U.S. Department of Homeland Security
United States Coast Guard

United States Coast Guard Liaison
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14 Aug 2012

MEMORANDUM

From: L. D. Leone, LT,
TRICARE Regional Office South

To: CG PSC (opm-1)
Thru: HSWL SC

Subj: COMMUNICATION TO SPECIAL BOARD

Ref: (a) Administrative Investigations Manual, COMDTINST M5830.1
(b) Officer Accessions, Evaluations, and Promotions, COMDTINST M1000.3
(c) Personnel Manual, COMDTINST M1000.6
(d) Officer Promotion Boards COMDTINST 1410.2

1. I respectfully request to make the following comments in response to this special board.

2. This submission to the Board consists of three (3) major areas:

a. I believe that I deserve to remain on the promotion list to Lieutenant Commander (LCDR) because my performance has remained at the same high level which the original Board recognized as worthy of promotion;
b. The Special Officer Evaluation Report (OER) which brought about the consideration is inappropriate under COMDTINST;
c. The Special OER and CG-3307 that brought about this consideration are based on biased and flawed information that has been factually discredited.

3. I was selected for promotion to Lieutenant Commander for PY 12 as announced in a message dated 2315137ZSEP11. I was number 160 on the list and, but for this delay, I would have been promoted on 1 August 2012. At the time of the announcement and, more importantly, at the time the promotion board met, the accident involving CG-6017 on 7 July 2010, was known throughout the Coast Guard. In fact, by May 2011, I had already been subjected to administrative action by the Commanding Officer (CO), AIRSTA Sitka, as approved by the then District Commander of CGD 17, Admiral Colvin, who had previously sent a memorandum to CO, AIRSTA Sitka on 13 May 2011 (shortly before his change of command) returning the investigation to the unit for any action deemed appropriate by AIRSTA. See Enclosure (1). In short, Admiral Colvin intended to take no further action as Commander, CGD 17. In response to guidance from CGD 17, the AIRSTA Sitka CO had previously ordered an annotation of my flight log and convened Aviator's Evaluation Board (AEB)- facts Admiral Colvin was privy to and were consistent with his wishes as evidenced by the 13 May 2011 memorandum. The AEB, which met in April 2011, found me fit to fly pending successful completion of a multi-step process put forth in the memorandum, which included a requalification course at ATC Mobile,

AL. See Enclosure (2). Throughout this time, I served AIRSTA Sitka both proficiently and enthusiastically as the Safety Officer.

Over the last two years, my conduct on 7 July 2010 has been closely examined, scrutinized, criticized, and praised. The accident which took the lives of LCDR (sel) Sean Krueger, AMT1 Adam C. Hoke and AMT2 Brett Banks was tragic. I do not live a day without thinking about them and their families. This tragic accident has given me a resolve unlike any other I have had. I am committed to the Coast Guard, its mission and my small role in ensuring that I uphold the principles we hold dearest; Honor, Respect and Devotion to Duty.

Thousands of hours have been spent dissecting that two-hour flight. My conduct on that day has been examined, reexamined and examined again. I have welcomed that examination. Those thousands of hours have revealed what I knew from the moment that Gods grace allowed me to escape from the submerged aircraft and explode to the surface amongst the debris field of the non-survivable accident on 7 July 2010: If I had told Sean to stay on the course I set, if I had told him more assertively of my discomfort; if only I had forgotten that I had not even stood duty at the unit and because I was considered a break-in, was unqualified to stand the watch; if I realized that even Sean Kruger, a decorated and heroic figure in my life, as well one of the best of the pilots I had flown with, was not infallible; my promotion would not be before you.

