DEPARTMENT OF THE NAVY
COMMANDER
UNITED STATES PACIFIC FLEET
250 MAKALAPA DRIVE
PEARL HARBOR, HAWAII 96860-3131

IN REPLY REFER TO:
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SECOND ENDORSEMENT on RADM Frank M. Drennan, USN ltrs of
1 July 2008 and Addendum of 15 July 2008

From: Commander, U.S. Pacific Fleet
To: File

Subj: COMMAND INVESTIGATION INTO THE FIRE THAT OCCURRED ONBOARD USS GEORGE WASHINGTON (CVN 73) ON 22 MAY 2008

Encl: (179) RADM R.J. O'Hanlon's ltr 5800 of 24 Jul 08
(180) [redacted] COMPACFLT N43B statement 29 July 08

(b)(6) & (b)(7)(C)

1. Pursuant to the Manual of the Judge Advocate General, subject investigation has been reviewed.

2. On 22 May, 2008, USS GEORGE WASHINGTON (CVN 73) experienced a fire in the unmanned Auxiliary Boiler Exhaust and Supply uptake space (6-189-1-Q). This fire developed into a major conflagration, fueled by significant amounts of improperly stored HAZMAT. The fire spread indirectly to several spaces adjacent to the uptake space extending from the 6th Deck to the 02 Level, between frames 180-190 on the starboard side. The crew went to GQ at 0820 and proceeded to fight fires for nearly 12 hours, securing from GQ at 2021. Extensive damage occurred to structure, electrical cables and equipment in the vicinity of the uptake space.

On 06 June 2008, I appointed RADM Frank Drennan per enclosure (1) as the Investigating Officer tasked to conduct a command investigation into the facts and circumstances surrounding the fire. Upon preliminary review of his first report dated 1 July 2008, I directed further investigation per enclosure (143). I also forwarded the draft report to USFF for endorsement, particularly to review possible shortcomings in ISIC and TYCOM oversight while USS GEORGE WASHINGTON was under USFF OPCON and undergoing unit level training (ULT) and transit from the Atlantic to the Pacific Fleet.

Together with a team of senior leaders and subject matter experts from my staff, I have carefully reviewed the basic investigation, investigation addendum, and the USFF endorsement.

It is apparent from this extensive study that there were numerous processes and procedures related to fire prevention and readiness and training for firefighting and firefighting management on board USS GEORGE WASHINGTON that were not properly functioning and did not receive the corrective attention that was warranted from the ship's senior leadership. These included deficient hazardous material control, zone inspection, 3M, DCTT, and DCPO programs.

This fire was entirely preventable. The ship's Chief Engineer had personally discovered below deck plates in an Auxiliary Boiler Room the improperly stored hazardous material that would eventually fuel this conflagration. He had ordered it properly disposed of and informed senior leadership up to and including the XO of his discovery. Even after his order to turn in the more than 300 gallons of HAZMAT was violated and 90 gallons of the flammable liquid was placed in the uptake space, a questioning attitude by any one of the officers and enlisted personnel who were witting of the Chief Engineer's discovery could have led to the material's recovery before the fire. Additionally, senior leadership had allowed shipboard inspection processes to lapse to a point that HAZMAT could be improperly stowed within the ship with little likelihood of discovery.

The extent of damage to USS GEORGE WASHINGTON could have been reduced had numerous longstanding firefighting and firefighting management deficiencies been corrected. DCTT, DCPO and 3M program shortcomings undoubtedly contributed to delays in discovery and decision making during the firefighting effort. It took leadership nearly eight hours to conclude that the uptake space was the source of the fire and to begin to extinguish it. In the intervening time, the fire had spread from the 6th deck to the 02 level and damaged more than 80 spaces. Additionally, equipage shortfalls hampered communications and the efficacy of fire teams. While Team Leaders and firefighters did a credible job fighting numerous fires under the circumstances, had the deficiencies in equipment and level of knowledge been corrected the extensive damage to USS GEORGE WASHINGTON could have been contained.

Clearly, the Commanding Officer must be constantly aware of his ship's deficiencies and be dealing with them appropriately. Though USS GEORGE WASHINGTON was involved in a complex series of events to culminate in a transfer to the FDNF and there were many important issues on the Captain's plate, deficiencies such these could not afford to become overshadowed by the next major event. Nor could the CO afford to take his eyes off what was

occurring below decks by his subordinates. The deficient programs in USS GEORGE WASHINGTON were under the purview of his Executive Officer in his responsibilities to carry out the CO's policies, his lead role in exercises and training including DCTT, his responsibility for the zone inspection program and in his duties to generally oversee the ship's departments. It was at the XO's eight o'clock reports that the CHENG had announced his discovery of the improperly stowed HAZMAT. To the extent this CO and XO were unable to effectively carry forward and appropriately act on the deficiencies uncovered during their ULT continuum, USS GEORGE WASHINGTON was not well served.

