibility, and seeing that the individual who committed suicide got a lot of attention posthumously. [Encl (8)]
8. While SMO did not believe there was the existence of a "suicide contagion" onboard GW, Psych Boss stated that it is always possible, due to the amount of deaths that had occurred, but it was "hard to say." [Encls (8) and (16)]
9. On 16 April 2021, the prior Commanding Officer (CO) of GW initiated crew move-aboard (CMA), in accordance with the pre-established and approved RCOH Key Events Schedule.
10. The prior CO stated there was pressure to get "out of the way for USS JOHN C. STENNIS," which meant they had to get off the Floating Accommodation Facility (FAF) so that the FAF could be overhauled for STENNIS' use. [Encl (47)]

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11. The prior CO stated that another element of the decision to initiate CMA was to boost morale by achieving a milestone and take back ownership of the GW. He stated that the GW “needed a victory.” [Encl (47)]

12. The prior CO stated that he consulted the RCOH Key Events Schedule, his Executive Officer (XO), Supervisor of Shipbuilding, Conversion and Repair (SUPSHIP), HII-NNS, and others before determining that they could safely execute CMA, after the aft crew berthing had been deemed “habitable.” [Encl (47)]

13. On 8 October 2021, the current CO of GW authorized the complete crew move-aboard (CCMA) in accordance with reference (g).

14. The shipyard is a hazardous and noisy industrial environment. Noises such as the sounds of needle gunning, bells going off, frequent announcements on the ship’s main circuit public announcement system (1MC), grinding, etc., are common. [Encls (2), (6), (17), (20), (21), (26), (40), and (47)]

15. Onboard GW, the work necessary for RCOH causes many loud noises throughout the day. [Encls (6), (21), (26), and (40)]

16. The shipyard operates 24 hours per day, 7 days per week, but has designated quiet hours between 2200-0600. [Encls (15), (26), and reference (g)]

17. Multiple Sailors interviewed stated that some junior Sailors seemed to struggle with the ability to adapt to shipboard and shipyard life. [Encls (2), (6), (25), and (38)]

18. Based on the shipyard environment, electrical power, heating, ventilation, and air conditioning (HVAC), and hot water are frequently interrupted to various sections of the ship in order to accommodate ongoing ship construction and to facilitate routine maintenance. [Encls (2), (17) (26), and (40)]

18a. Morale, Welfare, and Recreation services, such as television, were not available onboard. [Encl (35)]

18b. For crew residing onboard, there were limited places to sit and relax. [Encl (35)]

19. Some Sailors indicated localized outages (whether power or hot water), though the reported length of these outages varied. [Encls (2), (7), (26), and (40)]

20. The longer localized outages reported were anywhere from three days to two weeks. [Encls (2) and (26)]

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21. The policy of the current CO, who took command June 2021, is to move Sailors to unaffected berthing spaces prior to planned outages, or when made aware of unplanned outages. [Encls (7), (9), and (13)]
22. The CMC stated that “[t]here is always a Head you can find with hot water, but you do have to go looking for it.” [Encl (9)]
23. During the course of this investigation, multiple Sailors revealed their concerns with berthing spaces. When asked about these concerns, leadership at the E-9 level and above were unaware of some of these issues. [Encls (5), (7), (9), and (40)]
24. The GW XO, who checked onboard in March 2022, is responsible for berthing inspections, and coordinates them with the chiefs and berthing petty officers. [Encl (7)]
25. The current CMC and XO walk berthing spaces and note discrepancies. [Encls (7) and (9)]
26. CMC stated that if discrepancies were found, he would immediately notify Department Leading Chief Petty Officers (DLCPOs) and the Engineering Duty Officer (EDO). [Encl (9)]
27. The current CO stated he makes efforts to discuss issues the ship is facing over the 1MC, the overhead speaker system used to communicate to the crew, and to call the ship’s maintenance support line if any issues are encountered. [Encl (7)]
28. The investigation team observed that it is difficult to hear the 1MC, and Sailors may not be adequately getting information communicated to them each time. [Encls (7) and (17)]
29. Many Sailors in RCOH are required to work out of their specialized Navy job rating (or “rate”). [Encls (2), (5), (6), (16), and (40)]
30. Multiple Sailors interviewed, who were working outside of their rates, conveyed there is a lack of ownership and investment in GW, and the present mission. [Encls (2), (6), (16), (40), and (47)]
31. Multiple Sailors interviewed felt it was depressing to work onboard the ship during RCOH. [Encls (6), (18), (21), and (40)]
32. Junior Sailors discussed not feeling comfortable making complaints to leadership about issues they encounter while living and working aboard the GW during RCOH. [Encls (2), (17), (38), and (40)]
33. For junior Sailors with cars, the nearest free parking option is the parking lot at 50th Street. [Encl (16) and Figure-1]

CUI

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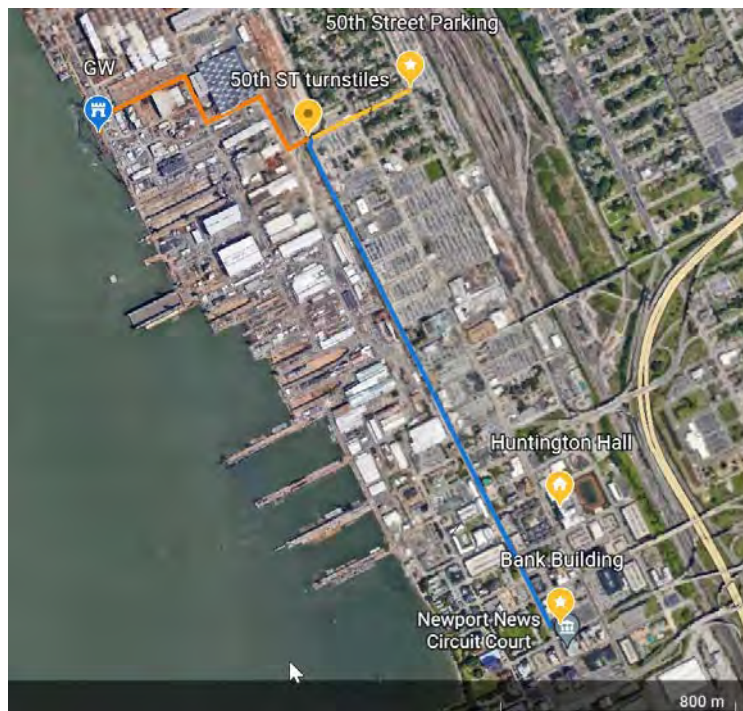


Figure-1

34. From the 50th Street parking lot, Sailors must walk approximately one mile to where the GW is located at shipyard Outfitting Berth 1 (OB1), as calculated by the investigation team. [Figure-1]

35. Some Sailors park at satellite locations and are bussed in to the 50th Street gate. [Encl (6)]

36. Some junior Sailors choose to sleep in their cars rather than sleep onboard GW. [Encls (2), (5), (15), and (38)]

37. The GW has one billet for a Behavioral Health Technician (Psych Tech) and one for a ship's psychologist (Psych Boss). [Encls (14) and (16)]

38. Psych Tech believes that many techs like him get out of the Navy because they get “burned out” from sea duty due to the high demand onboard ships. [Encl (14)]

39. Between January 2021 and January 2022, there were an estimated 2,615 patient encounters between Psych Boss, Psych Tech, and the two Substance Abuse Rehabilitation Program (SARP) Counselors. [Encls (14) and (16)]

40. At the time of the incidents, there was, and presently is, a high demand and backlog of patients waiting to receive mental health treatment from Psych Boss. [Encls (6), (14), and (16)]

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41. Sailors seeking an initial routine, non-emergent, mental health assessment from Psych Boss may experience a wait of one to two months due to the significant backlog. [Encls (6), (14), and (16)]
42. Some Sailors choose to seek mental health treatment off-ship, through Navy or civilian providers (both in the TRICARE network and out), rather than wait for appointments onboard GW. [Encls (6), (8), and (10)]
43. SMO was concerned about the high mental health patient volume the ship had been dealing with, and had communicated these concerns with his immediate superior in command (ISIC). [Encls (8), (14), and (16)]
44. Even before the three Sailors died in April 2022, the patient volume that Psych Boss and Psych Tech had been seeing was described as “overwhelming.” [Encls (8), (14), and (16)]
45. In order to help triage the patient backlog, Psych Tech will see patients weekly or every other week in order to follow up on patients’ well-being. [Encl (14)]
46. Daily, Psych Tech and Psych Boss each see up to 20 patients. [Encls (14) and (16)]
47. According to the Psych Tech, Psych Boss works very hard and the command had to “force” him to take leave as he hasn’t had a break, during which time Psych Tech would deal with any immediate concerns. [Encl (14)]
48. If a Sailor had an emergent reason to be seen before his or her initial appointment, Psych Tech will see the patient that day and provide resources until the appointment date. [Encls (14) and (16)]
49. SMO and Psych Boss had considered switching from individual-based therapy to group therapy in order to handle the high volume, but chose not to because group therapy “hadn’t worked well in the past.” [Encl (8)]
50. If a Sailor is evaluated for mental health reasons at Navy Medical Center Portsmouth (NMCP) emergency room (E.R.) or another local E.R. and not admitted to the hospital, then they are instructed to have a follow-up appointment with GW mental health providers on the next business day. [Encls (6), (14), and (16)]
51. According to Psych Tech, if a Sailor reports suicidal ideations, the process is as follows: the sailor will first fill out paperwork for assessment; they undergo a screening interview with Psych Tech to evaluate if they have any current plans or intentions to harm themselves; and then they see Psych Boss, who determines if they meet the criteria to go to the E.R., NMCP, etc. [Encl (14)]

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52. GW transmits a Navy situation report (SITREP) via official message traffic up the chain of command for every instance of suicidal ideation, if it results in the Sailor being admitted to the hospital. Per reference (e), a SITREP should be transmitted for each instance of suicidal-related behavior, which includes both suicidal ideation and suicide attempt. While an “appropriate competent authority” is to decide whether behavior qualifies as suicide-related behavior, whether or not a Sailor was admitted to the hospital is not a listed element. [Encls (8) and (19)]

53. If a Sailor has suicidal ideations but is not admitted, medical will send out an internal “5-W’s” email (i.e., who, what, when, where, why) to the CO, XO, and CMC (the TRIAD) to inform them of the incident. [Encl (8)]

54. If a Sailor sees an out-of-network provider, that medical encounter data is not available in the electronic military health record, unless provided by the member. [Encl (8)]

55. According to the investigation team’s medical care providers, if a Sailor sees an out-of-network provider for a routine, non-emergent matter without a referral from a military health provider, then he or she is normally responsible for covering any related costs.

56. Some Sailors are hesitant to seek mental health treatment through Navy channels due to concerns it would affect future career opportunities. [Encls (5) and (10)]

57. Psych Tech stated that “leadership,” and specifically Leading Petty Officers (LPOs), “don’t have time” to deal with mental health issues of their subordinates and want to refer them to Psych Boss and Psych Tech to deal with, but he did not specify any particular departments. [Encl (14)]

58. The Deployed Resiliency Counselor (DRC)⁷ is located off ship, approximately a three-mile walk away from the ship. [Encls (2), (4), (14), (16), and Figure-1]

59. The DRC saw approximately 46 patients since January 2021. [Encls (14) and (16)]

60. The only Sailor interviewed who utilized the DRC reported positive interactions and support. [Encl (5)]

61. Multiple Sailors interviewed stated they had not seen, or had hardly seen, the DRC onboard the ship. [Encls (8), (12), (14), (16), and (24)]

62. Multiple Sailors interviewed did not know who the DRC was, what the DRC offered, or where the DRC was located. [Encls (2), (4), (12), (14), (18), (21), (26), (29), and (30)]

⁷ DRCs are professionally licensed civilian clinicians assigned to all aircraft carriers (CVNs) and large deck amphibious assault ships (LHDs/LHAs) throughout the Navy. DRCs offer confidential, short-term, non-medical counseling and psychoeducational training to Sailors while deployed and in port.