The formal scrutiny has been, it seems, never-ending. It included an Administrative Investigation Manual (AIM) investigation, a MAB investigation, two AEBs, an Article 32 attempting to hold me criminally responsible for the three deaths that day, and an attempted public humiliation from the District Commander in front of 200 fellow Coast Guard men and women. With each of these processes I have been told to "trust the system, follow the procedures and the right thing will occur." So far, what I believe is the 'right thing' has occurred; but ***only after*** all the facts were put before each set of impartial and unbiased decision makers. I have also learned just how biased certain processes can be and rely on the ethical fortitude of several officers I barely know, if at all, to do what they believe is right- sometimes even in the face of pressure from above. I have had to defend myself vigorously in each instance and I do so with a sense that I am being singled out not for being a bad pilot but rather so that others can hold me up as an example of a misplaced sense of accountability. I have been, I am and I will be accountable every day. What follows is what the sum of the various inquiries into my conduct on that day has shown. I have divided the presentation into three distinct areas that are headed by bold print. I have also added attachments to simplify your access to information contained in thousands of pages.

4. ***I should remain on the promotion list since my performance has remained at the same high level that the original board recognized as worthy of promotion.***

There is not one new fact or opinion that has been developed since my selection for promotion that casts doubt on my abilities or potential. The Supervisor and Reporting Officer were aware of the investigation convened pursuant to the AIM throughout the rating period before selection and the rating period after selection. The AIM was completed on 11 November 2010. Not one minute of investigation occurred after that by the Coast Guard. See Enclosure (3, 4 and 5) Page 131, lines 13 to page 132, line 2. The only "new" facts developed were developed by or with the assistance of my legal counsel after charges were preferred in September 2011.

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What we found out was that there were: 1) at least three previous wire strike mishaps involving the same Coast Guard owned and maintained span of wires which caused my mishap, and 2) the mishaps were attributed directly to the multiple and repeated failures of Coast Guard leadership at CGD 13 and Pacific Area (PACAREA) command to comply with FAA standards for proper marking of power lines.

These CGD13 and PACAREA failures were long standing and in the case of CG-6017's mishap, occurred despite being explicitly told by the STA Quillayute River Officer-in-Charge, a Master Chief Boatswainsmate who routinely jogged underneath the span for PT, that the wires posed a clear hazard to aviation operations and must be appropriately marked. Prior to his retirement approximately a year before the crash of CG-6017, the BMCM had asked CGD 13 for funding for the aviation warning ball marking project. See Enclosure (5), Page 536 line 16 to Page 545 line 22. Sworn testimony at the Article 32 revealed that the project was never completed having hit an administrative glitch at CGD 13. In the second of the four wire strikes involving this same span of wires, the Coast Guard was sued and determined to be negligent for failing to adequately mark the wires and "that such negligence was a proximate cause of the accident." Both of these additional factual issues, confirmed under sworn testimony, were exculpatory (See Enclosure 4).

I have taken accountability for my actions. It seems, however, that the U.S. Coast Guard, the organization that I have chosen to give my career to, has not taken accountability for its on-going recklessness concerning these wires. Despite the fact that the Coast Guard, in the Final Action Memorandum (FAM), indicates that there was 'no guarantee' that the accident would have been averted had the lines been visible as prescribed from 4000 feet; what cannot be denied is that there was a 100% guarantee that we could ***not*** see the wires. They were, by all accounts, invisible to us.

As it turns out, the use of the wires was totally unnecessary for the lights they powered. They were replaced soon after the accident with a remote operated mechanism. I have to question why this did not occur in 2002 when the wires were replaced; a project managed by CEU Oakland. I cannot help but think that, despite setting a course to avert the wires and the unannounced actions of LT Kreuger to change course, the Coast Guard as an organization needed to allege my 'negligence' to cover its own responsibility and accountability.

This leads to the analysis of my performance over the last two rating periods. I will start with this last rating period. CDR Rush and CAPT Cameron's assessment in the potential block "Leadership skills and career accomplishments justify recent selection for LCDR." The comments of the supervisor are equally compelling. Despite an AEB and direction by Commander, Coast Guard Personnel Services Center (PSC) for my return to aviation duties, the new Commander, CGD 17 refused to allow me to neither return to flight status nor initiate any portion of the process to eventually return by repeatedly ordering the cancellation of my orders to ATC Mobile, AL. See Enclosure (6). Yet, the array of duties taken on by me and commented on by the Supervisor is, according to his portion of my OER, consistently Exceptional and Superior. In fact, it fits well within the guidance provided by the Commandant to Promotion Boards that selectees must be "willing to work outside their comfort zone and continually learn from those around them."

