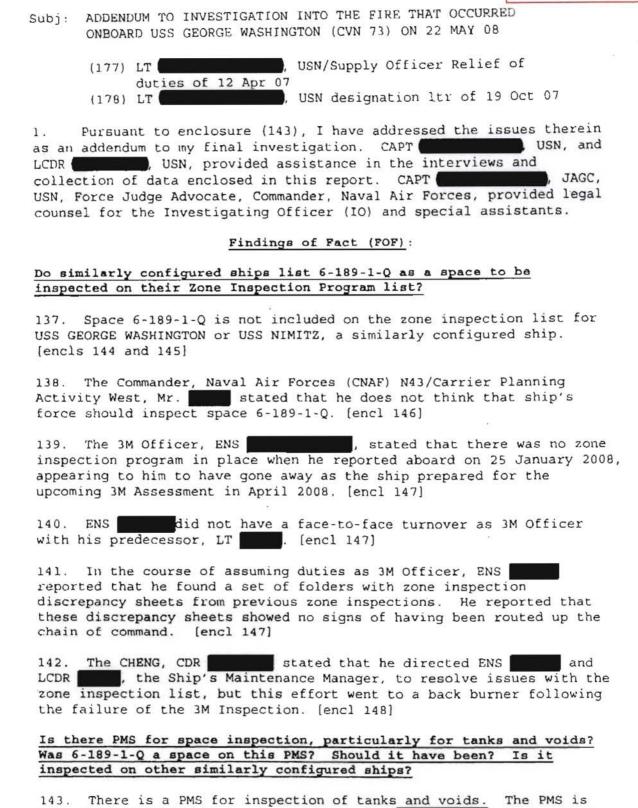
5830 Ser 00/ 15 Jul 08

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RADM Frank M. Drennan, USN
To:
      Commander, U.S. Pacific Fleet
Subj:
      ADDENDUM TO INVESTIGATION INTO THE FIRE THAT OCCURRED
       ONBOARD USS GEORGE WASHINGTON (CVN 73) ON 22 MAY 08
Encl:
       (143) CPF ltr 5830 Ser 00/0693 of 9 Jul 08 Order to Conduct
             Further Investigation of 9 July 08
       (144) CVN 73 Space List to zone inspection undated
       (145) CVN 68 Space List to zone inspection undated
                      Statement of 14 Jul 08
       (146)
       (147) ENS
                              , USN Statement of 11 Jul 08
                         , USN Statement of 11 Jul 08 and 14 Jul 08
       (148) CDR
       (149) PHONCON
                                , PMS 312C/LCDR
                                                    of 15 Jul 08
       (150) LT
                          , MSC, USN memo of 15 Jul 06 and 11 May 07
       (151) CDR
                          USN Statement of 11 Jul 08
       (152) CAPT David Dykhoff, USN/CVN 73 Department Heads of
             19 Jan 08
       (153) CAPT Dave Dober, USN Statement of 11 Jul 08
       (154) CAPT Dave Dober, USN Statement of 14 Jul 08
       (155) CAPT Dykhoff, USN/CDR
                                         email of 10 Apr 08
       (156) CAPT David Dykhoff, USN Statement of 11 Jul 08
       (157) LCDR
                              , USN Statement of 10 and 14 Jul 08
       (158) LCDR
                                USN email of 12 Apr 08
                                                             (b)(6) & (b)(7)(C
       (159) LCDR
                               USN/CVN 73 Department Head
             of 12 Apr 08
       (160) CDR
                             , USN/CAPT David Dober, USN email
             of 21 Jan 08
       (161) CVN 73 Mustang Association Meeting minutes of 30 Jan 08
       (162) DCCS
                             , USN telephone summary of 11 Jul 08
       (163) DCC
                             , USN telephone summary of 14 Jul 08
       (164) LT
                          , USN Statement of 10 Jul 08
       (165) LT
                           USN Fire Marshall Qualification
             304 of Mar 08
       (166) CAPT Dober, USN/ITT of 12 Mar 08
       (167) LCDR
                              , USN/CDR
                                              , USN email of
             13 Mar 08
       (168) LCDR
                              , USN TSTA/FEP Plan of Action and
             Milestones undated
       (169) LCDR
                        USN/CDR
                                      , USN email of 11 Apr 08
       (170) LCDR
                             Improved DCPO Program undated
       (171) DCA Ships Weekly Reports of 28 Apr 08 w/encls
       (172) CVN 73 General Quarters Debrief of 19 Apr 08, 8 and
             21 May 08
       (173) CDR
                                , USN Statement of 11 Jul 08
       (174) LT
                           , USN Statement of 11 Jul 08
       (175) MMC
                               , USN Statement of 11 Jul 08
       (176) ENS
                                       s, USN of 11 Jul 08
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(b)(6) & (b)(7)(C)



of the Carrier

Planning Activity, PMS-312C, this PMS does not cover 6-189-1-Q since

MIP 1231/005-B7 MRC AP-1. According to Mr.