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63. Multiple Sailors interviewed stated they did not have a mentor. [Encls (2), (3), (18), (21), and (26)]

64. Multiple Sailors interviewed stated they hardly heard from their assigned sponsors when checking onboard GW. [Encls (3), (18), and (22)]

65. Some members of GW leadership interviewed reported that khaki leadership (E-7s and above), especially E-7s, were spread “really thin,” and that not all billets were filled. [Encls (2), (7), (40), and Figure-2]

		NOV 21			DEC 21			JAN 22			FEB 22			MAR 22			APR 22		
		BA	Onboard	Fill %	BA	Onboard	Fill %	BA	Onboard	Fill %	BA	Onboard	Fill %	BA	Onboard	Fill %	BA	Onboard	Fill %
N21412 - CVN 73 GEORGE WASHINGTON	APPRENTICE	1,548	1,360	87.9%	1,548	1,337	86.4%	1,548	1,362	88.0%	1,548	1,368	88.4%	1,548	1,381	89.2%	1,546	1,468	95.0%
	JOURNEYMAN	1,022	850	83.2%	1,022	884	86.5%	1,022	883	86.4%	1,022	879	86.0%	1,025	892	87.0%	1,027	884	86.1%
	SUPERVISOR	260	180	69.2%	260	181	69.6%	260	178	68.5%	260	177	68.1%	260	176	67.7%	260	169	65.0%

BA: Billets Authorized
 APPRENTICE: Paygrades E1-E4
 JOURNEYMAN: Paygrades E5-E6
 SUPERVISOR: Paygrades E7-E9

Figure-2: Current GW billets authorized vs billets filled (“Fill”)

66. Due to restrictions related to the COVID-19 pandemic, MWR events had previously been shut down and, at the time of this investigation, were only beginning to bring these types of events back online. [Encl (17)]

67. Multiple Sailors reported leadership doesn’t want to talk about, or otherwise feels uncomfortable talking about, mental health issues with junior Sailors. [Encls (6), (14), and (40)]

Facts Pertaining to RS3 Sharp

68. At the time of his death, RS3 Sharp did not reside onboard GW, and had been on Temporary Assigned Duty (TAD) to a barber school at Joint Expeditionary Base (JEB) Little Creek in Virginia Beach, VA. [Encls (18), (27), (29), (30), and (37)]

69. RS3 Sharp lived with his mother at her house, while his wife, whom he married in May 2021, lived separately at her mother’s house. His wife was previously enlisted in the Navy. [Encls (18), (30), and (37)]

70. RS3 Sharp was assigned to the barber shop onboard GW. [Encls (6), (20), (31), and (37)]

71. RS3 Sharp did complain about being onboard GW during RCOH, but would “just make the best of it.” [Encls (18), (20), and (37)]

72. RS3 Sharp loved working in the barber shop onboard GW, and would stay there to relax, even when off shift. [Encls (20), (27), and (31)]

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73. RS3 Sharp enjoyed playing online video games with his friends, while discussing life events. [Encls (18), (20), (28), and (30)]

74. RS3 Sharp was described as a “gun enthusiast” and owned three firearms. [Encl (37)]

75. RS3 Sharp felt he had often been overlooked by the Navy, and had not received the proper recognition for his work. [Encls (18), (29), and (31)].

76. While attending barber school, then-RSSN Sharp was notified that he was selected for meritorious advancement to the next pay grade – i.e., RS3. [Encls (9), (17), (18), (27), and (29)]

77. At least until the last few weeks before he died, RS3 was described to have a great-looking uniform. [Encls (27), (29), and (31)]

78. RS3 Sharp had recently gained weight, possibly 15 pounds. [Encls (18), (29), and (37)]

79. RS3 Sharp often argued with his wife, but they were “normal” marital arguments. [Encls (18), (28), (31), and (37)]

80. According to Mrs. Sharp, when describing their marriage over the last few months before RS3 Sharp died, she stated “we weren’t the best.” [Encl (37)]

81. YNSN stated she had seen Mrs. Sharp post on Facebook that the two of them would fight and argue a lot. [Encl (31)]

82. RS3 Sharp and his wife were both engaged in relationships outside of their marriage. [Encls (18), (28), and (37)]

83. RS3 Sharp’s concerns about his wife having a relationship outside of their marriage caused him stress and anxiety. [Encls (18), (28), and (37)]

84. Multiple Sailors interviewed stated that when RS3 Sharp would drink, he would drink to excess. [Encls (18), (28), (29), and (30)]

84a. The GW Drug and Alcohol Program Advisor (DAPA) had no records regarding alcohol abuse by RS3 Sharp. [Encl (67)]

85. RS3 Sharp started drinking heavily while his wife was deployed overseas, which she described as his “coping mechanism.” [Encl (37)]

86. Mrs. Sharp stated that when RS3 Sharp would get drunk, he would get “a little hostile,” and she was concerned about his drinking. [Encl (37)]

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87. RS3 Sharp told RS2 that his mind “sometimes goes off the deep end,” or words to that effect. [Encl (28)]

88. Mrs. Sharp stated that, while she did not believe RS3 Sharp to have mental health issues, when they first started dating he would say things like “I don’t see myself in the future.” [Encl (37)]

89. Approximately a month and a half prior to his death, RS3 Sharp discussed having anxiety issues with friends. [Encls (18) and (28)]

90. Friends of RS3 Sharp described him as a happy person who liked to dance and joke a lot with others. [Encls (18), (20), (29), (30), (31), and (37)]

91. RS3 Sharp did not appear to have a mentor. [Encl (18)]

92. On the day he died, RS3 Sharp was attending a “gender reveal” party for his sister-in-law with his wife and 20-30 members of his wife’s family. He was reportedly excited to be there. [Encls (18), (20), (28), and (37)]

93. RS3 Sharp got along well with his mother-in-law and his wife’s family. [Encl (37)]

94. RS3 Sharp was drinking straight liquor during the party and was described as “too intoxicated.” [Encls (18), (28), and (37)]

95. During the party, RS3 Sharp and his wife got into an argument over pictures and text messages from other women purportedly contained on RS3 Sharp’s phone. [Encls (18), (28), and (37)]

96. RS3 Sharp and his wife went to a bedroom to continue the argument, where RS3 Sharp closed the door and would not let her leave. RS3 Sharp’s “brother” (a close friend since childhood) was in the room, but did not intervene. [Encl (37)]

97. Mrs. Sharp stated that this argument was “something different,” and she said “it was just a look in his eyes.” She stated he wasn’t “resonating anything anyone was trying to say” to him, that he “was already gone at that point.” [Encl (37)]

98. The argument quickly became physical, with the two slapping and pushing each other, until RS3 Sharp pinned his wife down on the bed, causing her to have an anxiety attack. [Encl (37)]

99. According to RS3 Sharp’s wife, this was the first time an argument had escalated into a physical altercation. [Encl (37)]

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100. Family and friends heard the altercation and attempted to get into the bedroom, and when the door was opened, Mrs. Sharp left the room and party with her friend. [Encl (37)]

101. RS3 Sharp attempted to follow his wife, but family and friends at the party stopped him and called the police. [Encl (37)]

102. Mrs. Sharp returned to the party and observed RS3 Sharp arguing with his “brother.” [Encl (37)]

103. Mrs. Sharp stated that he may have felt that he was “all alone” at this point. [Encl (37)]

104. When the police arrived, RS3 Sharp was “very erratic” and would not calm down. He was yelling in a law enforcement officer’s face. [Encl (37)]

105. Law enforcement officers asked if “anyone put hands on each other” and Mrs. Sharp told them “no.” [Encl (37)]

106. Mrs. Sharp was directed by law enforcement to leave, and her friend drove her away. [Encl (37)]

107. Mrs. Sharp received a FaceTime video call from RS3 Sharp and observed him with a firearm in his hand. [Encl (37)]

108. Mrs. Sharp asked her husband why he had the firearm, but he “kept going” and did not calm down. She hung up and tried to call RS3 Sharp’s mother. [Encl (37)]

109. Approximately 10 minutes after they left the party, while RS3 Sharp’s wife was attempting to contact the mother, her friend received a phone call informing her that RS3 Sharp had shot himself. [Encl (37)]

110. RS2, a mutual friend of RS3 Sharp and his wife, stated that, the morning after RS3 Sharp had died, RS3 Sharp’s sister told her in a phone call that he was “drunk” and got in a fight with his wife. [Encls (18) and (28)]

111. RS2 stated that RS3 Sharp’s sister further stated that RS3 Sharp “got mad, went outside, and killed himself,” or words to that effect. [Encls (18) and (28)]

Facts Pertaining to IC3 Huffman

112. IC3 Huffman did not permanently reside onboard GW. [Encls (10) and (12)]

113. IC3 Huffman was described as being “happy” and “full of life.” She was further described as having a lot of friends, and being very funny. [Encl (36)]

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114. IC3 Huffman's mother stated that her daughter "wanted to see the world, but then got assigned to GW, so that didn't happen, but that didn't seem to bother her." [Encl (36)]

115. IC3 Huffman was in a relationship with EM1. [Encls (6), (10), (33) and (36)]

116. EM1 stated that they had "basically" been living together since December 2021. [Encl (10)]

117. EM1 had officially been living with IC3 Huffman at their joint residence for two to three weeks prior to her death. [Encls (10) and (11)]

118. Before she lived with EM1, IC3 Huffman lived in a one-bedroom apartment in Newport with her dog, cats, and tarantula. [Encl (36)]

119. IC3 Huffman was married to a former Sailor, but was legally separated and seeking a divorce. [Encls (10), (33), (36), and (42)]

120. IC3 Huffman was originally assigned to Combat Systems. [Encl (10)]

121. IC3 Huffman was then re-assigned to Air Department. [Encls (4), (10), and (19)]

122. IC3 Huffman did not have an assigned mentor. [Encl (2)]

123. Air Department discussed mental health resources at quarters every two months, and largely in reaction to an incident that occurred in July 2021. [Encl (19)]

124. Psychologist #1 and the CNAF Force Psychologist of the investigation team both reviewed the notes in IC3 Huffman's medical file in the military health care system (not included as a separate enclosure to limit exposure of sensitive medical information). They noted that IC3 Huffman had been seen for 34 different mental health appointments since she joined the Navy in July 2018. Of note, 9 of the 34 appointments were during IC3 Huffman's initial accession training at Great Lakes. She was seen by the SMO approximately five times, and Psychiatrist #1 at NMCP on two occasions. On or about 2 February 2022, SMO prescribed IC3 Huffman's medication, Seroquel, with 2 refills (each a 30-day supply). In mid-February 2022, IC3 Huffman filled her initial prescription from SMO. On 28 March 2022, IC3 Huffman filled the first of her two refills. IC3 Huffman had been treated for mental health concerns by both psychologists and psychiatrists on different occasions.

125. Of the three GW Sailors who died in April 2022, IC3 Huffman was the only one who was a patient of the GW mental health team. [Encls (8) and (14)]

126. IC3 Huffman was a patient of the previous Psych Boss starting in 2019. [Encl (14)]

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127. IC3 Huffman first came to the previous Psych Boss to discuss stressors relating to relationship issues. [Encl (14)]

128. According to EM1, IC3 Huffman stopped seeing the previous Psych Boss because she “didn’t trust him.” [Encl (10)]

129. Multiple Sailors interviewed stated they didn’t trust the mental health care Sailors received at NMCP. [Encls (2), (10), and (11)]

130. In summer 2020, IC3 Huffman was admitted to NMCP after a suicide attempt by overdosing on pills, and was diagnosed with borderline personality disorder. This suicide attempt was not reported in the Defense Information Service System (DISS). Pursuant to reference (h), reporting of information that suggests an individual may have an emotional, mental, or personality condition that impairs judgment, reliability, or trustworthiness are required to be reported in DISS. [Encls (8), (10), (48), and (61)].

131. In December 2020, IC3 Huffman was admitted to the psychiatric inpatient ward and kept for a few days for mental health concerns. [Encls (10), (36), and (48)]

132. After reviewing the military health care system notes for IC3 Huffman after her death, SMO noted that there was indication she had been seeing a civilian therapist since September 2021. [Encls (8) and (48)]

133. According to EM1, IC3 Huffman was once told by her supervisor that she was taking too much time off to get care, and her supervisor prevented IC3 Huffman from going to an appointment to see a “psych in town.” It is unclear whether this was a psychiatrist or a psychologist. [Encl (10)]

134. According to EM1, her out-in-town provider dropped her as a patient due to the missed appointment, and she was forced to see another care provider that was more expensive, which caused her stress. [Encl (10)]

135. In November 2021, the current SMO began providing mental health care to IC3 Huffman. [Encls (8) and (48)]

136. IC3 Huffman self-reported a history of cutting herself, dating back to when she was 14 years old. [Encls (8), (10), and (48)]

137. According to her mother, IC3 Huffman was diagnosed with anxiety and saw a therapist while in high school in Iowa. She was 17 years old at the time. [Encl (36)]

138. IC3 Huffman’s medical record indicated she self-reported having received therapy from ages 14 to 17, and was prescribed Zoloft, with limited benefits. [Encl (48)]

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139. Per reference (c), receiving treatment for depression within 36 months (such as prescription Zoloft), outpatient care including counseling required for longer than 12 cumulative months, and any history of self-mutilation are all disqualifiers from entry into the military service, unless an individual receives a waiver.

