

DEPARTMENT OF THE NAVY

COMMANDER UNITED STATES PACIFIC FLEET 250 MAKALAPA DRIVE PEARL HARBOR, HAWAII 96860-3131

> IN REPLY REFER TO: 5830 Ser N00/074 17 Apr 14

FINAL ENDORSEMENT on CDR

(b)(3), (b)(6)

and CDR (b)(3), (b)(6)

b 3 b 6) ltrs of 23 Nov 13

From: Commander, U.S. Pacific Fleet

To: File

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167985, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013

Ref: (k) COMNAVAIRSYSCOM 142000Z Feb 14

Encl: (72) My ltr 5830 Ser Code N00/013 of 17 Mar 14

1. I have reviewed the subject investigation and, pursuant to enclosure 72, I have taken this investigation as a matter within my cognizance. As modified below, I approve the investigating officers' findings of fact, opinions, and recommendations.

2. Executive Summary

- a. <u>Background</u>. HSC-6 helicopter "INDIAN 617" experienced a mishap on deck USS WILLIAM P. LAWRENCE (WPL) in the Red Sea on 22 September 2013 at 1245(C). The Class A Mishap resulted in the loss of two Naval Aviators and the total loss of the MH-60S aircraft.
- b. All relevant personnel were qualified for the positions they held and the aircraft was in compliance with all periodic maintenance inspections and applicable technical directives.
- c. The investigating officers (IO) opined that the officer of the deck (OOD) did not violate published procedures and that the conning officer's rudder-and-speed combination was not excessive. They also opined the following:

While the chosen course likely put the ship in a position to experience the large rolls which caused the water impact, neither the initial choice of course nor the decision to come to course 195° were the result of negligence on the part of the crew of WPL. It was not reasonably foreseeable that such a large roll or rolls would occur in such a manner that would set in motion the chain of events which resulted in this mishap.¹

Five of the six endorsers, including Commander, Naval Surface Force, U.S. Pacific Fleet (CNSP) agreed. However, Commander, Naval Air Force, U.S. Pacific Fleet (CNAP) did not agree.

- d. In his endorsement, CNAP opined that a series of seemingly minor, innocuous misjudgments had a cumulative catastrophic outcome when graded against the harshness of the unforgiving nature of operations at sea. The Commanding Officer and her crew failed to obviate the potential effects of the environmental conditions, and did not take advantage of the opportunities to break the chain of events that ultimately led to a wall of water impacting the helicopter's spinning rotor blades, resulting in the mishap. CNAP found that there was more that the Commanding Officer could and should have done to properly and thoroughly assess the risk factors that led to this mishap.
- e. <u>Causation</u>. This mishap was the product of (1) accepting unnecessary risks during routine, yet inherently dangerous, shipboard helicopter operations, (2) failing to systematically train frigate and destroyer Commanding Officers on previous mishaps, and (3) failing to incorporate the findings of these mishaps into NATOPS procedures. Though several factors contributed to this mishap, the primary cause was the Commanding Officer's failure to fully account for the combined effects of wave height and starboard quartering seas, exacerbated by maintaining a speed of over 30 knots. The risks induced by a totality of these factors were not warranted. The roll of 12° to starboard 2 minutes prior to the mishap provided warning of increasing risk; actions as simple as immediately slowing or altering course to a more

¹ IO Opinion 16.

stable heading were not taken. While the surface and aviation communities should have done more to train the CO on similar mishaps, she was ultimately responsible for the safe operation of her ship.

3. Administrative Changes

- a. Insert page number 23 at the center bottom of the SECOND ENDORSEMENT on CDR (b)(3), (b)(6) and CDR (b)(3), (b)(6) 1tr of 23 Nov 13.
 - b. Change the THIRD ENDORSEMENT to read "THIRD ENDORSEMENT on CDR (b)(3),(b)(6) and CDR (b)(3),(b)(6) ltr of 23 Nov 13."
- c. Insert page number 25 at the center bottom of the FOURTH ENDORSEMENT on CDR $_{(b)(3),\,(b)(6)}$ and CDR $_{b\ 3,\,b\ 6}$ ltr of 23 Nov 13.
- d. Delete page number 145 and replace with page number 26 at the center bottom of the FIFTH ENDORSEMENT on CDR (b)(3), (b)(6) and CDR (b)(3), (b)(6) ltr of 23 Nov 13.
- e. Delete "FOR OFFICIAL USE ONLY" from the FIFTH ENDORSEMENT on CDR (b)(3), (b)(6) and CDR (b)(3), (b)(6) ltr of 23 Nov 13.
- f. Change the SIXTH ENDORSEMENT header to read "SIXTH ENDORSEMENT on CDR (b)(3), (b)(6) and CDR (b)(3), (b)(6) ltr of 23 Nov 13."
- g. Change the SIXTH ENDORSEMENT recipient from "File" to "Commander, U.S. Pacific Fleet."
- h. Change the subject of SIXTH ENDORSEMENT to read "COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167985, WHICH OCURRED AT N 22° 34' 18" E 037° 25' 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013".
- 4. Findings of Fact. I concur with all findings of fact.

