#### DEPARTMENT OF THE NAVY

COMMANDER SEVENTH FLEET UNIT 25104 FPO AP 96601-6003

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5830 Ser N013/102 27 Feb 05

FIRST ENDORSEMENT on Rear Admiral (Select) USN, ltr 5830 of 03 Feb 05 (as modified by change transmittal of 18 Feb 05) (U)

From: Commander, SEVENTH Fleet

To: Commander, U.S. Pacific Fleet

Via: Commander, Submarine Force U.S. Pacific Fleet

Subj: COMMAND INVESTIGATION OF THE SUBMERGED GROUNDING
OF USS SAN FRANCISCO (SSN 711) APPROXIMATELY 360 NM
SOUTHEAST OF GUAM THAT OCCURRED ON 8 JANUARY 2005

Encl: (261) Final Report of Autopsy for Joseph A. Ashley of 14 Feb 05 (U)

(262) USS SAN FRANCISCO (SSN 711) Grounding Technical Assessment, w/encls (NOFORN)

(263) COMSEVENTHFLT ltr 5812 Ser N013/073 of 12 Feb 05

#### 1. (U) Background.

a. On 8 January 2005, USS SAN FRANCISCO (SSN 711), while submerged at 525 feet and transiting at flank (maximum) speed in the vicinity of the Caroline Islands, grounded by hitting a seamount, causing more than \$88 million in damages, rendering the submarine out of service for approximately 400 days, and resulting in injuries to 98 of 137 crewmembers, to include one fatality. The command investigation concluded that failure to properly develop and execute a safe and effective voyage plan for submerged transit caused the grounding. After reviewing the investigation, I assert that responsibility and accountability reside with USS SAN FRANCISCO's command leadership and navigation team. Given the circumstances prior to and at the time of the grounding, I find it difficult to conclude absolutely that grounding could have been avoided. It is absolutely clear to me, however, that if command leadership and the navigation team followed basic specified procedures and exercised prudent navigation practices, they would have been aware of imminent navigation hazards and therefore

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compelled to operate the ship more prudently. At a minimum, the grounding would not have been as severe.

- b. The seamount USS SAN FRANCISCO hit was not annotated on Chart E2202, the chart being used for navigation when the ship grounded. Chart E2202 did not denote a navigation hazard in close proximity to the intended ship's track and grounding location. Other valid, readily available navigation charts in USS SAN FRANCISCO's inventory -- including Chart 81023 -- displayed a navigation hazard located in the vicinity of the Caroline Islands near USS SAN FRANCISCO's SUBNOTE track and intended ship's track. The command investigation revealed that, although relevant directives and ship procedures mandated review of all available navigation charts and annotation of pertinent data to the primary chart used for navigation, USS SAN FRANCISCO's navigation leadership/personnel did not adequately review other charts. Of note, Chart 81023 contains a "discolored water" site (surrounded by a "danger line") 2.5 nautical miles (NM) south of USS SAN FRANCISCO's intended track and 2.0-2.8 NM from the grounding location. The light blue coloring of this "discolored water" feature reflects a navigation hazard at 20 meters (66 feet) depth or less, leading one to conclude that a larger navigation hazard exists in deeper water, particularly at 525 feet.
- c. The command investigation examined and assessed USS SAN FRANCISCO's voyage planning, navigation watchstanding practices, casualty and medical response after the grounding, and navigation training programs. Parent squadron (COMSUBRON FIFTEEN) support; SUBNOTE generation; Submarine Force navigation standards; inspections and evaluations; Submarine Force navigation pipeline training; and Navy's (National Geospatial Agency) navigation chart generation, distribution, and management directives were also reviewed. While opportunities exist for systemic improvement in functional (formal and on-the-job training) and administrative (directives and inspections) areas external to USS SAN FRANCISCO, there were no factors beyond the ship's control which caused, or dramatically affected, circumstances that led to the grounding.

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#### 2. (U) Administrative Actions.

- a. Add enclosure (261), Final Autopsy Report for MM2(SS) Ashley.
- b. Add enclosure (262), USS SAN FRANCISCO (SSN 711) Grounding Technical Assessment, with enclosures.
  - c. Add enclosure (263),
- d. Add Finding of Fact 526: The Final Autopsy Report confirms the findings of the Preliminary Autopsy Report, to include blunt force injury to the head as the cause of death. [encl (261)]
- 3. (U) Organizing, Training and Equipping the Force. By copy of this correspondence: Recommendations 9 and 10 are forwarded to COMNAVSUBFOR; Recommendation 12 is forwarded to COMSUBPAC; and Recommendation 13 is forwarded to COMSUBGRU SEVEN. The command investigation did not find significant deficiencies in submarine force ship departmental training, fleet and submarine force organizational oversight, or submarine force readiness. The investigation did, however, reveal opportunities to improve training of prospective and serving Commanding Officers and navigation leadership/personnel, particularly in operational risk management, comprehensive understanding of navigation chart accuracy and usage, comprehensive open ocean voyage planning, and acceptable standards of prudence in open ocean navigation.