140. IC3 Huffman's medical record does not indicate she ever received a waiver for Zoloft or for her previous self-harm, as would be required by reference (c). [Encl (48)]

141. On or about November 2018 and during her initial training pipeline, IC3 Huffman had been referred to the emergency department at Great Lakes because she had been scratching on her arm with a bread knife and complained of "overwhelming depression." During this visit, she denied any history of depression or self-harm, and was referred for follow-on mental health care, which consisted of therapy and anti-depressant medication. [Encl (48)]

142. Since she was 17 years old, IC3 Huffman had been in therapy and had been prescribed anti-anxiety and anti-depression medications. [Encls (8), (10), (36), and (48)]

143. SMO noted that IC3 Huffman experienced significant symptoms of depression and anxiety. [Encl (8)]

144. SMO stated that IC3 Huffman reported having daily thoughts of wanting to end her life. [Encl (8)]

145. According to EM1, since he met IC3 Huffman in August 2021, she would occasionally cut, pick and scratch at her arms and legs, and would also pull out her hair. [Encl (10)]

146. IC3 Huffman's mother stated that every once in a while, IC3 Huffman would get really angry and then 10-15 minutes later would be her normal self. She recalled her daughter even doing this back in high school. [Encl (36)]

147. On 25 January 2022, SMO diagnosed IC3 Huffman with Bipolar Disorder, and she prescribed medication that disqualified her from working onboard the ship. [Encls (8), (36), and (48)]

148. SMO stated that it was not uncommon for a patient with Bipolar Disorder to have internal anxiety and thoughts of depression, yet otherwise appear outwardly normal, due to the fact that the patient is so used to having these thoughts and feelings. [Encl (8)]

149. As a result of the prescribed medications, IC3 Huffman was deemed not medically suitable to remain onboard ship. [Encls (8), (10), and (48)]

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150. On or about November 2021, SMO referred IC3 Huffman to Limited Duty (LIMDU) and her care was subsequently transferred to Psychiatrist #1, a licensed psychiatrist at NMCP. [Encls (8), (10), and (48)]

151. Starting on or about December 2021, IC3 Huffman was assigned TAD to Huntington Hall (barracks) at HII-NNS for her daily duties. [Encls (4), (6), (10-12), (14), (19), (48), and Figure-1]

152. IC3 Huffman was still TAD to Huntington Hall when she died on or about 10 April 2022. [Encls (4), (6), (10), and (11)]

153. IC3 Huffman's duties at Huntington Hall mostly consisted of mustering every morning at 0700 and ensuring she attended any medical appointments assigned. [Encl (4)]

154. IC3 Huffman was disappointed to be assigned TAD to Huntington Hall. [Encl (4)]

155. According to EM1, IC3 Huffman thought her job at Huntington Hall was a "joke." [Encls (10)]

156. While she was assigned TAD to Huntington Hall, IC3 Huffman's chain of command from GW would routinely check up on her. [Encls (4) and (19)]

157. IC3 Huffman periodically came back onboard GW for various reasons. [Encls (4), (8), (12), and (48)]

158. IC3 Huffman wanted to stay in the Navy, and was upset that she would ultimately be separated. [Encls (10), (12), and (36)]

159. On or about January 2022, IC3 Huffman was referred to the Disability Evaluation System (DES). [Encls (8), (10), and (48)]

160. IC3 Huffman was upset about being referred to the DES process. [Encls (10) and (48)]

161. The DES process currently can take anywhere from 6-12 months to complete. [Encls (8), (10), and (48)]

162. Psychiatrist #1 initially disagreed with SMO's Bipolar Disorder diagnosis for IC3 Huffman, and diagnosed her instead with adjustment disorder and borderline personality disorder. [Encls (8), (36), and (48)]

163. During the DES process, IC3 Huffman was told by her Physical Evaluation Board Liaison Officer (PEBLO) that, due to Psychiatrist #1's diagnosis of adjustment disorder and borderline

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personality disorder, IC3 Huffman was no longer going to be medically separated from the Navy. [Encl (10)]

164. On 2 February 2022, Psychiatrist #1 re-diagnosed IC3 Huffman with Bipolar Disorder, and IC3 Huffman was again informed that she would be medically separated from the Navy. [Encls (8) and (48)]

165. Psychiatrist #1's notes indicate IC3 Huffman wanted to see a new provider. [Encls (8) and (48)]

166. IC3 Huffman had concerns with some of her interactions with Psychiatrist #1, and came back to see SMO. [Encls (8), (10), (12), and (48)]

167. IC3 Huffman told her mother that she didn't feel like her doctors were helping her, and that she wasn't getting the right medication. IC3 Huffman's mother said this was affecting her daughter's temper and "making her angry" because IC3 Huffman felt she didn't have "anyone she could talk to regularly." [Encl (36)]

168. EM1 stated that IC3 Huffman's "major issue" was when her mental health care was transferred from SMO to NMCP, as it "caused a major gap in her care" and caused significant stress. [Encls (10) and (33)]

169. SMO stated the military health care system notes indicated that IC3 Huffman's care ended in February 2022 when she sought a new provider, with no further documented mental health care. The notes in IC3 Huffman's medical record indicated that IC3 Huffman did not want to discuss getting a new doctor with Psychiatrist #1. [Encls (8) and (48)]

170. IC3 Huffman experienced stress from issues relating to her marriage to her husband, who also suffered from mental health issues. [Encls (2), (4), (10), (11), (12), (14), and (36)]

171. IC3 Huffman married her husband, a former Navy Sailor, in February 2019, and separated from him in May 2021. [Encl (36) and Ref (e)]

172. IC3 Huffman stated that her husband was unhappy and had been having suicidal thoughts, which similarly caused her to be unhappy and experience suicidal thoughts, months prior to the date of her death. [Encl (2)]

173. IC3 Huffman reported to her leadership that her husband was "mentally and physically abusive" towards her. [Encls (2), (4), and (36)]

174. In October 2021, IC3 Huffman's husband came over to her residence and yelled and screamed at her, which "rattled her." [Encl (19)]

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175. A Military Protective Order (MPO) was reportedly in place restraining IC3 Huffman's husband from contacting her. [Encls (4), (10), and (36)]

176. According to her mother, IC3 Huffman's husband was arrested for "sending her to the emergency room" the day before they separated. [Encl (36)]

177. IC3 Huffman's husband is currently in custody for domestic abuse, both against IC3 Huffman and against another unknown person, whom he allegedly "tried to choke." [Encls (10) and (36)]

178. According to EM1, IC3 Huffman was legally separated from her husband, but had not been able to serve the proper documents to him to complete the divorce due to him being moved from jail to jail. [Encls (10) and (36)]

179. According to EM1, IC3 Huffman was diagnosed with Post-Traumatic Stress Disorder (PTSD) from her marriage to her husband. However, no such diagnosis was observed in her medical record. [Encls (10) and (48)]

180. One of IC3 Huffman's major life stressors was the fact that her mother had lymphoma. [Encls (4), (8), (10), and (19)]

181. According to EM1, IC3 Huffman was experiencing stress regarding financial decisions her mother was making that IC3 Huffman didn't agree with. [Encl (10)]

182. On Thursday, 7 April 2022, IC3 Huffman was reported to have been "in tears" because she was in the midst of "changing medications," and per her request, her supervisor sent her home early to go to medical. [Encls (3), (4), (10), (19), and (49)]

183. IC3 Huffman's supervisors stated she reported receiving a Ketamine shot every Friday for at least two months. [Encls (3) and (49)]

184. IC3 Huffman's supervisors at Huntington Hall assumed she was going to NMCP for her Ketamine shots, but never clarified that with her. [Encls (3) and (49)]

185. SMO stated that Ketamine is a controversial drug, and, as a controlled substance, is only allowed to be used in the military system in certain situations. [Encl (8)]

186. SMO stated that, to his knowledge, Ketamine is not used in the Navy to treat psychiatric conditions. [Encl (8)]

187. SMO stated Ketamine is administered either via intravenous (IV) infusion, or intranasal. [Encl (8)]

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188. On Friday morning, 8 April 2022, according to her supervisors at Huntington Hall, after muster, IC3 Huffman “went to her appointment to get a Ketamine shot as usual.” [Encls (3) and (49)]

189. After she reported going to seek mental health treatment on Thursday, 7 April 2022, IC3 Huffman’s supervisors and friends made sure they were regularly checking in with her for the two days preceding her death. [Encls (2), (3), and (10)]

190. The investigation team did not find any documentation of either IC3 Huffman’s initial appointment on Thursday, 7 April 2022, with a provider off-ship, or a follow up appointment with GW medical afterwards. [Encl (48)]

191. Multiple Sailors interviewed reported that IC3 Huffman received anti-anxiety medication on Thursday, 7 April 2022. [Encls (4), (10), and (33)]

192. Her supervisor checked up on IC3 Huffman later on Thursday, and she stated everything was much better. [Encl (3)]

193. EM1 stated that IC3 Huffman told him that she received an “IV drip” when she went to medical and they “doubled her medication.” [Encl (10)]

194. IC3 Huffman’s mother, who last spoke to her daughter on Thursday, 7 April 2022, stated IC3 Huffman was laughing, going to get flowers to plant, and spoke of how much her dog was loving the new fenced-in yard. Her mother further stated that after IC3 Huffman got out of the Navy and started school, she was going to come home to Iowa, and that her daughter was “excited to do so.” [Encl (36)]

195. IC3 Huffman was planning to attend college to become a software engineer. [Encls (2), (10), and (36)]

196. According to EM1, IC3 Huffman was going to attend college locally in Virginia. [Encl (10)]

197. On Friday, 8 April 2022, while mustering at Huntington Hall, IC3 Huffman was reportedly back to her “normal self” and had been observed to be happy and dancing. [Encls (3) and (49)]

198. IC3 Huffman told her supervisors she was going to get her Ketamine shot on 8 April 2022. [Encls (3) and (49)]

199. On Saturday, 9 April 2022, EM2 came over at approximately 2130 to the joint residence of EM1 and IC3 Huffman, and EM2 and IC3 Huffman ate pizza, watched the show “Family Guy,” and drank through the night. [Encl (11)]

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200. EM1 stated he was playing in a football game on 9 April 2022, and didn't come back until much later that evening. EM2 was present when EM1 arrived. [Encl (10)]

201. EM2 stated that IC3 Huffman had been drinking heavily the night of 9 April 2022, and was "pretty blitzed." [Encls (6) and (11)]

202. When asked how much IC3 Huffman drank the night of 9 April 2022, EM2 stated she had "a half of a fifth" (12.5 oz) of whiskey mixed with soda, and was slurring her words a bit. When asked where IC3 Huffman was on a scale of 1-10, with 10 being the most intoxicated, EM2 stated that IC3 Huffman was a "7 or 8 that night." [Encl (11)]

203. IC3 Huffman told EM1 that when she drinks while taking Seroquel, it "affects her a lot more." [Encl (33)]

204. SMO stated that it was "never a good idea" to combine heavy alcohol consumption with Ketamine or Seroquel. [Encl (8)]

205. EM2 described IC3 Huffman as short and weighed about 110 pounds. [Encl (11)]

206. EM1 stated that IC3 Huffman was a "lightweight" when it came to drinking, and that "a few drinks were more than enough for her." [Encl (33)]

207. EM2 stated that when IC3 Huffman would drink, it was "a lot," and when they have a party, IC3 Huffman "binges." [Encl (11)]

208. EM1 believed that IC3 Huffman was insecure, especially with respect to his ex-girlfriend. [Encl (10)]

209. EM1 stated that IC3 Huffman's insecurities showed themselves the most when she would drink. [Encl (33)]

210. EM1 stated IC3 Huffman's husband had "cheated on her a lot" and that she was concerned he was "doing stuff behind her back," which would cause her to get upset. [Encl (33)]

211. EM1 stated that he was not cheating on IC3 Huffman. [Encls (10) and (33)]

212. According to IC3 Huffman's mother, her daughter had a notebook she used as a journal, and had written about "stuff with [EM1]" that had been upsetting her. When asked for specifics, IC3 Huffman's mother was unable to provide anything further. [Encl (36)]

213. EM1 stated that he and IC3 Huffman would argue every other weekend, and these arguments occurred after she started drinking. [Encl (33)]

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214. On the evening of Saturday, 9 April 2022, sometime after EM2 left, EM1 and IC3 Huffman got into an argument because she thought EM1 had pictures of his ex-girlfriend on his phone. [Encls (10), (11), and (33)]