Both of these leaders, CO and XO of AIRSTA Sitka, are experienced and credible professionals who witnessed my performance day-in and day-out. The previous promotion board relied on their judgment concerning my performance and my potential for service at the rank of LCDR. As you can see on my last annual OER, their judgment remains the same. Regardless of the administrative technicalities used by Commander, CGD 17 to support writing my Special OER, to my Supervisor and my Reporting Officer and my Reviewer, my performance on 7 July 2010 was not 'previously unknown' to them. My Supervisor and my Reporting Officer rated me fairly on my last two OERs knowing full well of every last detail of that fateful day.

5. ***The Special OER which brought about the consideration is inappropriate under COMDTINST M1000.3;***

As noted above, my first OER from *then* CDR Cameron and my direct supervisor CDR Rush documents the vast majority of my performance and was considered by the PY 12 Board. Completed by CDR Rush and CDR Cameron in June 2011, the OER was sent for review to CGD 17 (dr), Chief of Response, CAPT C.B. Lloyd. CAPT Lloyd, at the urging of Admiral Ostebo who took command on 11 May 2011, refused to perform his duties properly by sending the OER back to CO AIRSTA Sitka, ordering him to remove comments on my conduct during and after the accident. CAPT Lloyd's actions violated COMDTINST M1000.3, paragraph 5.A.2.f. (2) (c) since the comments were perfectly authorized to be made. Thus, CAPT Lloyd, the Reviewer could not require the comments to be deleted. **Note that paragraph 5.A.4.f. specifies that "these restrictions do NOT preclude comments on the conduct that is the subject of [in this case a completed AIM investigation from November 2010]" (emphasis added).** The comments included by CDR Rush and *now* CAPT Cameron included "Amazing resiliency in recovery from major mishap; grew as an aviator/officer/leader;" and "Portrayed ideal CG image and political savvy as class A mishap survivor…". See Enclosure (7). These facts loom large in the discussion of this case since they put a positive context to my performance.

As such, my OER signed in June 2011 was tainted by this unlawful command influence. The Special OER is likewise tainted under COMDTINST M1000.3, paragraph 5.A.3.c.(1)(d), To Document Significant Historical Performance. The plain language of the paragraph clearly states:

> **Special OERs may be submitted to document significant historical performance or behavior of substance and consequence *which were unknown when the regular OER was prepared and submitted (emphasis added).***

In the present case, facts and details of the accident were known to every officer in the chain of command up through the Commandant, except for the only new evidence – all of which was entirely exculpatory. Now, this Special OER 'documents' my performance during two hours some 2 years prior. Not only were facts known to the Command, they were evaluated and put into the previous OER only to be wrongfully ordered to be taken out by the Reviewer.

To the extent that this Board considers that their charter excludes the ability to consider that my OERs were wrongfully manipulated and submitted, I would respectfully offer that it is appropriate to consider the circumstances surrounding the OERs you are considering when

deciding whether I should remain on this promotion list. These circumstances should be viewed as tainting the Special OER since the District Commander chose to disregard the very regulations we are all bound by. It is much like his decision to disregard the order of the Commander, PSC to send me for requalification. Despite never seeing me perform and despite my daily supervisors recommendations, he does not want me to perform in my specialty in spite of Coast Guard direction to the contrary.