the space is neither a tank nor a void. [encl 149]

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What is the role of the Ship's Safety Department in the mishap? When did the safety department last evaluate the HAZMINCEN program and what were their findings and recommendations? OPNAVINST 5100.19E Navy Safety and Occupational Health (SOH) Program Manual for Forces Afloat Paragraph B0302.a.(6)(d) calls for annual evaluation for the compliance and effectiveness. Obtain copies of these evaluations and provide opinions and recommendations related to their findings and any action taken by the chain of command with regard to the findings.

144.	The	Safe	ety	Dep	artm	ent'	s las	anr	ual e	valuat	ion	of	the	HAZMINCE	EN
was	compl	eted	on	11	May	2007	. The	e Ind	lustri	al Hyg	iene	e 0f	fice	er,	
LT			con	duc	cted	the								Safety	
offi	cer,	Comma	ande	r					[enc]	150}	(b	)(6	6) &	(b)(7)(	C)

- 145. CDR stated that the Assistant Supply Officer was the most senior officer who had reviewed the 2007 annual report. [encl 151]
- 146. The 2006 annual report was completed on 15 July 2006. [encl 150]

Provide more information and analysis on the relationship and communication between the CO and the XO in addressing areas of deficiency discovered in the various inspections.

# a. Did the CO provide any written or verbal guidance to the XO to address deficiencies identified in the inspections?

- 147. The CO sent an e-mail dated 19 January 2008 to GW Department Heads, Principal Assistants and Department LCPOs noting his concerns about two areas that constituted a "serious threat" to the ship's transition to FDNF. One area was Force Protection in reaction to the recent failure of a TYCOM Phase IV Anti-terrorism Force Protection Program(ATFP) assessment. The other area was weakness in overall performance in areas that would have to be demonstrated during upcoming TSTA/FEP. He characterized the second area as follows: "The second worrisome problem is our overall performance demonstrating the capabilities that will be examined during TSTA/FEP. While there are pockets of strength, our overall, coordinated, command-wide effort has not stayed on the required profile and if we don't take some relatively substantive corrective action there's a good chance that we'll have significant difficulty with TSTA/FEP." [encl 152]
- 148. The XO, Capt Dober is included in the "GW Department Head" address group listed in the "To" line of the CO's 19 Jan 2008 email. (CHENG statement) [encl 148]
- 149. The XO could not recall the CO's 19 Jan 2008 email. The XO did not recall any specific discussions he had with the CO about these concerns. [encls 153 and 154]
- 150. The XO believed the DC program was on the right glideslope to be able to successfully complete TSTA/FEP. [encls 153 and 154]

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- 151. The CO sent an e-mail to the CHENG on 10 April 2008 after the ship had failed the 3M Assessment about his reservations with the ship's DC program and general expertise in engineering. The XO was included on the Cc line of the e-mail. [encl 155]
- 152. Neither the CO nor XO recall any communication in which the CO gave guidance specifically for the XO to address deficiencies identified in inspections. [encls 153, 154 and 156]
- 153. On about 12 April 2008, the CO approved a plan of action developed by the DCA to address deficiencies in the DCPO program which was subsequently sent to all Department Heads by the DCA. The plan was subsequently updated to include corrective action from the 3M inspection at the direction of the XO. [encl 157]