215. EM1 stated that the fight was not physical, but IC3 Huffman kept yelling “I can’t believe you lied to me about this,” or words to that effect. [Encl (33)]

216. EM1 tried to explain that he didn’t have pictures of his ex-girlfriend on his phone, but that he was showing EM2 an online picture from social medial of his ex-girlfriend because EM2 thought she worked at the gym he frequented. [Encls (10), (11), and (33)]

217. Once IC3 Huffman began to compare EM1 to her husband, this angered him, escalating the argument until IC3 Huffman stated she wanted to move out and that they had moved in together “too fast.” [Encl (33)]

218. EM1 then decided to “step away” from the argument and went down to the local gas station to “cool off.” [Encl (33)]

219. When EM1 returned, IC3 Huffman was in the bathroom and she started to apologize. However, once she stated “you can’t lie to me like my ex-husband did,” EM1 told her “I want some space” and decided to sleep on the couch that night. [Encls (10), (33), and (42)]

220. On Sunday, 10 April 2022, at or about 1130, EM1 found IC3 Huffman’s body the next morning. [Encls (4), (6), (10), (17), and (33)]

221. EM1 stated that he went to check on IC3 Huffman and, upon entering the bedroom, noticed she wasn’t in the bed. He looked around the room and saw her feet sticking out of the closet. [Encl (33)]

222. EM1 went to the closet and found IC3 Huffman hanging by her neck from a belt in the closet. The belt was looped around the closet rod, and was buckled around her neck, with the other end tied off. [Encl (33)]

223. EM1 checked to see if IC3 Huffman had a pulse, but couldn’t find one. He described her lips as dry, and her bottom lip split. [Encl (33)]

224. When EM1 was finally able to get IC3 Huffman down, he noticed her thighs didn’t have blood in them, and were white and clammy. [Encl (33)]

225. EM1 ran out of the room and called 911. [Encl (33)]

226. EM1 did not notice any wounds or blood on IC3 Huffman, or any other indication that she might have died from causes other than asphyxiation. [Encl (33)]

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227. Pursuant to the determinations of the ship's Line of Duty Investigation (LODI) and the Hampton Police Department, IC3 Huffman's cause of death was suicide by hanging. [Encls (33), (36), and (42)]

228. IC3 Huffman's bottle of her prescribed Seroquel, which had been at her house when she committed suicide, was taken by the Hampton Police Department as part of their investigation. [Encls (33) and (36)]

Facts Pertaining to MASR Mitchell-Sandor.

229. MASR Mitchell-Sandor did reside onboard GW, and had just turned 19 years of age on 26 March 2022. [Encls (6), (21-26), and (43)]

230. MASR Mitchell-Sandor was onboard GW for three months. [Encls (6), (23), (24), and (38)]

231. Though his parents stated he was initially nervous to find out what his next duty station after A-school would be, they stated he was excited to be assigned to the GW because he would be on the east coast and "he'd be close to home." [Encl (38)]

232. MASR Mitchell-Sandor worked in security and was assigned to Charlie Section. [Encls (6), (23), and (25)]

233. MASR Mitchell-Sandor's supervisor was MA2 (#3). [Encls (6), (13), and (34)]

234. MASR Mitchell-Sandor was described by his co-workers as someone who was quiet and kept to himself. [Encls (15), (23), (24), (34), and (35)]

235. MASR Mitchell-Sandor was described by his parents as being "caring, funny, happy, kind, helpful, and would do anything for anyone." [Encl (38)]

236. MASR Mitchell-Sandor's parents stated that he was someone who was naturally intelligent and "didn't have to study for a test, he would read it once and ace things." They stated if he had put in a "little more effort, he would have been a straight-A student, but he did enough to get by." [Encl (38)]

237. MASR Mitchell-Sandor's parents stated he was the quarterback of his football team in high school, and grew up with the same group of kids, who have all been friends since 5th or 6th grade. [Encl (38)]

238. MASR Mitchell-Sandor's parents stated that while their son liked being a Master-at-Arms (MA), he wanted to be a Corpsman. [Encl (38)]

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239. MASR Mitchell-Sandor told his parents that when his enlistment was complete he planned to go back to school for sports medicine. [Encl (38)]

240. MASR Mitchell-Sandor told MASN that he was “dissatisfied with his work on the ship” and said he “was looking forward to getting out of the Navy, which was like three years out still for him.” [Encl (26)]

241. MASR Mitchell-Sandor’s parents stated he was happy during A-School in San Antonio, and would often “eat and go bowling” with his roommates. [Encl (38)]

241a. Uncle #2 stated that MASR Mitchell-Sandor was unhappy during “A” school due to the restrictions of the training schedule. [Encl (64)]

242. MASR Mitchell-Sandor’s parents described their son as “very proud,” and he would not often tell others what was bothering him. This occasionally included his parents, with whom he most often communicated and shared his concerns. [Encl (38)]

243. MASR Mitchell-Sandor’s parents stated he had “no psychological problems.” [Encl (38)]

243a. During basic training, MASR Mitchell-Sandor was engaged in a long-distance romantic relationship with Friend #1. [Encl (56)]

243b. MASR Mitchell-Sandor’s relationship with Friend #1 ended less than a month prior to his death (sometime in March 2022). [Encl (56)]

243d. Friend #1 stated that when she was dating MASR Mitchell-Sandor, that both in basic training and in his “A” School, he would ask her if she would attend his funeral. [Encl (56)]

243e. Friend #1 recalled a phone call with MASR Mitchell-Sandor where he told her that while his step-brother was in the shower, he located his step-brother’s firearm in the dresser drawer, and stated to her that he “saw the pistol and wanted to just end it then.” She could not recall the exact date. [Encl (56)]

243f. Approximately one and half to two months prior to MASR Mitchell-Sandor’s death (on or about 14 February 2022), MASR Mitchell-Sandor’s step-brother found that his room had been “ripped apart.” [Encl (63)]

243g. Step-brother reported that he found MASR Mitchell-Sandor on the bed holding the step-brother’s unloaded pistol that he kept in his dresser drawer. [Encl (63)]

243h. Step-brother immediately grabbed MASR Mitchell-Sandor and took control of the weapon. [Encl (63)]

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243i. MASR Mitchell-Sandor was crying and stated that he did not want to go back to the ship. [Encl (63)]

243p. Friend #2 stated that a mutual and close personal friend died in July 2021, and that the loss of their friend weighed heavily on the group of friends. The friends would spend time together at the grave, and MASR Mitchell-Sandor would discuss this with his family and friends. In MASR Mitchell-Sandor's final text message to his family, he asked to be buried next to his deceased friend. [Encls (38), (57), (65)]

243q. MASR Mitchell-Sandor's friend died just before he left for basic training and the loss continued to weigh on him. [Encls (64) and (65)]

243r: No one at the command knew, or had a reason to know, of MASR Mitchell-Sandor's previous suicidal ideations. [Encls (38), and (64)]

244. The Security Officer (SECO) is, and had been during MASR Mitchell-Sandor's time aboard, on terminal leave and mostly has been off-ship. [Encl (7)]

245. With the SECO on leave, the assistant-SECO (A-SECO) has been the acting Division Officer (DIVO) for the Security Department since March 2022. [Encls (7) and (13)]

246. In order to carry a firearm in Security, an individual must complete a screening form, which goes through medical, is reviewed by Psych Boss, legal, and then sent back to security. Psych Boss then does a one-on-one interview/screening, and finally the A-SECO goes over the form with the member, discusses the CO's disqualifiers, and once the member is deemed competent and qualifies on the weapon, that person receives his or her gun card that A-SECO signs. [Encl (13)]

247. If a member is "red-tagged," it means they are placed on a "do not arm" memo due to mental health concerns until they are cleared by Psych Boss, and then go through a re-arming board. [Encls (4), (13) and (24)]

248. If a member is "red-tagged" for mental health reasons, he or she must complete the entire screening process again from the beginning before cleared to carry a weapon. [Encls (4), (13), and (24)]

249. If a member is "red-tagged" for mental health reasons, he or she cannot stand an armed watch. [Encl (24)]

250. There was no evidence to indicate that MASR Mitchell-Sandor was concerned about being "red-tagged." [Encl (24)]

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251. MASR Mitchell-Sandor went through the full screening process to get his gun card. [Encl (13)]

252. Leadership in Security stated that suicide prevention is discussed within the department, and had been discussed prior to the previous two deaths in April 2022. [Encl (13)]

253. According to IT3, despite being invited by other Sailors in Security to “hang out” after working hours, MASR Mitchell-Sandor “never did anything outside of work” and chose to go home instead. [Encl (15)]

253a. MASR Mitchell-Sandor confided to a shipmate that he was unhappy with life onboard the ship and was told by that shipmate that maybe he shouldn’t go home so often. [Encl (64)]

254. When asked if they knew of any of the people MASR Mitchell-Sandor was close to onboard GW, his parents stated he had never told them any names, but that some of his co-workers had attended his burial service and had kind things to say about their son. [Encl (38)]

255. IT3 stated that while MASR Mitchell-Sandor complained about living onboard ship, it wasn’t any more than anyone else. [Encl (15)]

256. MASR Mitchell-Sandor arrived to the GW in January 2022, and during that month there was at least one instance of the nearby head (bathroom) not having hot water during a cold day (approximately 40 degrees Fahrenheit outside). [Encl (24)]

257. With respect to his concerns regarding the living conditions onboard the GW, MASR Mitchell-Sandor told his parents that his supervisors “don’t give a shit, they don’t give a fuck,” or words to that effect. [Encl (38)]

258. Within a few weeks of his arrival onboard GW, MASR Mitchell-Sandor discussed his concerns with the living conditions in berthing with his mother’s cousin, a retired Army Lieutenant Colonel who he referred to as (b)(6) (hereinafter “Uncle”), who subsequently contacted the GW Command Duty Officer (CDO) to make these concerns known. His “Uncle” resides nearby in Yorktown, VA. [Encls (13), (22), (24), (38), and (41)]

259. Once the current CO was made aware of the issues with berthing, the leadership took immediate action to get the affected Sailors moved to another berthing location. [Encls (7), (13), and (21)]

260. MASR Mitchell-Sandor was given the option to move to a new berthing, but chose not to move. [Encls (7), (13), and (21)]

261. MASR Mitchell-Sandor sought opportunities to live off-ship. [Encls (21) and (26)]

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262. MASR Mitchell-Sandor found a place to live on Facebook that was reportedly “420 friendly” that MA1 and others recommended against, due to the Navy’s Zero Tolerance drug policy. [Encl (21)]

263. MASR Mitchell-Sandor wanted to put in an application for Public Private Venture (PPV) housing to live off ship, and was very excited to do so. [Encl (38)]

264. Prior to submitting an application for PPV, MASR Mitchell-Sandor needed to meet basic shipboard qualifications. [Encl (34)]

265. MASR Mitchell-Sandor’s squad leader stated that MASR Mitchell-Sandor was on the verge of falling behind on his qualifications and he had not yet attained his basic shipboard qualifications, which was confirmed by a review of his DIVO record. [Encl (24) and (41)]

266. MASR Mitchell-Sandor was living in berthing by himself, as no one else chose to stay there and instead found a place to live off-ship. [Encl (32)]

267. MASR Mitchell-Sandor told his parent’s that he was alone because most of his co-workers either have kids or live off the ship. [Encl (38)]

268. Some of the Sailors interviewed chose to live off ship at their own expense and were unmarried junior Sailors in a similar position to that of MASR Mitchell-Sandor. [Encls (5), (25), and (26)]

269. MACM stated that he had “25 Sailors living out in town on their own dime out of 149 total. Almost all are E-3 and below.” [Encls (25) and (26)]

270. MASR Mitchell-Sandor never spent the night at his “Uncle’s” home, nor did he ever ask to. [Encl (41)]

271. Some of the Sailors interviewed believed that MASR Mitchell-Sandor may have been teased in response to making a complaint about living conditions onboard GW to his relative. [Encls (24) and (41)]

272. This teasing or “locker talk,” as it was described, may have gone on for a month or longer. [Encl (24)]

273. Some of the Sailors interviewed stated the teasing in Security was “normal locker room banter,” but never personal. [Encls (22) and (24)]

274. Multiple Sailors who work in Security stated they were not aware of any incidents of MASR Mitchell-Sandor being teased or treated any differently as a result of the phone call. [Encls (13), (15), and (26)]

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275. Chapter 2 of reference (b) defines “bullying” as:

A form of harassment that includes acts of aggression by Service Members or DoD civilian employees, with a nexus to military service, with the intent of harming a Service Member either physically or psychologically, without a proper military or other governmental purpose. Bullying may involve the singling out of an individual from his or her coworkers or unit, for ridicule because he or she is considered different or weak. It often involves an imbalance of power between the aggressor and the victim. Bullying can be conducted through the use of electronic devices or communications and by other means including social media, as well as in person.