6. ***The Special OER and the Administrative Note (CG-3307) that brought about the consideration for delay of my promotion are based on biased and flawed information that has been factually discredited.***

At the outset I would point out that the AIM is the sole source of evidence upon which the FAM, the CG-3307 and the Special OER are based. In August or September 2011 the lead AIM Investigator, CAPT Heitsch, was called by his former supervisor from his present assignment, Admiral Ostebo. The purpose of the call was to ask CAPT Heitsch whether he still felt that I was negligent while flying. CAPT Heitsch assured Admiral Ostebo that this was still his feeling. Admiral Ostebo wanted to know this so that he could brief Admiral Papp on his proposed action. See Enclosure (3) Page 133 line 7 to line 23. I mention this for two reasons: first, at this point both Admiral Ostebo and CAPT Heitsch were locked into defending the quality of the AIM, regardless of what new evidence may be uncovered; and second, that Admiral Ostebo had taken such a personal interest and had invested his own credibility in my case that he became unable to fairly view the evidence developed, especially since he had briefed Admiral Papp on his actions. It must be unprecedented for these senior officers to take this kind of interest in an O-3's personnel actions. It is the primary reason why my case is before this Board especially given the actions already taken by my Supervisor and Reporting Officer- at the direction and with the express concurrence of Admiral Colvin, sitting Commander CGD 17 at the time of the mishap, during the pendency of the AIM, MAB & first AEB. I will not further comment as to the intent of Admiral Ostebo to resurrect these processes after his predecessor, Admiral Colvin, made and communicated- in writing- express decisions to the contrary.

It also explains why none of these Senior Officers are willing or able to see the flaws in the AIM. I will point out some of these below but I would like to begin with a finding of 'fact' in the AIM that is emblematic. Finding 39 reads "LT Leone was repeatedly evaluated and debriefed during his M-60 T transition course at ATC Mobile for being excessively heads down…" This Finding was used to infer later that I had made the same mistakes while flying on 7 July 2010. In fact, as can be seen from the transcript of the Article 32 testimony of CAPT Heitsch, the only evidence that supported this 'Finding' was a single written comment made during the first two days of this transition training for an entirely new avionics package in the Tango model platform having previously flown the MH60J model for three years. The word 'excessively' never appeared in the supporting evidence. Every training evaluation after that indicated that I had recognized and corrected this first day mistake on this new avionics system and, in the opinion of the instructors, I had done an exceptional job in transition to the Tango model. See Enclosure (3), Page 149 line 5 to page 156 line 20. Those real and actual facts were never mentioned in the AIM. Even when confronted with those facts during the Article 32 hearing, CAPT Heitsch's sworn explanation for why the favorable material was omitted was simply that the investigation team decided that "…***there was no line that we were following that would include that.***" See Enclosure (3), Article 32 Testimony at page 155, lines 14-15. In other words, the AIM was not

pursuing any information that might exonerate me or even provide a fair or truthful recitation of the facts. Its sole goal was to write to a predetermined conclusion- that I was culpably negligent and should be held accountable- consistent with Admiral Papp's espoused desire for accountability.

I respectfully submit the additional facts to address all information contained in the FAM, which is the sole basis for the CG-3307 and Special OER, both written by or ordered by Admiral Ostebo. The FAM has used information from the AIM without regard to the other evidence developed and presented by me. It used flawed and incomplete information contained in the AIM but later shown to be erroneous at the Article 32 and other forums. While not an exhaustive list, this includes but is not limited to two AEBs (that found me fit to fly) and the evaluations of my Supervisor and Reporting Officer.

On 12 March 2012, FAM of the AIM into the crash of CG-6017 that occurred on 7 July 2010 was signed by VCG. On 19 March 2012, CCG released the document via electronic mail presumably to the entire Coast Guard as well as the public at large by posting the FAM to the Coast Guard's FOIA reading room. Accompanied with the link to the FAM was an message and email from CCG that stated, "if we're going to do it - and we are - we're going to do it right." That is what I am asking from this Board.