Many of the deficiencies in USS GEORGE WASHINGTON appear to be systemic and may call for an overhaul of TYCOM-led CVN manning and training processes during the ULT period. Potential areas include a review of critical manning factors in key carrier billets and across training teams; more rigorous application of objective measures of shipboard performance during assessments; a review of passing criteria in circumstances where major deficiencies exist in critical performance areas such as damage control and damage control training; and expectations regarding oversight and corrective actions by TYCOMS and ISICS.

3. Enclosures (179) and (180) are added.

4. The Findings of Fact are modified as follows:

(6) Delete FF 6. Replace with "The estimated cost for the repairs to USS GEORGE WASHINGTON as a result of the fire is approximately $70 million. This includes cost for material and labor cost from the public and private sector ship repair activities. [Encls (12) and (180)]."

(31) Add Encl 163 as supporting to read "[Encl (40) and (163)]."

(39) Delete FF 39. Replace with "MM2 [redacted], MM2 [redacted] MMFN [redacted] admit placing approximately 90 gallons of refrigerant oil in the unmanned, not easily accessed Auxiliary Boiler Exhaust and Supply space (6-189-1-Q). MM3 [redacted] denies involvement but is implicated by several others. [Encls (65) through (67) and (69) through (71)]"

(b)(6) & (b)(7)(C)

(41) Delete FF 41. Replace with "Inconsistent and contradictory statements were provided by the EA-03 LPO, MM1 [redacted], and the division members involved in placing the refrigerant oil in 6-189-1-Q as to whether MM1 [redacted] and MM2

[redacted] colluded to hide the oil or whether MM1 [redacted] ordered MM2 to turn the oil into HAZMAT division. [Encls (65) through (67), (69) through (71)]" (b)(6) & (b)(7)(C)

5. The following Findings of Fact are added:

(199) ISIC, Commander Carrier Strike Group EIGHT and TYCOM, Commander, Naval Air Forces Atlantic, discuss their role in oversight of USS GEORGE WASHINGTON, as documented by RADM O'Hanlon's review. CSG-8 did not submit a Plan of Action and Milestones to address deficiencies documented at the end of basic phase of training as required by the COMNAVAIRFORINST 3500.20B, Carrier Training Manual [Encls (30) and (179)].

(200) Review of the last four end of basic phase reports revealed that none of the ISICS provided a POA&M to the TYCOM as required in COMNAVIRFORINST 3500.20B, even though three of the four carriers were cited for major weakness in their DCPO programs. [Encl 179]

(201) ATG provided over 200 hours of DC training during TSTA/FEP. This training included 72 hours of package writing, 42 hours of Zebra training, and 42 hours of Yoke training. It only included 4 hours of dedicated DCPO training - the only area graded **UNSAT** in TSTA/FEP. [Encl 36 and 179]

6. The Opinions are modified as follows:

(10) Move "[FOF 29 through 31 and 61 through 136]" from the end of para 10.d. to the end of 10.e.

(15) Delete Opinion (15). Replace with "Although USS GEORGE WASHINGTON's ULT period was not compressed, there were complicating factors that took time and manpower away from unit-level training events, including INSURV and events associated with the ship's transfer to Japan. [FOF 12 through 28 and 173]"

(22) Delete Opinion (22). Replace with "MM1 [redacted] and several members of EA-03, to include, MM2 [redacted] MM2 [redacted] MM3 [redacted] and MMFN [redacted] were complicit in hiding 90 gallons of refrigerant oil in 6-189-1-Q. [FOF 37 through 49]" (b)(6) & (b)(7)(C)

7. The following Opinion is added:

(47) While I support the CUSFF endorsement that "Inadequate or inappropriate oversight by the ISIC and/or TYCOM