276. Chapter 2 of reference (b) defines “hazing” as:

A form of harassment that includes conduct through which Service Members or DoD employees, without a proper military or other governmental purpose but with a nexus to military Service, physically or psychologically injure or create a risk of physical or psychological injury to Service Members for the purpose of: initiation into, admission into, affiliation with, change in status or position within or continued membership in any military or DoD civilian organization. Hazing can be conducted through the use of electronic devices or communications and by other means including social media, as well as in person.

277. Chapter 2 of reference (b) defines “harassment” as:

Behavior that is unwelcome or offensive to a reasonable person, whether oral, written or physical that creates an intimidating, hostile or offensive environment. In line with reference (b), harassment may include, but is not limited to, unwanted physical contact, offensive jokes, epithets or name-calling, ridicule or mockery, insults or put-downs, displays of offensive objects or imagery, non-verbal gestures, stereotyping, intimidating acts, veiled threats of violence, threatening or provoking remarks, racial or other slurs, derogatory remarks about a person’s accent or displays of racially offensive symbols. Types of harassment include, but are not limited to, discriminatory harassment, sexual harassment, hazing, bullying and stalking. Harassment can be oral, written or physical. Harassment can occur through electronic communications, including social media; other forms of communication and in person.

278. The investigation team did not find any evidence that MASR Mitchell-Sandor was bullied or hazed. [Encls (5), (9), (15), and (41)]

279. MASR Mitchell-Sandor’s parents were unaware of any specific instances of hazing or bullying. [Encl (41)]

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280. MASR Mitchell-Sandor's father stated he didn't think his "son was one to be bullied." [Encl (38)]
281. According to MA3, the command climate was worse under the previous commanding officer, but it is better now. [Encl (24)]

282. Many described the MAs in Security to be a "close" and "tight-knit" group. [Encls (6) and (24)]

283. Sailors in Security are in 4 duty sections, each working a 12-hour shift; however, shifts may take up to 14 hours after having to arm up and conduct turnover. [Encls (6), (15), and (25)]

284. The 12-hour shifts are from 0500-1700 and 1700-0500. [Encls (6), (15), (25), and (35)]

285. Sailors in Security work a "3-2-2-3" schedule, meaning they work three days, are off two days, work two days, and are off three days. This schedule results in a Sailor having 3 days off duty every other weekend. [Encls (6), (15), (25) (35), and (38)]

286. MASR Mitchell-Sandor worked the night shift, 1700-0500. [Encls (15) and (25)]

287. Multiple Sailors who were working or had worked on the night shift stated it was very difficult to sleep on the ship during the day due to all the noise. [Encls (26) and (35)]

288. When off duty, MASR Mitchell-Sandor would always go to his car or to the galley to get a better cell phone and internet signal, primarily to talk to his family and friends back home. He also slept in his car on different occasions. [Encls (15), (25), (32), (35), and (38)]

288a. MASR Mitchell-Sandor kept a sleeping bag in his car. [Encls (35) and (38)]

288b. MAC knew MASR Mitchell-Sandor slept in his car. [Encl (35)]

288c. MASR Mitchell-Sandor told multiple friends and family members that he would sleep in his car due to the noise onboard the ship. [Encls (63), (64), (65), (66)]

288d. MASR Mitchell-Sandor complained frequently to friends and family regarding the living conditions onboard the GW. [Encls (63), (64), (66)]

289. MASR Mitchell-Sandor owned a Toyota Corolla. [Encls (38) and (41)]

290. According to his parents, MASR Mitchell-Sandor did not have financial problems, because they "always made sure he had money" by putting money in a joint checking account they had with him. [Encl (38)]

291. MASR Mitchell-Sandor would drive home to his parents' house in Shelton, CT every other weekend on his three day off-shift periods. [Encls (9), (21), (38), and (41)]

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292. Shelton, CT is approximately 450 miles away from the shipyards, and equates to an approximate 8-hour drive time. [Encl (50)]

293. MASR Mitchell-Sandor would drive to South Carolina during the week on his two day off-shift periods to visit the girl he was dating. [Encls (38), (41), and (65)]

293a. According to his girlfriend, he made two trips to South Carolina — the first on or about February/March and the second on or about March/April — and was planning to make a third at the end of April or beginning of May. [Encl (65)]

294. The parents of the girl he was dating described the relationship between her and MASR Mitchell-Sandor as a “blossoming friendship.” [Encl (38)]

295. MASR Mitchell-Sandor’s parents described this relationship as a “new friendship.” [Encl (38)]

296. Charleston, SC is approximately 444 miles away from the shipyards, and equates to an approximate 7-hour drive time. [Encl (51)]

297. The distances to both Shelton, CT and Charleston, SC are outside the 350 mile liberty radius as defined in enclosure (39), measured from the member’s residence to the liberty location via road travel. [Encls (15), (21), (39), (50), and (51)]

298. MASR Mitchell-Sandor’s chain of command was not aware he was traveling to Connecticut every other weekend, and most were unaware he was traveling to Connecticut at all. [Encls (7), (21), (25), and (35)]

299. When MASR Mitchell-Sandor would go home to Connecticut, he would visit family and friends during normal daylight hours, opposite of his work schedule. [Encl (38)]

300. When MASR Mitchell-Sandor was staying at his parents’ home, they would feed him, do his laundry, and occasionally iron his uniform. [Encl (38)]

301. During visits home, MASR Mitchell-Sandor would visit with his friends from high school, see his grandmother, and on Saturday night would have dinner with his parents and Aunt and Uncle. His grandmother was described as MASR Mitchell-Sandor’s “spiritual adviser,” and the two were very close. [Encl (38)]

302. In February 2022, after he had been onboard GW for only one month, MASR Mitchell-Sandor had a scheduled appointment to meet with the CMC, but requested to have the meeting moved to a time that was “more convenient.” MA2 (#1) informed him that this is “not how this works, you show up to the meeting when CMC schedules it.” [Encl (22)]

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303. MASR Mitchell-Sandor did not go to the meeting with CMC as scheduled, which was his place of duty, and instead went home to Connecticut. [Encls (9) and (22)]

304. This put MASR Mitchell-Sandor in an Unauthorized Absence (UA) status, though he was never charged with a violation of Article 86 of the Uniform Code of Military Justice (UCMJ). [Encls (9) and (41)]

305. On or about February 2022, MASR Mitchell-Sandor was verbally counseled by MAC that traveling to Connecticut exceeded the liberty boundary of 350 miles in violation of GW's Leave and Liberty Policy, and that he could not do so without taking leave. [Encls (35) and (39)]

306. MASR Mitchell-Sandor stated to MAC that he was traveling home to see his grandmother who was having medical issues. [Encl (35)]

307. MAC stated that this was the first time he was aware of MASR Mitchell-Sandor receiving verbal counseling (or correction). [Encl (35)]

308. MAC stated that MASR Mitchell-Sandor got "teary-eyed" and emotional during the verbal counseling, but he wasn't sure if it was due to the fact that he was counseled or due to his grandmother's health. [Encl (35)]

309. MASR Mitchell-Sandor had seven days of leave accrued at the time of his verbal counseling by MAC. [Encl (35)]

310. No one in MASR Mitchell-Sandor's chain of command ever approved a leave chit for him at any time to take leave to Connecticut or South Carolina, nor were they aware of any subsequent trips after he was counseled. [Encls (7), (9), (13), and (21)]

311. Despite being counseled by MAC, MASR Mitchell-Sandor continued to violate the GW's Leave and Liberty Policy by repeatedly driving to Connecticut to see his family and to South Carolina to see the girl he was dating. [Encls (9), (21), (38), and (41)]

312. MASR Mitchell-Sandor was never charged with violating Article 92 of the UCMJ for multiple violations of the GW's Leave and Liberty Policy. [Encls (35) and (41)]

313. MASR Mitchell-Sandor was reported to have once left his watch (post) early before his relief arrived. Once it was discovered that MASR Mitchell-Sandor had left his post early, his supervisor confronted him on the phone, as he had already departed the ship. MASR Mitchell-Sandor claimed that his watch commander had given him permission to depart his watch early, but his watch commander, who was present during the phone call, informed MASR Mitchell-Sandor he had not given him permission to leave his watch early. [Encl (41)]

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314. MASR Mitchell-Sandor was never charged with a violation of Article 95 of the UCMJ, for leaving one's post without being relieved. [Encl (41)]

315. When MASR Mitchell-Sandor was counseled, it was only verbally and was generally done in a professional manner, with the exception of one report of swearing and "belittling" over the telephone when he left his post without a relief. [Encl (41)]

315a. MASR Mitchell-Sandor was having problems with the chain of command for his lack of military bearing, his failure to address people professionally, his lack of motivation, and delays in getting his qualifications. [Encl 41]

315b. Two Petty Officer Third Classes in security department stated that the chain of command's interactions with MASR Mitchell-Sandor did not amount to bullying, but were appropriate corrections to motivate him to be a better Sailor. The interactions were described as "professional." [Encl (41)]

316. MASR Mitchell-Sandor told his parents and "Uncle" that, at least on one occasion, he had violated COVID travel restrictions by driving home to Connecticut. [Encl (41)]

317. MASR Mitchell-Sandor was never charged with violating Article 92 of the UCMJ for violating COVID travel restrictions, nor is it clear whether the command knew he had violated these restrictions. [Encl (41)]

318. There was no documented counseling found in MASR Mitchell-Sandor's DIVO record. [Encl (41)]

319. MASR Mitchell-Sandor told his parents that the command "ultimately approved" his travel back home to Connecticut in order to see his ailing grandmother, though he never actually received such an approval, nor was any record of such a request discovered. [Encl (41)]

320. Based on the evidence gathered during the course of the investigation, the investigation team made the following calculations and observations with respect to MASR Mitchell-Sandor's sleep pattern while assigned to the GW.⁸ Based on the team's calculations, on weeks MASR

⁸ To make these calculations, the team made the following assumptions: 1) periods that MASR Mitchell-Sandor did sleep were for 8 hours each; 2) since the sleep quality is unknown, the team conservatively assumed that each 8-hour period of sleep was quality sleep; 3) that MASR Mitchell-Sandor went to his home in Connecticut every other weekend during the 3-day periods off duty, and that he went to South Carolina every 2-day period off duty, since purchasing his car (which was in February 2022); 4) turnover/guard mount was assumed to be 1 hour at the beginning and end of each shift; 5) each week period is defined as 1500 on Saturday until 1459 on Saturday; 6) drive times to Connecticut and South Carolina assume no traffic delays; and 7) from 0600-0700 and from 1500-1600, it was assumed MASR Mitchell-Sandor was awake in order to take care of personal matters, such as eat, change, shower, call family and friends, etc. Given the time required to walk to his vehicle at 48th Street where he parked, MASR Mitchell-Sandor had about a 20-minute walk from the parking lot to the ship. Therefore, it is likely that the time allocated for MASR Mitchell-Sandor to take care of personal matters, to include calling family and friends, would exceed the one-hour periods before and after his watch. However, the team made these conservative

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Mitchell-Sandor traveled home to Connecticut, he would receive approximately 46 hours of sleep for the entire week, resulting in a sleep debt of 10 hours.⁹ Those weeks would include one 25-hour period with no sleep, one 27-hour period with no sleep, and one 31-hour period with no sleep. On weeks he would travel to South Carolina, the team calculated he would receive 40 hours of sleep for the entire week period, resulting in a sleep debt of 16 hours. These weeks would include one 25-hour period with no sleep and two 31-hour periods with no sleep. Therefore, over a 10-week period,¹⁰ MASR Mitchell-Sandor accumulated a sleep debt of approximately 130 hours. [Encls (6), (9), (15), (21), (23), (25), (32), (34), (35), (38), (41), and (50-52)]

321. According to medical professionals, sleep may be the most important biological factor that determines service member's health and combat readiness. [Encl (45)]

322. Medical experts recommend between 7-9 hours of sleep per night for most adults. [Encl (44)]

323. Total sleep deprivation is defined as a period of continuous wakefulness that exceeds 24 hours, or getting zero sleep time during the typical sleep-wake cycle. [Encl (45)]

324. Partial sleep deprivation (or sleep restriction) is defined broadly as at least one night of partial or interrupted sleep. Although the amount of sleep needed each night varies by individual, partial sleep deprivation is operationalized typically as less than seven hours of sleep per night for adults. [Encl (45)]

325. Sleep debt is cumulative, and progressive nights (that is, 7-14 days) with less than the recommended amount of sleep requires several days of recovery to overcome. Full recovery from several days of progressive sleep debt takes "longer than 3 consecutive days" to recover from, "despite 8 hours of sleep per night throughout" the recovery period. [Encls (44) and (46)]

326. Inadequate sleep is linked to decreased emotional expressivity, decreased emotional regulation, increased emotional reactivity, increased impulsivity, increased irritability, anger, and hostility, and decreased friendliness, happiness, and empathy. Decreased sleep has also been associated with increases in mood disorders including depression. [Encls (44) and (46)]

327. Continued, sustained wakefulness from 20-24 hours has been likened to decrease in performance comparative to 0.08-0.10% Blood Alcohol Content. [Encl (44)]

assumptions in order to give MASR Mitchell-Sandor the benefit of the doubt with respect to maximizing his available sleep periods.