While the term, "misconduct" does not appear in the FAM, my actions or inactions are referred to as "failures" and that I "failed to comply" or "failed to carry out [my] responsibilities" throughout and any reasonable reading of the FAM would surmise that I engaged in misconduct since failure to comply with regulations is a common definition of misconduct for Coast Guard purposes. Further, the FAM directed CG-3307 clearly places the deaths and injuries that resulted from the mishap at my feet.[1] "Your failure……directly contributed to the deaths of your shipmates and destruction of CG-6017." See Enclosure (8). That is, the Coast Guard believes my alleged misconduct was due to willful neglect that demonstrated a reckless disregard for the foreseeable and likely consequences of the conduct involved. In addition to being unjust and defamatory, these assertions were made by the Coast Guard in conjunction with the deliberate concealment of exculpatory evidence in the FAM. The FAM is therefore flawed and must not be used as "newly discovered evidence".

The express purpose of the AIM as described in reference (a), Article 1.A., is to "provide the convening and reviewing authorities with information upon which to base decisions and take actions about matters investigated." This effort has been fatally compromised by a reckless "failure to comply with the procedures of the manual" and complete and utter "failure to collect

[1] I note that by not expressly using the word "misconduct" in the FAM, the Coast Guard has insulated itself from any reasonable scrutiny of the facts as presented in the FAM- even though the FAM was drafted well after the CGD 17 convened the Article 32 in December 2011. CGD 17 (dl) and CG-0944 claim that I have no right to appeal the facts in the FAM per reference (a) because the word "misconduct" was replaced by "failure(s)". The decision to publically state in the FAM that my purported failures caused or resulted in the deaths of the crew was made with full knowledge that the AIM facts had been completely debunked several months earlier. In essence, the decision was made to stick with bad facts and ensure I couldn't assert any enforceable right to insist the facts be accurate by simply using a synonym.

sufficient evidence or to resolve conflicting evidence." These failures of the AIM, and consequently the FAM, render both documents useless for their intended purposes. The selective, incomplete and erroneous facts, as weaved in the FAM are wholly unsupported by any reasonable reading of all evidence available to the Coast Guard. Worse, CGD 17 knows the AIM and FAM are fatally flawed and continue to use them as the sole basis of, among other processes, this proceeding.

By way of example, any conclusion that CG-6017 operated in excess of any operational limit for sixty-seven percent of the flight is erroneous, misleading and fails to account for evidence at the Article 32 hearing, convened by CGD 17. See Enclosures (4) & (5), Pages 215 to 216 and page 620.

By way of another example, any conclusion that any required checklist was not done is erroneous, misleading and fails to account for evidence at the Article 32 hearing, convened by CGD 17, that is, all the checklists were completed save for a new checklist which was to be published in the M-60T manual – not published at the time. See Enclosure (4), Page 403 line 10 to page 406 line 20.

By way of another example, any conclusion drawn that the sectional chart "appropriately depicts" the lines is woefully misleading both in light of the evidence at the Article 32 hearing convened by the Coast Guard and the endorsements provided by CGD 17 and PACAREA. See Enclosures (9), (10) & (14). It also completely fails to account for the fact that the evidence from the Article 32 showed that it is not reasonable that I would've been looking at the sectional for that area in the first place. Further, failing to mention that I had plotted a course away from the area and that the Pilot-in-Command (PIC) deviated from that course during an unannounced, unanticipated maneuver displays a disregard for any reasonable or fair accounting of the facts. See Enclosure (4) Page 203 line 13 to page 213 line 24.

By way of another example, any conclusion drawn that suggests that I did not acknowledge or challenge altitude at various points in the flight is both erroneous, misleading, and reflects a lack of understanding of both common practices and Crew Resource Management (CRM) procedures and methodologies. It also disregards how pilots are formally trained in the Coast Guard. If you limited your inquiry to reading the black box transcript looking for me to say "come up now" or words to that affect, you will not find it. That is what the AIM did. I assert that should you look with a trained eye, the black box transcript repeatedly shows me challenging the PIC in exactly the way we teach aviators to do so- by "floating trial balloons" and other techniques. See Enclosure 14. It is all there in the transcript if you know what to look for. I should note that CRM procedures and methodologies were not included in any part of the original charges so neither the government or defense was adequately prepared to speak to or present evidence on this issue at the Article 32 hearing. Since the Article 32 hearing in December 2011, we have approached the Coast Guard witnesses who are best able to speak to this issue and rely on their expertise for the conclusions herein.