#### b. Did the CO identify any weaknesses in the XO's or CHENG's performance?

- 154. The CO sent an e-mail to the CHENG on 10 April 2008, following the out brief of the failed 3M Assessment, in which he expressed reservations about the ship's DC program and engineering expertise in general. He directed the CHENG to review results of INSURV, TSTA/FEP and the 3M Assessment and then wanted to have a meeting with the CHENG to solve the issues he saw in Engineering. He mentioned that "some of your guys spend a lot of their time on the bridge. I think that's a great thing, but it might also be pulling them away from their primary billet to the extent that the ship is suffering." There is no other evidence prior to or after this email indicating that the CO was not satisfied with the performance of the Engineering Department under the leadership of the new CHENG. [encl 155]
- 155. When asked how he assessed the CHENG's performance to date, the CO stated that the CHENG was definitely stretched thin and his staff was not as strong as other departments. He stated that the CHENG was not as strong as other Department Heads, but he had not personally sat down with the new CHENG to discuss his performance. [encl 156]
- 156. The CHENG had been onboard for approximately three months at the time the 10 April 2008 e-mail from the CO was sent. [encl 148]
- 157. The 10 April 2008 e-mail was copied to the XO. [encl 155]
- 158. The CO expressed confidence in and strong support for his XO and has not had a reason to counsel him on any weaknesses in performance. [encl 156]
- 159. The XO could not recall any communication from the CO identifying weaknesses in his performance. [encls 153, 154]
- c. As DCTT-lead did the XO recognize weaknesses in DC and attempt to fix them? Did he present his plan to the CO? Did he voice

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# his non-concur with the CO or did he actively/passively concur with the leadership direction?

- 160. The XO had concerns over the manning of the DCTT dating back to June 2007 when he spoke with the Command Master Chief (CMC) about getting more bodies for DCTT. [encls 153 and 154]
- 161. After Crew Certification Phase 2(Crew Cert), the XO was told by DCCM COMNAVAIRLANT N7 Department that the DCTT was "not forward leaning and not properly running some drills." [encls 153 and 154]
- 162. After CART II, the XO was told by ATG LANT that the overall training teams were not integrated with respect to running drills and that there was poor integration with the briefing of drills. [reference enclosure (28) of original JAGMAN, encls 153 and 154]
- 163. After CART II, the XO was in contact with ATG LANT to help the DCTT get up to speed on drills, specifically help on drill packages. [encls 153 and 154]
- 164. The XO stated that even after the DC discrepancies that were identified during CART II and INSURV, he felt the DC program was on track to successfully complete TSTA/FEP. [encls 153and 154]
- 165. In January 2008, the XO was still concerned about the number of personnel on DCTT and the overall experience and seniority of the team. He sent e-mails to the ship's LCPOs and Mustang Association asking for support in the departments assigning more experienced personnel to the DCTT. [encls 153, 154, 160 and 161]
- 166. The XO did not discuss DCTT membership issues with the incoming CHENG during his turnover brief in January 2008. The XO told him to focus on 3M and INSURV deficiencies. Further, the XO did not provide specific guidance to the incoming DCA, LCDR regarding DCTT or other DC issues that needed to be resolved based on recent external evaluation reports. [encls 148, 153, 154 and 157] (b)(6) & (b)(7)(C)
- 167. The new DCA and CHENG assumed their duties in January 2008. [encls 148 and 157]
- 168. During TSTA/FEP, the XO stated that the ship had a huge learning curve in setting Condition Zebra and had some problems with DC fittings. He stated that ATG LANT raised questions about DCTT's ability to go from a training mode to a self-assess mode and provided extra training (approximately 200 hours) with the major focus being basic DC training. When asked whether he was concerned about the progress of the DCTT, the XO stated that he did not think the TSTA/FEP report showed a trend in problems in DCTT and believed that the ship's crew was improving and on the right glide slope. He also stated that, based on conversations with the old CHENG, he believed that it was

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normal to have a steep learning curve and ramp up in Damage Control until the end of TSTA/FEP. [reference JAGMAN enclosure (36) and encls 153, 154 and 162]

- 169. The XO stated that prior to January 2008, the ship did basic and advanced DC training and some dedicated DCTT training. There is no record of DC training between October 2007 and April 2008. [encl 163]
- 170. Prior to TSTA/FEP, the XO did not direct or issue any specific POA&Ms nor discuss with the CO any specific action plans dealing with DC. Until TSTA/FEP, the XO believed that the DCTT and DCPO programs were on track. [encls 153, 154, and 157]
- 171. DCC ACG LANT stated that "We did see the number of qualified members of DCCT increase from CART II but not by much." [encl 163]
- 172. The DCPO program improvement plan was the only DC-related plan presented to the CO. This plan was developed by the DCA and was presented by the DCA, CHENG and XO to the CO after the completion of the 3M Assessment on about 12 April 2008. [encls 153, 154 and 157]
- 173. The XO stated that preparing for INSURV and events associated with the ship's transfer to Japan took time and manpower away from other unit-level training events. [encls 153 and 154] (

Provide more information and analysis on the Damage Control Chain of Command. The CHENG, DCA, and Fire Marshal appear to have taken over programs with past problems. What was their plan to address past deficiencies? Were the CO/XO satisfied with the plan? Did the entire leadership team feel the DC training and drill schedule were appropriate considering their inspection performance?