⁹ Based on the assumption that a normal night of sleep consists of 8 hours, as is recommended.

¹⁰ Assuming MASR Mitchell-Sandor bought his vehicle in the middle of February 2022.

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328. In addition, fatigue that degrades cognitive performance can result from long, monotonous tasks such as highway driving and can be exacerbated by poor sleep hygiene and sleep environment. [Encls (44) and (46)]

329. Several meta-analyses “demonstrate a clear association between sleep disruptions –resulting in chronic partial sleep deprivation – and suicidal behavior. This includes increased risk of suicidal ideation, suicidal planning, suicide attempts, and death by suicide.” [Encls (44) and (45)]

330. Within groups already at risk of suicide, such as those with depression or PTSD, “sleep disruption and associated chronic partial sleep deprivation approximately doubles the risk of individuals to engage in suicidal behavior.” [Encls (44) and (45)]

331. It is Psych Boss’ opinion that switching from being on a night shift through the week to a normal daytime routine every other weekend, coupled with long 8-hour drives to and from Connecticut and/or South Carolina every other weekend and the fact that it is challenging to get a full night of sleep during the day on a ship undergoing RCOH, may have affected MASR Mitchell-Sandor’s decision-making ability and the ability to “discern right from wrong.” [Encl (16)]

332. It is Psych Boss’ opinion that continuing to leave the ship and returning home every weekend, coupled with the fact that this was MASR Mitchell-Sandor’s first ship, may have inhibited MASR Mitchell-Sandor’s ability to adequately adapt to the shipboard environment. [Encl (16)]

332a. MASR Mitchell-Sandor was never diagnosed with or treated for depression. [Encl (62)]

332b. According to the CNAF Force Psychologist, MASR Mitchell-Sandor exhibited several behaviors, which are indicative of someone battling with depression (e.g., socially isolating himself; recurrent thoughts of suicide (with plan); unhappiness, sadness, feelings of being alone, and feeling stuck in his job). [Encl 62)]

333. On or about Wednesday, 13 April 2022, MASR Mitchell-Sandor traveled to his parents’ house in Connecticut, on his two day off-shift period. [Encl (38)]

333a. The day before his death, on 14 April 2022, MASR Mitchell-Sandor invited Friend #3 and another friend out to breakfast and lunch, and paid for both meals. [Encl (58)]

333b. Friend #3 stated that although MASR Mitchell-Sandor was generous, it was out of the ordinary that he would buy both of their meals. [Encl (58)]

333c. Friend #3 stated that during breakfast MASR Mitchell-Sandor talked about a shortened two year service obligation because he felt “trapped.” [Encl (58)]

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333d. When Friend #3 asked MASR Mitchell-Sandor what would happen if he did not go back, he responded that the “FBI would be after me.” [Encl (58)]

334. MASR Mitchell-Sandor did not tell his parents that he was coming home this day. This was unusual, because he would normally inform his parents that he was coming home prior to arriving. [Encl (38)]

335. MASR Mitchell-Sandor’s parents stated that it was “an odd time for him to come home” because he had never come home during the week or during his two-day off duty period before this. His father stated that he “wouldn’t take the trip for that short of a time.” [Encl (38)]

336. MASR Mitchell-Sandor’s mother stated when she arrived home at 1500 on Wednesday, MASR Mitchell-Sandor had left her a note that he had gone to eat with a friend. [Encl (38)]

337. MASR Mitchell-Sandor called his father when he was traveling through Newtown, CT on his way home. MASR Mitchell-Sandor told his father that he originally planned to go see the girl he was dating in South Carolina, but she told him that her roommate had a cold or the flu, and that he couldn’t go there, so he decided instead to come home to Connecticut. [Encl (38)]

338. MASR Mitchell-Sandor’s parents stated that “everything seemed normal” with their son during this visit, and that there were no red flags. [Encl (38)]

339. MASR Mitchell-Sandor drove back to the ship Friday morning, 15 April 2022. On the way back to the ship, he called his father and told him that he was stuck in traffic and running late. According to his father, his son was “worried he wasn’t going to make it back in time.” [Encl (38)]

340. MASR Mitchell-Sandor had also called his mother on his drive back to Virginia, and she stated “nothing seemed off” when she spoke to him. She also told her son that they would come and visit him in Virginia that weekend. [Encl (38)]

340a. MASR Mitchell-Sandor also texted his girlfriend on his drive back to Virginia saying that he was having a mental breakdown, that he was very upset, and that he wanted out of the Navy. [Encl (65)]

340b. His girlfriend tried to reassure him via Snapchat that everything would be ok, and that she would see him in a few weeks. Her final Snapchat message was sent around 1900 hours and was never opened. She also texted him numerous times, but he did not respond. [Encl (65)]

341. MA2 (#3) stated that MASR Mitchell-Sandor was on-time for his watch the evening of 15 April 2022. [Encl (34)]

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342. After the two day off-shift period immediately preceding his death, IT3 stated that after MASR Mitchell-Sandor returned from visiting his home in Connecticut, he seemed “down and missed home.” [Encl (15)]

343. At some point on the evening of Friday, 15 April 2022, MASR Mitchell-Sandor told IT3 that he “didn’t want to keep doing this job” and that he “felt trapped,” or words to that effect. [Encl (15)]

344. (b)(6) (hereinafter “AMAN”) stated that at approximately 1700 he observed MASR Mitchell-Sandor to be “extremely tired” and his eyes looked “dark red.” [Encl (41)]

345. Watch commanders are trained to assess whether watch standers express any concerning indicators during guard mount procedures. [Encls (13) and (24)]

346. MA2 (#3), who was the Watch Commander that evening, did not note any issues with MASR Mitchell-Sandor during guard mount procedures, and later observed MASR Mitchell-Sandor afterwards at approximately 1730 in the head, and described him as seeming “perfectly normal.” [Encl (34)]

347. AMAN stated he last saw MASR Mitchell-Sandor at or about 1800 in Security Department spaces, where he was studying for a qualification. At that time, AMAN described MASR Mitchell-Sandor as “zoned out a little.” [Encl (41)]

348. MASR Mitchell-Sandor was roving on first watch, and spoke to MA2 (#2) during at least a portion of that watch. [Encls (15) and (23)]

349. At approximately 2000, MASR Mitchell-Sandor sought out MA2 (#2) to discuss concerns regarding conditions on the ship, such as power outages, hearing footsteps while he was trying to sleep during the day, and the fact that his berthing was too cold or too hot. According to MA2 (#2), MASR Mitchell-Sandor wanted him to communicate these concerns up the chain of command, which MA2 (#2) stated he would. [Encls (23), (32), and (41)]

350. Also during this conversation, MA2 (#2) told MASR Mitchell-Sandor he would first need to obtain his necessary qualifications in order to “earn a room in PPV.” [Encl (41)]

351. MASR Mitchell-Sandor told MA2 (#2) that he was “feeling lonely” and “was not hanging out with anyone in the area.” [Encl (41)]

352. MASR Mitchell-Sandor also informed MA2 (#2) that he would frequently drive home to Connecticut to visit his family, and occasionally stay out in his vehicle to talk with his family and friends back home on the phone. MA2 (#2) stated he did not like the idea of his Sailor driving all the way to Connecticut on his off days or staying in his vehicle, and told MASR

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Mitchell-Sandor that he could stay with MA2 (#2) at his 3-bedroom house in military housing on his off days so he could get some rest. [Encl (32)]

353. MA2 (#2) stated that MASR Mitchell-Sandor did not seem interested in taking him up on his offer, but didn't say one way or the other. [Encl (32)]

354. MA2 (#2) described MASR Mitchell-Sandor as being "really neutral," not happy nor sad, during this encounter. [Encl (32)]

355. MA2 (#2) then tried to discuss other matters to get to know his Sailor, MASR Mitchell-Sandor, better. They discussed MASR Mitchell-Sandor's girlfriend, and how he would go home in his off time to hang out with his high school friends. MA2 (#2) reported that MASR Mitchell-Sandor described himself as a "home body," referring to his home back in Connecticut rather than the ship. [Encls (23) and (32)]

356. MA2 (#2) did not note any further issues with MASR Mitchell-Sandor, and assessed he was good to stand the watch that evening. [Encls (23), (32), and (41)]

357. MA2 (#2) saw MASR Mitchell-Sandor about 30 minutes later, at approximately 2030, in the passage way by Security. MA2 (#2) then asked if he was doing all right, to which MASR Mitchell-Sandor responded "yes, MA2." [Encls (32) and (41)]

358. Whenever a member of security is on roving watch, he or she must have a partner roving with them at the same time, pursuant to policy. [Encls (15) and (23)]

359. At or near the time of his death, MASR Mitchell-Sandor was on roving watch, but he had not been observed with a roving partner. [Encls (15), (21), (23), and (32)]

360. At approximately 2000, MASR Mitchell-Sandor called his father. He told his father he was onboard GW and was in the bathroom. His father said that MASR Mitchell-Sandor was "sniffling, maybe crying." [Encl (38)]

361. When his father asked him what was wrong, MASR Mitchell-Sandor stated "ah nothing, I'm in the bathroom, I just came in here for a few minutes to wash my face." His father asked him if he was all right, and MASR Mitchell-Sandor stated "yeah Dad, I'm all right." His father said he knew his son was down. [Encl (38)]

361a. On 15 April 2022, at approximately 2030 hours, Friend #3 received a Snapchat video message (i.e., instant messages accessible for only a short time) where she recalled that MASR Mitchell-Sandor was crying. [Encl (58)]

362. MASR Mitchell-Sandor sent a group text message to both his parents at 2058, which indicated he planned to commit suicide. [Encl (38)]

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363. The text message was long and included specific instructions as to where MASR Mitchell-Sandor wished to be buried. [Encl (38)]

364. In the text message, MASR Mitchell-Sandor stated he “couldn’t keep fighting anymore” and that “being away from everyone and not being able to live happily has put me in this position,” or words to that effect. Further, he stated to his parents that he was “looking for a way out, maybe never coming back and just trying to get a job and be with you guys and Patrick, but I didn’t want to disappoint you two, ever,” or words to that effect. [Encl (38)]

365. MASR Mitchell-Sandor’s text message also stated “I tried talking to someone and they gave me decent advice, but not what I needed to hear. He told me that going home was only going to make things worse for me, but that was the only thing keeping me happy...that’s what made me want to be alive,” or words to that effect. [Encl (38)]

366. Upon reading this text message, MASR Mitchell-Sandor’s mother called her cousin (“Uncle”), who then called GW, though it is not clear with whom he spoke. [Encl (38)]

367. MA2 (#2) needed to use the restroom around 2100, and, upon entering the Security male head, discovered MASR Mitchell-Sandor lying on the floor. [Encls (32) and (41)]

368. MA2 (#2) reported not having heard a gunshot, but may have heard a loud noise he attributed to RCOH work being conducted on the ship, as was a normal occurrence. [Encl (32)]

369. Upon entering the head where MASR Mitchell-Sandor was observed laying on the ground, MA2 (#2) stated he smelled smoke and saw blood spilt past MASR Mitchell-Sandor’s shoulder on the floor. There was no observed blood splatter on the wall. MASR Mitchell-Sandor’s Navy-issued firearm on the ground to his left side near his left hand. MASR Mitchell-Sandor’s head was towards the door, with his feet away from the door. [Encls (32) and (41)]

370. MASR Mitchell-Sandor was left-handed. [Encls (32), (34), and (41)]

371. MASR Mitchell-Sandor was observed to have an entry wound on his left-side temple and an exit wound on his right-side temple. [Encls (32), (34), and (41)]