By way of another example, I note that the non-operational chatter was determined to be a contributing factor to the mishap listed in the FAM. I challenge the basis of that conclusion outright and assert that the picture being painted of how this flight was conducted is misleading,

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fails to account for evidence at the Article 32 hearing and runs counter to the express opinions of even the most senior pilots. This kind of twisting of facts is deliberately included to affirmatively mislead. I have informally compared the transcript of the mishap to a cross section of other flights and assert that if you do the same; a different picture emerges. The transcript reflects an operational and training focus that far exceeds what is "normally" seen in other operational/training flights. In short, there was far less non-flight related "chit chat" than in most flights. I challenge any conclusion to the contrary. See Enclosure (11).

By way of yet another example, any conclusion that this was a ferry flight deliberately conceals facts within the Coast Guard's knowledge that this was also a training flight and several actions referred to as failures were legitimate training activities. Failing to fully discuss that in the FAM conceals evidence within the Coast Guard's purview and is deliberately misleading. See Enclosure (4) Page 375 line 8 to page 377 line 23.

By way of a final example, Admiral Ostebo indicates in the CG-3307 that my failure to perform my duties in accordance with applicable laws, regulations and policies "directly contributed to the deaths of [my] shipmates and the destruction of CG-6017." After an extensive three day hearing which included over 9 hours of testimony by the lead investigator for the AIM, CAPT Heitsch, the Article 32 Officer, CAPT Norris, found that I violated no laws or regulations. He found that "**reasonable grounds do not exist** to believe that [I] committed the crime of dereliction of duty as alleged." He found this for each of the charges that Admiral Ostebo sent for investigation. In addition, I would urge you to consider that the standard there was not proof beyond a reasonable doubt but rather "reasonable grounds " based on evidence presented. This standard for considering evidence is below even a standard of "more likely than not."

In addition, CAPT Norris found that he was "unable to conclude from the evidence that [I] negligently navigated at all." Finally, CAPT Norris found that he believes that the Government could not causally link my purported failure to tell LT Krueger to fly higher to the deaths of my crew mates because it was the PIC who made a 'snap decision' to veer from the safe course I had charted and it was the PIC who piloted the aircraft nearly the entire time of the flight. To the extent that I did not follow optimal CRM as I accept, I would once again say that I told that to both AEBs who found me fit to fly pending completion of a series of requisite steps. I would add that the VADR Data of the course I charted clearly shows that the course was NOT directed at a charted hazard but rather was charted to be considerably above and west of the Coast Guard's ill marked power lines.

Any conclusion in the FAM that the AEB needs to be reevaluated because new information was not available during the first proceeding is entirely misleading and now moot due to the finding of the second AEB that I should continue flying- exactly what the first AEB concluded. The FAM relied on faulty information when it made that conclusion and recommendation to reconvene the AEB because it erroneously assumed that the only way the AEB could have concluded that I should fly is that the panel must not have had access to the AIM. Contrary to this factual predicate, the AIM was available to and used by the first AEB as evidenced by the AEB referring to, the AIM's "Findings of fact (1 through 323)". See Enclosure (2). The six findings of fact not mentioned by the AEB pertain to policy definitions, not relevant mishap information. As articulated at the Article 32, no further investigation activity occurred after

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November 2010 when the AIM was completed. To simplify, the FAM again missed or ignored critical facts and then made nonsensical recommendations.