- 174. The new CHENG and DCA assumed their duties in January, prior to the beginning of TSTA/FEP underway period. LT the new Fire Marshall, reported in January and has not yet been qualified as Fire Marshall as of July 2008. DCCS took over as interim Fire Marshall in October/November 2007. He was also the DCTT Coordinator from August to December 2007. DCCS began turn over to LT in January 2008 but remained as Fire Marshall through TSTA/FEP per the request of ATG LANT. [encls 148, 157, 164, and 165] (b)(6) & (b)(7)
- 175. The DCA's prior shipboard assignments were Fire Control Officer on USS California, Electrical Division Officer on USS Carl Vinson, Combat Direction Center Officer on USS Enterprise, and Combat System Officer on USS Samuel B. Roberts. He was also the Force Protection Officer for DESRON 15. [encl 157]
- 176. During his turnover interview with the XO, the new CHENG stated that they focused their discussion on preparing for the 3M Assessment and correcting INSURV discrepancies. [encl 148]

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- 177. The CHENG was unaware of DC deficiencies identified in the CART II report. [encl 148]
- 178. In January, 2008 the DCA prepared a POA&M to address DC deficiencies identified during CART II and INSURV. He did this on his own initiative. [encl 157]
- 179. The Training Officer sent an e-mail to the XO on 12 March 2008 recommending the ship plan one GQ per week during the transit from Norfolk to Japan. The XO responded that the ship now needed to tailor its training to meet the requirements of COMPTUEX. [encl 166]
- 180. Following TSTA/FEP, the DCA prepared a POA&M to correct deficiencies addressed in the ATG LANT final report. He also made recommendations to the CHENG on improving the DCPO program. He did this on his own initiative. [encls 157, 167, 168 and 169]
- 181. Following the CO's email of 10 April 2008, the DCA sent an updated draft of a new DCPO Program to the CHENG. Around 14 April 2008, XO and CO approved the DCA's plan of action with a scheduled kick off date of 28 April 2008. [encls 157, 159, 166 and 170]
- 182. The routing of Ship's Weekly DC Reports began on 28 April 2008. [encl 171]
- 183. It was after TSTA/FEP when the CHENG realized that the DCPO program had problems. The CHENG stated that he began work on the program in early April 2008. [encl 148]
- 184. Following the TSTA/FEP report, and at the direction of the CO, the CHENG began to pay more attention to improving the DCPO program. [encl 148]
- 185. The ship held three GQs from the time they departed Norfolk on 7 Apr 2008 until the fire on 22 May 2008. [encls 153, 154 and 172]
- Did CO/XO consider issuing letters of instruction for the former CHENG, DCA, and Fire Marshal that were in place during the series of DC failures in the Fall/Early Winter of '07?
- 186. The CO and XO stated that they were satisfied with the performance of the old DCA, CHENG, and Fire Marshall, and they did not see a need to give a letter of instruction to them regarding DC related issues. [encls 153, 154 and 156]
- Did the Supply Officer and HAZMAT Officer investigate and then take corrective action for the system not controlling 350 gallons of HAZMAT? If corrective action was taken, why wasn't the failure to turn in 90 gallons of HAZMAT noted?

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- 187. The CHENG stated that he described to the XO and other Department Heads the incident in April 2007 involving finding a large number of cans of refrigerant oil in a bilge as "lots of HAZMAT cans found illegally stored," but did not did not see it as a HAZMAT program issue. He did not recall if he informed the HAZMAT Coordinator of the incident. [encl 148]
- 188. The XO confirmed that the CHENG mentioned the incident at a daily Department Head meeting. [encls 153 and 154]
- 189. The CO stated that he did not recall the incident in April 2007 when the CHENG found the improperly stored HAZMAT. He did recall the Supply Officer, CDR conducting amnesty periods for HAZMAT. [encl 156]
- 190. The Fire Marshall was not informed of the HAZMAT incident in April 2007. [encl 165]
- 191. The Supply Officer did not investigate why the HAZMAT program was not tracking the 350 gallons of refrigerant oil found by the CHENG. He also did not inform the HAZMAT Division Officer, LT or the HAZMAT LCPO, MMC of the incident. [encls 173, through 175]
- 192. MMC discovered the cans of oil in the HAZMAT storage room a few days after the oil was initially discovered by the CHENG.