372. While inspecting the Security male head, the investigation team observed where the bullet from MASR Mitchell-Sandor’s firearm impacted the right-side wall (when entering through the main hatch), a picture of which is included in the Naval Criminal Investigative Service (NCIS) Interim Report of Investigation. [Encl (41)]

373. From the gun-shot wound to his head, as well as the proximity of his weapon to his left hand, it appeared to first responders that MASR Mitchell-Sandor shot himself with his own firearm, and then fell backwards on to the floor, with his head towards the entrance, and dropped the weapon on his left side. [Encls (32), (34), and (41)]

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374. MA2 (#2) went to MASR Mitchell-Sandor to see if he was responsive, and tapped on his vest to get a reaction. He observed that MASR Mitchell-Sandor attempted to talk, but could only gasp for air. [Encls (32) and (41)]

375. At or about 2100, MA2 (#2) then radioed the report a medical emergency in the Security male head. [Encls (32), (34), and (41)]

376. MA2 (#3) heard the medical emergency call, and responded to the Security male head. [Encl (34)]

377. Until EMS arrived at approximately 2124, MA2 (#2) continued to try to talk to MASR Mitchell-Sandor, though he never got a verbal response. [Encls (32) and (41)]

378. Upon the arrival of emergency medical services, MA2 (#2) moved the firearm to the side and out of the way, taking care not to touch it with his hands. [Encl (32)]

379. MASR Mitchell-Sandor was observed to continue gasping until EMS was able to take him out of the head, but his eyes were “glossed over” when he was moved up to the hangar bay. [Encls (32), (34), and (41)]

380. MASR Mitchell-Sandor was placed in the ambulance at or about 2146, and was declared dead at or about 2222, when he arrived at Riverside Regional Medical Center in Newport News, VA. [Encls (41) and (43)]

381. At 2320, after not establishing further communications with their son or GW, MASR Mitchell-Sandor’s parents departed for Virginia. They did not receive a phone call from the ship updating them on their son’s status until 0500 the next morning, while they were driving to Riverside Regional Medical Center. [Encl (38)]

382. MASR Mitchell-Sandor’s death certificate states the cause of death is a self-inflicted gunshot wound to the head. [Encl (43)]

383. According to the ship’s line of duty investigation and NCIS’ Interim Report of Investigation, MASR Mitchell-Sandor’s cause of death was suicide by a self-inflicted gunshot wound to the head. [Encls (32), (34), (41), and (43)]

384. The GW Command Chaplain recalls meeting with MASR Mitchell-Sandor as part of his required check-in process. [Encl (59)]

385. Consistent with references (i) and (j), the Command Chaplain could not discuss the specifics of their encounter. [Encl (59)]

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386. The GW Command Chaplain stated that MASR Mitchell-Sandor declined the chaplain's offer to sit down with him. [Encl (59)]

387. The GW Command Chaplain did provide MASR Mitchell-Sandor with a card that contained the Chaplain's office numbers, in case he ever needed to contact a duty chaplain. [Encl (59)]

Opinions

General Opinions

1. While there were common stressors amongst the three GW Sailors who died on or about April 2022, such as the general stress associated with conditions in the shipyard environment, it is the opinion of the investigation team that the deaths of RS3 Sharp, IC3 Huffman, and MASR Mitchell-Sandor were not related or connected. Based on the available evidence collected, there were no indications that RS3 Sharp, IC3 Huffman, or MASR Mitchell-Sandor had any social or working relationships with one another. Each Sailor was experiencing unique and individualized life stressors, which were contributing factors leading to their deaths. [FF 1-6, 8, 12-16, 18, 31-35, 68, 71, 75, 79-88, 94-97, 102-105, 112, 119, 124-132, 136-139, 143-155, 159-188, 201-219, 229, 238, 240, 242, 243a-q, 253, 255-258, 261, 257-265, 285-288, 291-293, 302-309, 320-333, 340-340b, 342-344, 349-357, and 360-365]

2. The ship's Psychologist (Psych Boss) and Behavioral Health Technician (Psych Tech) are overwhelmed and require additional resources to keep up with the demand for mental health services. The Ship has reported at least 2,600 mental health encounters since January 2021 between two Substance Abuse Rehabilitation Program (SARP) Counselors, Psych Boss, and Psych Tech. Between Psych Boss and Psych Tech, they see between 5-20 patients each day, and have a significant backlog for initial appointments, ranging from 4-6 weeks. [FF 37-49, and 57]

3. Some Sailors choose not to seek care for mental health concerns within the Navy system for fear that it will affect their ability to do their job. Sailors in Security Department specifically noted that, if one of them were experiencing mental health concerns and sought help, they would be "red tagged," and thus be unable to carry a firearm and stand their watch. Some of these Sailors noted that there was a negative perception of being "red tagged," as they would be unable to fulfill their duties. One Sailor noted a desire to keep mental health related issues out of his medical record. [FF 56, 57, 67, and 247-250]

4. Sailors interviewed were generally not aware that the Deployed Resiliency Counselor (DRC) is an available resource who does not readily share patient information, and any information shared with the DRC is not entered into Sailor's military health record. The DRC is underutilized because: 1) Sailors don't understand what the DRC does; 2) Sailors don't know who the DRC is; 3) Sailors don't know where the DRC is located; or 4) Sailors know where the

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DRC is located, but it is a three-mile walk from the ship and they are hesitant to take that much time off to go there (or don't believe they can). [FF 58-62]

Opinions Relating to RS3 Sharp

5. RS3 Sharp's decision to take his life was an impulsive decision influenced by multiple contributing factors, not directly related to the GW. [FF 68, 69, 75, 76, 79, 81-89, 98, 104, and 111]

6. RS3 Sharp's work environment was not a contributing factor in his death. [FF 68, 72, 76, and 90]

8. Heavy alcohol consumption coupled with a physical altercation with his wife, the degradation of his reputation with his wife's family, and the involvement of law enforcement resulted in RS3 Sharp feeling his actions would have irreconcilable negative consequences to his relationship, life, and career. [FF 94-111]

9. At the time immediately preceding RS3 Sharp's death, his judgement was impaired due to being heavily intoxicated. It was common for him to drink excessive amounts of alcohol when he drank, often leading to arguments and hostile behavior. [FF 84-86, 94, 97, and 110]

10. Because the events leading up to his suicide escalated so rapidly, as well as his impaired judgment due to heavy intoxication, RS3 Sharp was unable to rationally develop an exit strategy from the situation. [FF 94-111]

11. RS3 Sharp likely felt that there would be additional career and disciplinary implications when he returned to his command due to the involvement of law enforcement. [FF 75, 76, 98, and 104-106]

12. The irreversible consequences and embarrassment caused by RS3 Sharp's actions, coupled with impaired judgment due to being intoxicated and his readily-available firearm, likely pushed him to reach the impulsive decision that suicide was his only way out. [FF 94-111]

Opinions Relating to IC3 Huffman

13. IC3 Huffman's decision to take her life was an impulsive decision influenced by multiple contributing factors, not directly related to living or working on GW. [FF 3-5, 112, 116, 124, 149-156, 158, 160, 166-168, and 173]

14. IC3 Huffman had a history of mental health challenges, which included previous suicide attempts and a history of self-harm. These mental health challenges were exacerbated by the excessive use of alcohol mixed with her prescribed medications. This history, alcohol use, and

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relationship difficulties all contributed to her decision to take her own life. [FF 130, 136, 141-145, 173, 198, 201-207, 209, and 213-215]

15. Based on her pre-service mental health history, unless a waiver was granted, IC3 Huffman should not have been qualified for Naval service. Pursuant to reference (c), receiving treatment for depression within 36 months, outpatient care including counseling required for longer than 12 cumulative months, and any history of self-mutilation are all disqualifiers from entry into the military service. While there is no evidence that her previous mental health history was reported during her initial entry process, IC3 Huffman had been prescribed Zoloft for depression within 36 months of entry, saw a therapist from age 14 to age 17, and had a history of cutting herself, all of which should have disqualified her from Naval service. [FF 136-140]

16. In 2018, during her initial training pipeline, once she was diagnosed with “overwhelming depression” and “self-harm,” IC3 Huffman should have been separated from the Navy via an “Entry Level Separation” (MILPERSMAN 1910-308). The nine mental health encounters reported during her accession training pipeline should have indicated she was not qualified for Naval service and resulted in further review. [FF 141 and 142]

17. When considering her extensive mental health history and trends, IC3 Huffman should have been referred to LIMDU following her suicide attempt in 2020. This would have removed her from operational duty and allowed her dedicated time to focus on receiving medical care. [FF 124 and 130]

18. The transition between providers onboard GW and at NMCP created confusion for IC3 Huffman and disrupted her continuity of care. Although she continued to receive care during the transition, the transition and the conflicting diagnoses were added stressors. [FF 147-150, 159, and 167-169]

Opinions Relating to MASR Mitchell-Sandor

19. MASR Mitchell-Sandor experienced several hardships and physiological issues that were contributing factors to his decision to commit suicide. [FF 240, 241a, 243a-243i, 243p-243q, 242, 271, 288, 288c-288d, 301, 315a, 320, 332b, 333c-333d, and 340a]

20. MASR Mitchell-Sandor’s death was not an impulsive decision, but was contemplated and planned prior to the incident. [FF 241a, 243d-243k, 332b, 333a-333d, 340a, and 362-365]

21. Quality of life (QoL) concerns were major sources of stress for MASR Mitchell-Sandor, but these were not the sole cause of his suicide. [FF 255, 256, 258, and 288c]

22. While QoL issues were not identified as the reason MASR Mitchell-Sandor committed suicide, off-ship housing would have enabled him to sleep without interruption and provide a needed physical separation from the ship and shipyard environment. MASR Mitchell-Sandor

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would have likely traveled home to Connecticut and to South Carolina even if habitability was not at issue, but his concerns with living onboard GW increased the frequency of these trips. [FF 237, 255, 256, 258, 288c, 291, and 312]

23. A significant contributing factor to MASR Mitchell-Sandor's decision to commit suicide was chronic sleep deprivation with a continual circadian rhythm shift. [FF 320-332]

24. Other contributing factors included substantial life stressors, undiagnosed and untreated depression, as well as an inability to acclimate to the shipboard and shipyard environment. [FF 240, 242, 271, 288, 301, 320, and 332-332b]

25. Departmental leadership did not fully identify, nor adequately correct, the issues associated with daytime sleeping on a ship undergoing RCOH. Considerations should have been made to prevent Sailors that permanently reside on the ship from working on night shifts. [FF 229, 232, 256, 286, 287, and 288c]

26. Departmental leadership failed to properly address and document disciplinary infractions committed by MASR Mitchell-Sandor, which would have provided reason and means for the chain of command to suspend MASR Mitchell-Sandor's authorization to carry a firearm per reference (q). Additionally, properly addressing and documenting disciplinary infractions would have provided leadership with the ability to identify that MASR Mitchell-Sandor was struggling to adapt to shipboard and shipyard life, and to determine what appropriate corrective actions were needed, what resources MASR Mitchell-Sandor might require, and review suitability for continued naval service. [FF 302-318]

27. A strict adherence to and enforcement of the ship's leave and liberty policy would have provided the command an opportunity to flag and address potential concerns relating to MASR Mitchell-Sandor's frequent trips to Connecticut and South Carolina. Additionally, this would have provided leadership a chance to counsel MASR Mitchell-Sandor on how to best make use of his off-duty time. [FF 291-318]

28. MASR Mitchell-Sandor did not seek guidance outside of Security Department leadership with respect to concerns he had, nor did he utilize available resources. [FF 125, 384, and 386-387]

29. MASR Mitchell-Sandor felt trapped in his job and onboard the ship, and did not feel he was able to leave the service without disappointing his family, leading to his conclusion that suicide was his only way out. [FF 241a, 243d-243e, 243i, 332b-333d, 340, 343, and 362-383]

30. MASR Mitchell-Sandor was experiencing chronic partial sleep deprivation, and had a "sleep debt" of approximately 130 hours at the time of his death. It is very likely this affected his decision-making ability, increased his social-isolation, and put him at a higher risk for suicidal behavior. [FF 289-310, and 320-383]

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31. Pursuant to reference (k), junior enlisted (E-1 to E-4) are in the highest risk group for suicides. As a first-term Sailor onboard his first ship, increased attention and care should have been devoted to ensuring proper assimilation, mentorship, and sponsorship. With the benefit of command programs such as The Command Resilience Team Human Factors Council (CRT-HFC), multiple command members knew or should have known that MASR Mitchell-Sandor was experiencing displeasure with Navy life and could have intervened to help him better cope or seek out available support services. Missing a scheduled meeting with the CMC, remaining alone in berthing, sleeping in his car, and violating the command's leave and liberty policy were all "red flags" that indicated MASR Mitchell-Sandor was having problems. [FF 229-230, 234, 240, 253a, 256, 259, 260, 266, 288a-288b, 302, 304-305, 307, 312, 315a, and 332b].