Several conclusory statements in the FAM blindly carry over opinions or sentiments from the AIM while not taking into account even the endorsements from CGD 17 and PACAREA See Enclosures (9) & (10). The AIM was drafted by a board of Coast Guard personnel, none of whom were MH-60T pilots nor had any Tango experience. The Article 32 testimony and transcript reflects a consistent theme where the technical aspects of this distinction (MH-60T as to any other platform) caused the credibility of AIM board to be severely and irrefutably dismantled. That is not to suggest their efforts were in bad faith, necessarily, but rather that their conclusions are not supportable due to a lack of technical competency as to critical facts. Accordingly, it is inappropriate and affirmatively deceptive to carry over conclusions that have been proved to be without merit. See Enclosures (3) & (4), Page 156 line 13 to page 157 line 13 and page 386 line 5 to page 368 line 23.

Further, the FAM fails to adequately address several key points including the true extent of Coast Guard culpability with respect to wire strike protection systems (WSPS), whether or not FAA regulations apply, what the markings of the wires should have been at the time of the mishap, and so forth. For example, with respect WSPS, the FAM indicates that "could potentially have mitigated this mishap" and "potentially avoid[ed] an entanglement" whereas the Article 32 testimony revealed the U.S. Army was approached on this issue and they determined that WSPS "would most likely have sheared the wires and allowed the aircraft to land safely." In fact the AIM its self-states "if CG-6017 had a wire strike prevention system installed on the aircraft, the system would have cut the wires and the aircraft would have been able to safely land." See Enclosure (12). The FAM version is deliberately misleading and, as with all of the misstatements, is done so in a manner that is to my personal detriment.

If CGD 17 or higher authority had a good faith belief that the facts in the FAM were, in fact, a true representation of the events of 10 July 2010, referral of charges would have been appropriate and a courts-martial should have been convened.[2] Instead, Admiral Ostebo dismissed those charges based on the recommendations of the Article 32 Officer. The Article 32 officer, who is the second most senior Military Judge in the Coast Guard, concluded that the government could not link my failure to more assertively tell the PIC, in essence, to fly higher or stay on the course I charted, to the deaths of my fellow crew members because it would be unable to "prove.... to a reasonable fact-finder, as it requires speculations and suppositions" that it would have made any difference. See Enclosure (13), Page 12. This senior officer, experienced in the analysis of evidence, reviewed impartially, fully and dispassionately the AIM and the evidence I presented and arrived at that conclusion. He had no stake in his conclusions other than his sense that he was required by law to give the Convening Authority a fair and impartial analysis. See Enclosure (13 & 14).

[2] Had criminal charges been referred to a courts-martial, the rules of evidence would apply from that point on and all facts relied upon by the Coast Guard for any decision making purpose would be subject to scrutiny and appeal. This decision has perpetuated the faulty AIM and FAM conclusions.

The selective, incomplete and erroneous facts, as weaved in the FAM Enclosure (15), as carried over from the AIM, are wholly unsupported by any reasonable reading of all evidence available to the Coast Guard or to you now. Simply stated, the AIM is irreparably flawed. Those conclusions were carried over and are the sole basis of the FAM, the CG-3307 and the Special OER. By relying on the AIM/FAM, the bases for the administrative actions that followed are also flawed beyond usefulness. I have included full enclosures of critical documents which comprise additional information that was apparently not appropriately considered in drafting the FAM. I trust that you will diligently review the documents for yourself and render an appropriate decision based on the facts.

7. Finally, I want to thank you for your thoughtful and thorough review of my case. It has been a long journey to this point. I would have let it go long ago and resigned my commission but for my respect for and faith in my fellow Coast Guard servicemen and women. My record in the Coast Guard had been deemed already worthy of promotion. Despite the trials of these last two years I have tried to perform at the highest level, not just for myself but also for LCDR (sel) Sean Krueger, AMT1 Adam C. Hoke and AMT2 Brett M. Banks who can no longer serve the country we love. I cannot help but feel that they and I have been treated unjustly throughout the process. We were 'growing up' in the Coast Guard and felt that when we served our best the Coast Guard would care for us. Yet I feel like the Dickens character in *Great Expectations* who said:

> "In the little world in which children have their existence, whosoever brings them up, there is nothing so finely perceived and so finely felt, as injustice."