  MMC was primarily concerned with cleaning up the oil that had leaked from the cans. He informed LT a few days later. [encls 174 and 175]
- 193. Both LT and MMC asked HAZMAT Division members how the oil got into the storage room but got no satisfactory answers.

  They did not further investigate this matter. [encl 174 and 175]
- 194. ENS relieved LT as HAZMAT Division
  Officer on 12 April 2007. LT relieved ENS as
  HAZMAT Division Officer on about 1 December 2007. LT relieved
  LT as HAZMAT Division Officer on 20 April 2008. [encls 174, 176, 177 and 178]

# After failing the 3M inspection (11APR08), what was the corrective action taken by ship's leadership? (FF #28 says they "began a plan.")

- 195. On 10 April 2008, the CO sent an e-mail to the CHENG about his reservations with the ship's DC program and general expertise in engineering. [encl 155]
- 196. On about 12 April 2008, the CO approved a POA&M developed by the DCA to address deficiencies in the DCPO program which the DCA subsequently sent to all Department Heads. [encls 157, 158, 159 and 170]

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197. The salient aspects of the action plan were to: (1) stand up a DCPO organization IAW with the ship's SORM; (2) provide regularly scheduled DCPO training; (3) supervise the completion of Fire Marshall and DC discrepancies; (4) conduct weekly, monitored spot checks by DCPOs; and (5) issue a weekly DCPO report to the chain of command. [encl 170]

198. The routing of Ship's Weekly DC Reports began on 28 April 2008. [enclosure 171]

#### Opinions:

- 29. It should not be expected that space 6-189-1-Q be part of a properly run zone inspection program because such inaccessible spaces are not typically included in a zone inspection program. [FOF 137 and 138]
- 30. 3M Officer, ENS took over a dormant zone inspection program and did not receive adequate support the CHENG and XO to restart it. He displayed adequate initiative in attempting to perform his duties. [FOF 139, 140 and 142] (b)(6) & (b)(7)(C)
- 31. Since space 6-189-1-Q is neither designated a tank or void, there is no applicable tank and void or other Maintenance Requirement Card. [FOF 143]
- 32. The Safety Department's annual evaluation of HAZMINCEN was not a comprehensive review of the ship's program and was not provided to those personnel responsible for the program as outlined in OPNAVINST 5100.19E. The number of repeat findings in the 2007 annual evaluation of the HAZMINCEN program with the same or nearly the same wording supports that program deficiencies got little or inadequate correction action following the 2006 report. [FOF 144,145 and 146]
- Prior to about April 2008, neither the CO nor the XO were adequately involved in assessing and improving the DC readiness of the command. Neither recognized that the consistent problems that the ship was having in DC, as reported by external evaluators, was the result of fundamental weaknesses in the ship's DC training program and DCPO program. The fact that they stated that they were satisfied with the outgoing CHENG's and DCA's performance and made no specific mention of DC program issue during in-calls with the new CHENG and DCA implies that the CO and XO felt the DC program was generally on track. While the XO and CO recognized that the DCTT needed more seniority as early as July 2007, they did not take forceful action to increase the number of senior DCTT members soon enough to be able to train and qualify members prior to TSTA/FEP, leaving the DCTT poorly prepared to meet the demands of TSTA/FEP and to conduct post-FEP training. The CO and XO shared information well but may have re-enforced each others view of the ships performance. [FOF 147 through 152]