32. Although MASR Mitchell-Sandor's frequent return trips home provided temporary relief from the associated stressors of the shipboard environment, they also deprived him of the opportunity to develop self-reliance within a new and unique environment. MASR Mitchell-Sandor derived strong support from his family and friends, but was unable to replicate the same social-connectedness onboard the ship, in part due to his self-isolating behavior. Even though his home and former life offered an escape from hardships onboard GW, MASR Mitchell-Sandor was repeatedly reintroduced to the same adversities with each return trip back to the ship, and never developed adequate coping strategies. [FF 234, 253, 254, 266, 267, 351, and 355]

33. Had the Navy been aware of MASR Mitchell-Sandor's previous suicidal ideations, existing programs and procedures were in place that make it likely that he would have been placed in a "do not arm" status and received necessary care. [FF 243e-243o, 246-249, 340a]

Recommendations

Immediate Recommendations

1. Recommend GW conduct supplemental suicide prevention training, focused on peer-to-peer suicide awareness, intervention, and prevention. Training should not exclusively be Navy General Military Training, but should also include interactive and discussion-based elements.
2. Recommend GW conduct an aggressive advertising strategy designed to promote mental health reporting, and to guide Sailors towards additional resources to help alleviate the mental health appointment backlog. Advertising should include locations and contact information for the Command Chaplain, DRCs, Fleet and Family Service Centers, Naval Medical Center Portsmouth, Military OneSource, Tricare network, and virtual mental health (VMH) options. This advertising strategy shall promote and reinforce that all communications with chaplains will remain confidential pursuant to references (i) and (j).
3. Recommend GW conduct a review of its suicide prevention program and bolster training beyond the yearly General Military Training (GMT) requirement on suicide prevention to include more in-depth, interactive training programs such as the LivingWorks curriculum,

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suicide alertness training (safeTALK) and Applied Suicide Intervention Skills Training (ASIST) program. RCOH ships should be properly staffed with ASIST-trained personnel in a ratio congruent with the size of the ships' departments and divisions prior to entering and throughout the duration of the shipyard environment with strong consideration of training all leading petty officers (LPOs), leading chief petty officer (LCPOs) and Division Officers. RCOH ships should also train additional Assistant Suicide Prevention Coordinators (SPC). The RCOH ship's SPC should report number of ASIST-trained personnel each month to the TYCOM Suicide Prevention Program Manager (SPPM).

4. Recommend GW be given emergent priority to fill the gapped Deployed Resiliency Counselor (DRC) billet. Recommend CNIC review and amend CNICINST 1754.3A to include a role for TYCOM oversight of DRC allocation to CVNs/LHDs/LHAs.
5. The Commanding Officer of the GW evaluate the current locations of the assigned DRCs to ensure the locations are convenient for the crew. The locations should be conducive to providing counseling services and be in accordance with Commander, Navy Installations Command Instruction 1754.3A (reference (1)). While location of the DRC on the ship provides more physical proximity, there should be consideration of the advantages to location of the DRC off-site (i.e. at the Bank Building) such as quieter and more comfortable office spaces away from the industrial shipyard environment stressors.
6. The DRC, GW Chaplain, and the GW Psych Boss should collaborate and report common trends and areas of concern to the TRIAD every two weeks, or as appropriate. Sailors must also be better-educated about this additional resource. The DRC, Chaplain, and mental health provider are all required members of the Command Resilience Team (CRT) where they have the duty and opportunity to apprise command leaders of common trends, including increases in destructive behaviors.
7. Recommend GW conduct a comprehensive review of the sponsorship program.
8. Recommend GW conduct a comprehensive review of the mentorship program.
9. Recommend first term Sailors assigned to ships in RCOH receive additional mentorship on the personal and professional challenges of shipyard life. Training should include the qualification process, the phases of the Optimized Fleet Response Plan (OFRP) and what to expect in the various phases, off-ship housing options, Morale, Welfare, and Recreation (MWR) resources, etc.
10. Command Resilience Teams (CRT) are required to meet quarterly as a minimum per reference (b). Recommend the GW Command Resilience Team (CRT) meet monthly until completion of RCOH. In accordance with reference (r), the CRT's function is to provide the commander with information and insight into concerns of command personnel in order to

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implement positive measures to promote well-being and resilience. Recommend CRT team consist of various junior ranks, per reference (r) and consist of a cross-section of paygrades, sex, race, and departments.

11. Recommend the GW CRT maintain a Quarterly and Semi-Annual Prevention Scorecard.¹¹ The report can highlight topics related to positive trends, areas that need improvement or additional resources, and how to implement plans to address areas of concern. These scorecards should be utilized to identify and report trends to the ISIC.

12. Recommend GW continue to closely monitor the first responders and those Sailors who were closely associated with the recent deaths. It was discovered in the interview process that some Sailors elected not to receive counseling or only received short-term care. Some members affected by the recent deaths stated they are currently utilizing family members as their only counseling resource.

13. Recommend GW assign additional crew members as full time Drug and Alcohol Program Advisors (DAPA). There is currently only one full-time primary duty DAPA for the crew of approximately 2,700 Sailors. Per OPNAVINST 5350.4E the requirement for an assigned DAPA is 1 for a minimum of 300 personnel.

14. Recommend GW review the adequacy of the current DAPA program.

15. Recommend GW DAPA create and conduct an aggressive training strategy designed to promote the responsible use of alcohol, peer-to-peer intervention, and encourage self-referral without fear of reprisal.

16. Recommend GW increase the frequency of off-site team building events as multiple Sailors interviewed appeared to have a lack of ownership and investment in the ship and the present mission.

17. Per reference (p), the CRT-Human Factors Council (CRT-HFC) is required to meet quarterly, or more frequently as needed. Recommend GW execute monthly CRT-HFCs until completion of RCOH to review at risk sailors that have been forwarded by their respective Engaged Deckplate Leaders (EDLs). In addition to reference (p) requirements, recommend EDLs conduct monthly individual Sailor reviews for all personnel assigned to the security department and all personnel that have direct access to or handle weapons, regardless of the Sailor's previous month risk assessment, to recommend an additional Arms, Ammunition and Explosives (AA&E) screening if the Sailor's circumstances suggest that a review would be prudent, per reference (q).

¹¹ A scorecard already exists and can be found at <https://www.mynavyhr.navy.mil/Support-Services/21st-Century-Sailor/Culture-of-Excellence/Resources/>.

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18. Recommend Commander, Naval Air Forces (CNAF) standardize procedures for reporting suicidal related behaviors (SRB) to ensure consistency in unit reporting. Reporting should be in accordance with the OPNAVINST 3100.6K to ensure Sailor Assistance and Intercept for Life (SAIL) referrals, follow-up SITREPs, and final SITREPs are completed within the required timelines. It is important to ensure all suicide related behaviors are reported to the Command Suicide Prevention Coordinator, regardless of whether the service member is admitted or seen at a military or civilian treatment facility.

19. Recommend Ships in RCOH minimize the number of Sailors who permanently reside onboard Ship who are assigned to any type of routine night shiftwork, or otherwise maintain close oversight of these Sailors. Adequate rest is not easily attainable for day sleepers during RCOH due to the constant industrial noise that is unique to the shipyard environment.

20. Recommend CNAL fill a billet for a Human Factors Engineer. This position is responsible for improving force operational safety, to include improving human performance in a team setting, integrating human and team performance factors into a predictive analysis approach for operational risk, and advising on improving human factors in system and training integration.

21. Recommend, in accordance with enclosure (45), that Recruit Training Command (RTC) promote the use of available mobile applications used for sleep management, to include ensuring Sailors have an opportunity to download these mobile applications onto personal mobile devices prior to completion of basic training.

Long-Range Recommendations

22. Recommend BUMED (Naval Medical Forces Pacific and Naval Medical Forces Atlantic) review the policies, instructions, and procedures required for sailors to transfer their primary care provider and specialty consultation care from CNAF to shore side MTF and/or civilian care. Emphasis of the review should include identifying common mistakes, challenges and barriers sailors encounter when transferring their care, with the intent of BUMED to provide Type Commanders and Commanding Officers a standardized and easy to follow set of instructions that can be provided to sailors and overseen by the individual's command.

23. Recommend a review of the adequacy of mental health care and mental health practitioner manning for ships entering RCOH, in order to better balance manning with demand.

24. Recommend CNAL conduct a comprehensive review of Crew Move Aboard (CMA) policies.

25. Recommend CNAL conduct a comprehensive review of all available Sailor housing options, to include the shortfall of berthing barges, PPV availability, and exceptions to policy for BAH.

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26. Recommend CNAL conduct a comprehensive review of the HII-NNS amenities to include barge availability, parking, dining facilities, workout facilities, MWR programs, and access to reliable internet and cell phone service.
27. Recommend RCOH ships receive prioritization for Military Family Life Counselors (MFLCs) to provide increased shipboard counseling and educational resources. Recommend all CVN COs request at least one MFLC to provide additional non-medical counseling support to augment shipboard mental health services. The MFLC contract is centrally managed by the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy.
28. Recommend Navy request that the Defense Health Agency (DHA) conduct a review of mental health care capacity and access for both inpatient and outpatient services in the local area. This should include analysis of both the military treatment facilities as well as local area Tricare network resources.
29. Recommend the United States Military Entrance Processing Command conduct a comprehensive review of the Navy's initial accession screening process for psychological suitability. This process should not be intended to prevent individuals from entering Naval service, but designed to identify those that may be at risk for psychological hardship. This review should be focused on proactive measures to identify unresolved and/or untreated disorders, and to develop a treatment plan to help Sailors better assimilate to the arduous environment of Naval service.
30. Recommend Commander, Naval Personnel Command (CNPC) conduct a review of MILPERSMAN 1910-308 to validate the appropriateness of the 180-day limit for entry level separation (ELS). The current time limit does not allow for Sailors to be adequately exposed to the Fleet, hindering the ability to identify potential barriers to adaptability. The time limit should be reviewed and adjusted, based on analysis of separations within the first year of service, initial pipeline class availability, and time to train.
31. Recommend CNPC review the assignment policy for first-term Sailors assigned to ships in RCOH, and consider an option for Sailors to execute a "split-tour." The first two years would be performed on a non-RCOH unit with the possibility of the second half of the sea-duty tour completed on an RCOH unit. This policy will prevent Sailors from completing the entirety of their initial enlistment in a shipyard environment, and allow Sailors to more easily gain their initial qualifications and gain in-rate work experience.
32. Recommend a comprehensive review of Fleet-wide manning shortages, and consider changes to policy that would man operational units at 100% or more, regardless of the OFRP phase, in order to account for unplanned losses due to Sailors with medical issues and Sailors

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seeking to attend off-ship training, and additionally to provide overlap for other unexpected and/or emergent matters.

33. Recommend expedited Fleet implementation of the Warrior Toughness and Expanded Operational Stress Control (E-OSC) program, which are the two primary resilience/toughness building programs under the Navy's Culture of Excellence initiative.

34. Recommend OPNAV N17 use Get Real Get Better principles to better align the Warrior Toughness and E-OSC programs into a single curriculum to decrease administrative requirements on the fleet.

35. Recommend DHA create a process for ensuring treatment records of Active Duty Sailors seen in the Tricare network are entered into the Service member's electronic medical record (i.e., AHLTA, MHS GENESIS) to facilitate continuity of care as well as ensure the provision of safe and quality care by Navy Medicine providers.

36. Recommend senior leaders receive training on generational differences in communication and thinking styles to acquire generational intelligence to connect and engage with younger Sailors (e.g., embed training module within curriculum at Navy Leadership and Ethics Command).

37. Recommend CNAF Culture of Excellence (CoE) team develop a checklist of all the various CoE programs and Sailor support programs, to include sponsorship and mentorship programs, and schedule CNAF Assist Visit Team annual inspections of all CVN and Naval Aviation Units to ensure program compliance and enable learning through dissemination of best practices.

38. Recommend OPNAV N1, in conjunction with the action required in Recommendation 29, coordinate with the United States Marine Corps' High Risk Sailor Identification Initiative to develop a risk management tool for Commanding Officers to use in order to define, identify, manage, and oversee high risk Sailors more effectively and transparently within their command and during transfer processes (e.g., PCS, LIMDU, etc.).

(b)(6)