#### 4. (U) Chart Management.

- a. I concur with Opinion 72. Charts and supporting documentation/products aboard USS SAN FRANCISCO were sufficient to identify navigation hazards along, and adjacent to, the ship's intended track. Continuous and complete reliance on the accuracy and fidelity of a single navigation chart--when other charts with critical information were readily available--led to this grounding.
- b. Generally speaking, "Echo series" bottom contour charts are considered the most complete and accurate charts for submerged navigation. Certainly it would be best to consolidate and print, with constant and automatic updates, all available and relevant information regarding navigation hazards on Echo series charts. In

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this regard, I concur with Recommendation 10. COMNAVSUBFOR should work with the OPNAV Staff and NGA to review and improve the process by which charts and navigation products are updated. Process and resource constraints, however, inevitably result in delay between collating information (regardless of relevancy) and updating chart libraries. Indeed, because one chart may not, in fact, reflect all known and current navigation hazards, submarine force navigation directives mandate review of all available navigation charts and supporting documentation associated with a ship's intended track. Of note, at least three charts in USS SAN FRANCISCO's inventory, as well as descriptions in Sailing Directions and digital charts in the Voyage Management System, identified hazard/shoal markings in reasonable proximity to the ship's intended track and subsequent grounding location.

5. (U) Casualty and Medical Response. Post-grounding damage control and medical care were proper and exceptional in all critical respects. External response in support of USS SAN FRANCISCO was rapid and appropriate. Contingency planning adapted quickly to challenging circumstances. I commend HM1(SS/SW) and LTJG for care provided to MM2(SS) Ashley and other injured crewmembers under difficult conditions. I concur specifically with Opinions 45, 46, and 47. MM2(SS) Ashley's head injury was inevitably fatal. His death was in the line of duty and not due to misconduct. Injuries to other USS SAN FRANCISCO crewmembers were also sustained in the line of duty and not due to misconduct. By copy of this correspondence, Recommendation 11 is forwarded to BUMED for action. Recommendation 14 is forwarded to COMNAVSUBFOR for coordination with BUMED, and to enable provision of lessons learned.

### 6. (U) Accountability.

a. Responsibility, authority, and accountability at sea are essential hallmarks of the U.S. Navy. Rendering an account of USS SAN FRANCISCO's grounding begins, necessarily, with the Commanding Officer. A Commanding Officer's responsibility is absolute. Authority in command is commensurate with this responsibility. While authority may be delegated to subordinates, such delegation in no way relieves a Commanding Officer of responsibility. Such absolute responsibility and authority mandates accountability in command. This fundamental tenet does not mean, however, that when

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bad things happen the Commanding Officer is necessarily or inevitably punished. I assessed CDR performance by reviewing circumstances surrounding the grounding. In this regard I asked three basic questions: (1) Were the Commanding Officer's actions, before and after the grounding, in accordance with expected performance standards for officers in command?; (2) Did the Commanding Officer exercise due care before and after the grounding?; and (3) Did the Commanding Officer fail to take a directed or expected action that would have, or could have, changed the outcome and/or eliminated the grounding?

- b. In my opinion, CDR actions before the grounding fell below Navy standards commensurate with command. He failed to consider and implement all available navigation information. In so doing, he precluded the opportunity to recognize the need for a more conservative approach as his ship conducted a submerged transit in a region potentially hazardous to navigation. Neither he nor his navigation team exercised due care. He chose to operate USS SAN FRANCISCO at maximum speed with no navigation risk mitigation measures in effect, despite several islands, atolls and rapidly shoaling areas in the vicinity of the ship's intended track. Further, he chose not to take precautions such as stationing additional navigation watchstanders, establishing limits on speed and depth, and reducing the navigation sounding interval. Had the Commanding Officer instituted specified operational procedures and exercised prudent navigation practices, the grounding--even if not avoided altogether--would have been significantly less severe.
- c. Accordingly, I convened on 12 February 2005.

  After considering results and evidence presented by this investigation, CDR written and oral statements, and matters submitted in extenuation and mitigation, I concluded that CDR , and awarded him a Enclosure (263) pertains. I also relieved him of command and His poor judgment in this instance and failure to exercise due care in open ocean navigation and submerged operations caused me to lose confidence in his ability to effectively execute his duties in command.

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- d. I did not, however, recommend that CDR be required to show cause for retention. Although the grounding incident compelled me to punish CDR and remove him from command, in my opinion it does not negate 19 years of exemplary service. Prior to the grounding incident, USS SAN FRANCISCO demonstrated a trend of continuing improvement and compiled an impressive record of achievement under CDR leadership. Moreover, the crew's post-grounding response under his direct leadership was commendable and enabled USS SAN FRANCISCO's recovery and safe return to port.
- e. Accountability begins, but does not end, with the Commanding Officer. In this instance, the Executive Officer and navigation team share responsibility for USS SAN FRANCISCO's grounding. Failure to adequately and critically review applicable publications and available charts led to submission of an illadvised voyage plan and hindered the Commanding Officer's ability to make fully informed safety-of-ship decisions. Similarly, due to inattentiveness and poor performance, watch standers failed to recognize discrepancies between navigation sounding data and charted water depth on Chart E2202. These lapses deprived watch officers and command leadership of the opportunity to reassess the navigation posture prior to the grounding and take appropriate measures. By copy of this correspondence, Recommendations 2 through 8 are forwarded to Commander, Submarine Squadron FIFTEEN for appropriate action. COMSUBRON FIFTEEN is directed to report remedial actions taken to COMSEVENTHFLT not later than 30 days from receipt of this endorsement.
- 7. (U) Subject to the foregoing, I approve the findings of fact, opinions, and recommendations.
- 8. (U) My point of contact is CAPT JAGC, USN, who may be reached at DSN 243-7782, afloat DSN (315)453-2110, and by e-mail at 013@c7f.navy.mil.

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