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- 34. Despite DC weaknesses noted by external evaluators during the ship's unit-level training period, the XO believed that the DCTT and his crew were undergoing the standard learning curve for a carrier undergoing that phase of training. As a result of this belief, the XO was insufficiently involved in demanding and tracking more aggressive corrective action. [FOF 150, 160 through 166]
- 35. In regard to DC Training, Fire Marshall, Zone Inspection, 3M, and HAZMAT programs, there was a conspicuous lack of routine reports to the department head level and higher on George Washington. [FOF 144 through 182]
- 36. At least tacitly, the CO and XO allowed routine zone inspections to lapse for significant periods of time during the ship's unit-level training period (August 2007 to April 2008) to allow for efforts to prepare for the ship's INSURV and TSTA/FEP. In the same period, the XO allowed a large portion of damage control training to lapse. The CHENG, 3M Officer, and the DCTT Coordinator indicated that there was implicit or explicit direction from above to forego routine efforts in favor of reactive efforts to prepare for the next external evaluation of the ship. [FOF 144 through 182]
- 37. While both the CO and XO indicated that they communicated frequently while each other there are some conspicuous indicators of a lack of common focus. For example, the XO did not discuss with the CO how to translate into tangible actions the concerns expressed by the CO in his 19 January 2008 e-mail. There is no evidence that the CO held follow-up discussions with the XO to ensure his concerns were being addressed. Similarly, neither the CO nor the XO held follow-up discussions with the CHENG to clarify the concerns about problems in the Engineering Department, in addition to the DC program, as expressed by the CO in his email of 10 April 2008. [FOF 144 through 182]
- 38. The XO was not effective at directing cross-departmental support based on his inability to get the DCTT properly manned and get the DCPO Program back in place before the CO expressed his concerns on 10 April 2008. [FOF 160, 165, 166, and 171]
- 39. While it is clear that the CO is confident and satisfied with his XO's performance, there are some concerns about how the CO is using his XO in executing his command responsibilities. He appears overly empathetic to the challenges facing his XO to the degree that it may affect his objectivity regarding the XO's performance and the demands he places on him. This concern is primarily based upon the CO's discussion of how he is dividing responsibilities with the XO. [FOF 158, 159 and 186]
- 40. Conducting three GQ Drills in the six-week period following underway from Norfolk was insufficient to address the major concern to

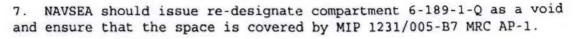
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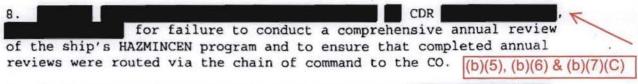
increase basic DC training and knowledge throughout the ship's crew expressed by ATG during TSTA/FEP. [FOF 179 and 185]

- 41. Based upon several plans of action he developed on his own initiative, the DCA was the most proactive in correcting past problems among those responsible for DC. His efforts were commensurate with the diligence expected of an officer of his grade and experience. [FOF 178, 180, 181, 182, 196 through 198]
- 42. There is no evidence that the DCA's primarily operations-related background has had an effect on his ability to execute his duties as DCA on George Washington. [FOF 175, 178, 180 and 181]
- 43. It is apparent that the CHENG did not recognize earlier than April 2008 the fundamental problems with the DCPO Program and direct appropriate action. Further, he did not provide forceful direction and support for restarting the ship's routine zone inspection program. There is evidence, however, that he was taking action to address the INSURV discrepancies and focus on the 3M program as directed by the XO. He appeared to meet an acceptable standard of performance for a CHENG who was in the first months of his tour. While the CO expressed some concerns about the CHENG's performance in April 2008, neither he nor the XO formally counseled the CHENG regarding aspects requiring improvement, as would be appropriate given the CO's concerns. [FOF 167, 172, 174, 176, 177, 180, 181, 183, 184 and 195]
- 44. LT did not have the operational experience normally found in a CVN's Fire Marshall, and he did not aggressively pursue designation. LT delay in designation and taking leadership of the Fire Marshall position negated the benefit of an officer giving the position more seniority and subsequent ship-wide impact. [FOF 174]
- 45. The Supply Officer did not recognize the significance of the CHENG's finding of a large amount of HAZMAT in the Engineering Division spaces. He did not inform his HAZMAT Division Officer as would be appropriate. As a result, a proper investigation into why the HAZMAT was outside the required control was not initiated. Because there was no investigation, there was no way for HAZMAT personnel to recognize that 90 gallons had not been turned into HAZMAT Division. [FOF 186 through 191]
- 46 Neither the HAZMAT Division Officer nor the HAZMAT LCPO took adequate action to determine the circumstances surrounding the large amount of oil recently moved to their storage room when they learned about it. [FOF 192 through 194]

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#### Recommendations:





9. No further action should be taken against ENS

10. LT for failure to adequately look into the circumstances of how a large amount of HAZMAT was placed in a HAZMAT storeroom without their knowledge.

E. M. DRENNAN