It has been difficult to succinctly tell you why I believe I, and the crew of CG-6017, have been treated unjustly. What I can tell you is that my desire to serve and serve well my country in this Coast Guard has never been stronger. Every direct supervisor, every Reporting Officer and every Board convened to review my actions and hold me "accountable" has found that I met the standard for continued service as an aviator and as an Officer. I can only hope that your review leads you to simply say that those judgments were correct; it is time to move forward and delay my promotion no longer.

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Enclosure(s): (1) CGD SEVENTEEN (d) memo 5830 of 13 May 11 (1 page)
(2) CG PSC (AEB) memo 5420 of 13 Apr 11(9 pages)
(3) Full Article 32 Hearing Transcript, 07 Dec 12 (49 pages)
(4) Full Article 32 Hearing Transcript, 08 Dec 12 (79 pages)
(5) Full Article 32 Hearing Transcript, 09 Dec 12 (34 pages)
(6) LT L.D.LEONE memo 5100 of 29 Mar 12 (5 pages)
(7) L.D.LEONE, OER of 31 May 2011 (4 pages)
(8) CGD SEVENTEEN (d) CG-3307 of 18 Mar 12 (2 pages)
(9) CGD SEVENTEEN (d) memo 5830 of 13 May 11 (21 pages)
(10) CG PACAREA (PAC-00) memo 5830 of 19 Jul 11 (3 pages)
(11) CG6017 Transcript, of 07 Jul 10, (45 pages)
(12) Excerpt: CAPT T.J. Heitsch memo, 5830 11 Nov 2010 (1 page)
(13) Article 32 Report, CAPT A. J. Norris memo 5830 of 05 Jan 12 (13 pages)
(14) CG AIRSTA SITKA memo 5830 of 07 Aug 11 (7 pages)
(15) VCG memo 5100 of 12 Mar 12 (12 pages)

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14 August 2012

FIRST ENDORSEMENT on LT Leone's memo 1420 of 14 AUG 2012

From: M. R. Munson
CG HSWL SC (hd)

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Digitally signed by MUNSON.MARK.ROGER.1090576654
DN: c=US, o=U.S. Government, ou=DoD, ou=PKI, ou=USCG, cn=MUNSON.MARK.ROGER.1090576654
Date: 2012.08.14 09:20:22 -04'00'

To: CG PSC (opm-1)

Subj: COMMUNICATION TO SPECIAL BOARD

1. I recommend LT Lance D. Leone for promotion without delay to the grade of Lieutenant Commander. I make this recommendation based on the time LT Leone has served under this command. Despite the pressures and challenges before him, LT Leone has, without question, demonstrated those traits and shown that performance which warranted his original selection.

2. LT Leone has excelled while operating in this joint and interagency position as the Coast Guard liaison to TRICARE South. He quickly demonstrated his leadership, at a level commensurate with a seasoned LCDR, as well as his articulate and polished representation of the Coast Guard in a new and challenging environment. He has utilized his operational expertise to ensure policy is aligned with the critical area of mission support, with respect to access to healthcare. He has actively focused on aligning private industry, DOD, and Coast Guard goals to ensure accessibility of this most personal support to members our active duty, reserve components and their families.

3. LT Leone, although new to the medical support field and under external pressures, maintains a positive attitude and enthusiastically seeks out and accomplishes the most complex and difficult tasks. One of these innovations is the Coast Guard Urgent Care/Emergency Room Demonstration that has the potential to save millions of dollars, streamline processes, and improve the TRICARE experience to all Coast Guard forces and their families. LT Leone has provided briefings and insight to the highest level of the TRICARE community concerning this project. He has championed the goal of expanding the program to all regions and services.

4. Each of the other services has assigned a LCDR in similar positions because of the requirement for active interagency and civilian coordination, and LT Leone has masterfully performed his duties thus far at this grade. He has shown the maturity, skill and ability of an O4, and I expect long and continued, superior service from this officer. He is and will be an asset to the service in years to come.

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