cannot be substantiated to be a direct factor in the causation or appropriate response to the fire," their actions did little to assist USS GEORGE WASHINGTON to be better prepared to deal with a fire of this magnitude. Both of their inputs to this investigation focused on rationalizing the training and assessments that were accomplished rather than assisting in identifying what might have been improved. Further, they overstated the benefits of pro forma ULT events that contributed too little in the way of focused training. As an example, it was pointed out that over 200 hours of personalized DC training by ATG during TSTA/FEP illustrated the effort made to correct the ship's discrepancies. In fact, this training was a standard part of TSTA/FEP exams. More than two thirds of it was administrative "package writing" and "yoke and zebra training." Only four manhours were dedicated to DCPO training - the only DC area graded **UNSAT** in TSTA/FEP. Additionally, COMNAVAIRFORINST 3500.20(series) required that the CSG Commander "report within two working days (of TSTA/FEP) to the TYCOM the Plan of Action to correct or accomplish any deficiencies or missed training noted by ATG." This was not done. And despite the fact that "DCTT not continuing to run DC drills" was identified as a TSTA/FEP **Major Concern,** together with "**of major concern** is a needed effort to increase basic DC training and knowledge throughout the ship's crew," only three GQ drills were run during the six weeks before the fire and while the ISIC and his staff were embarked. Lastly, TYCOM and CCG8 ISIC statements regarding the extent of their personal engagements with GW leadership concerning the ship's DC deficiencies were not evidenced by resultant improvements. In the future, CUSFF and CPF must demand more complete oversight and hands-on engagement in ULT corrective actions by TYCOM and ISIC commanders and their staffs. (FOF 14,16, 21 through 33, 153, 169 through 173, 179 through 185, 195 through 201)

8. The Recommendations are modified as follows. Replace Recommendations (6) through (10) with the following:

"6. NAVSEA should consider designating compartment 6-189-1-Q as a void and ensuring the space is covered by MIP 1231/005-B7 MRC AP-1."

"7. Forward this report to the current Commanding Officers of CDR [redacted], former GEORGE WASHINGTON CHENG, and LCDR [redacted] former GEORGE WASHINGTON DCA for review and subsequent administrative and disciplinary action they deem appropriate." (b)(6) & (b)(7)(C)

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"8. Commander, Task Force SEVENTY (CTF 70) is directed to take administrative and disciplinary action he deems appropriate for those individuals involved in the chain of events leading to the fire onboard GEORGE WASHINGTON. This includes the HAZMAT and Engineering personnel named in the investigation and others as he deems appropriate:

a. CDR [redacted]
b. ENS [redacted]
c. LT [redacted]
d. MMC [redacted]
e. CDR [redacted]
f. CDR [redacted]
g. LCDR [redacted]
h. LTjg [redacted]
i. MMC [redacted]
j. MMC [redacted]
k. MM1 [redacted]
l. MM1 [redacted]
m. MM2 [redacted]
n. MM2 [redacted]
o. MM2 [redacted]
p. MM3 [redacted]
q. MMFN [redacted]
r. ENFN [redacted]"

(b)(6) & (b)(7)(C)

"9. Commander, Task Force SEVENTY (CTF 70) is directed to consider administrative and disciplinary action he deems appropriate for those individuals responsible for the oversight, readiness, execution and training of fire fighting and fire fighting management. This includes the following persons named in the investigation and others as he deems appropriate:

a. CDR [redacted]
b. LCDR [redacted]
c. LT [redacted]
d. DCCS [redacted]
e. CDR [redacted]

"10. Commander, Naval Air Forces Pacific is directed to:

a. Relieve CAPT David Dykhoff, Commanding Officer USS GEORGE WASHINGTON (CVN 73), initiate Detach For Cause proceedings and consider other disciplinary or administrative actions he deems appropriate.

b. Relieve CAPT David Dober, Executive Officer USS GEORGE WASHINGTON (CVN 73), initiate Detach For Cause proceedings and

consider other disciplinary or administrative actions he deems appropriate."

9. The following Recommendations are added:

(11) This investigation has revealed numerous serious flaws in the carrier Unit Level Training program. USFF and CPF should review the entire certification process for appropriate rigor and oversight. USFF, CPF and CNAF should consider increasing the required frequency of outside inspections from ATG and the level of scrutiny and direct oversight from the TYCOM and Strike Group Commanders and their staffs, more rigorous application of objective measures of shipboard performance during assessments, a review of passing criteria in circumstances where major deficiencies exist in critical performance areas such as damage control and damage control training.

(12) CNAF should review the key and essential billets on board aircraft carriers that contribute to ULT preparedness and identify what experience, background, and training should accompany each key billet.

(13) CNAF should consider adopting an automated training and tracking system, such as the SURFOR TORIS-TFOM system in an effort to track critical training, key personnel, and key NEC's required on board the carriers.

10. By copy of this endorsement, the recommendations are forwarded for consideration and/or action as appropriate.

11. Subject to the foregoing, I concur with and approve the findings of fact, opinions and recommendations of the investigating officer. This investigation is closed.

12. The injuries sustained by MM2 [redacted] occurred in the line of duty and not due to his own misconduct. (b)(6) & (b)(7)(C)

13. During the events of 22 May 2008, many crew members of USS GEORGE WASHINGTON (CVN 73) displayed courage and resolve in fighting the fire and particularly rescuing their trapped shipmates. Their actions exemplify our Navy core values of honor, courage and commitment.

R. F. Willard

R. F. WILLARD

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