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167985, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
- 5. Opinions. I concur with all opinions as modified through the SIXTH ENDORSEMENT, except as modified below.
- a. Opinion 7: Modify Opinion 7 to read: "Though BUNO 167895 "INDIAN 617" was properly authorized and scheduled for the assigned mission on 22 September 2013, subsequent changes to the CSG's schedule did not trigger changes to the helicopter logistics schedule. WPL's Commanding Officer accepted a higher risk helicopter evolution at flank speed with quartering seas in an effort to execute a schedule that was pressurized on one side by delays to the helicopter logistics schedule, and on the other side by the need to have WPL proceed to relieve the USS STOCKDALE (DDG 106) as plane guard in support of the STOCKDALE's replenishment-at-sea schedule. By attempting to accomplish both tasks simultaneously, without appropriately managing risk, the ship's Commanding Officer traded away safety margin during the execution of these two competing events. [Findings of Fact 7-11]"
- b. Opinion 10: Modify Opinion 10 to read: "Though the OOD did not violate any published procedures during WPL's course change, the Commanding Officer and OOD failed to heed the caution contained on page 7-4 of reference (c), which advises that "special care should be exercised when maneuvering while helicopters are turning on deck." As a result, they failed to identify and properly assess the increasing danger to the vessel, aircraft, and crew associated with maneuvering at flank speed on a heading that placed swells on the starboard quarter while a helicopter, though chocked and chained, operated on the flight deck. [Findings of Fact 32-36, 38, 68 and 69]"
- d. Opinion 11: Modify Opinion 11 to read: "The Commanding Officer accepted increased risk to life and property by maneuvering at flank speed and permitting the OOD to execute a course change that placed the seas on WPL's starboard quarter while INDIAN 617 operated on deck when the operational urgency to do so could have been negated had she communicated her situation to the Helicopter Element Coordinator (HEC). [Findings of Fact 38, 40 and 41]"
- e. Opinion 12: Modify Opinion 12 to read: "The combined effects of wave height, starboard quartering seas, and ship's speed set the

conditions for this mishap. [Findings of Fact 26-29, 31, 38, 47-50, 67, 68]"

- f. Opinion 16: Modify Opinion 16 to read: "A truly strong safety climate regarding helicopter operations should have included training on previous mishaps and HAZREPs associated with DDG 51/79 Class ship handling, and should have allowed flight-deck personnel the opportunity to communicate their concerns during the evolution. [Findings of Fact 75]"
- g. Add Opinion 16A: "Once the ship achieved the ordered course of 190° and began to experience heavy rolls, including a roll that exceeded 12° that preceded the mishap by 2 minutes, the CO had ample warning that the ship's new heading created risk to life and property; yet she proceeded to course 195°, exacerbating the situation. An experienced Commanding Officer exercising prudent seamanship and situational awareness should have foreseen that the combination of WPL's course, speed, and the prevailing seas could cause larger and more dangerous rolls. [Findings of Fact 29, 31, 37, 47-50, 67, 68]"
- 6. <u>Recommendations</u>. I approve and adopt the recommendations of the Investigating Officers. The actions directed by CNAP in the SIXTH ENDORSEMENT are modified as described in paragraph 7 below.
- 7. Necessary Action. The dangers associated with seawater intrusion over the flight deck of DDG 51/79 Class ships are well known. Navy leaders concluded that we need to manage these types of risks better; yet in this instance we did not and two men were lost.
 - a. By copy of this endorsement, I direct the following action:
- (1) CNSP and CNAP shall conduct a safety stand-down for all helicopter commands and all frigates and destroyers to address the dangers of seawater intrusion during helicopter operations.

 Commanders shall ensure that reference (k), which is Change 11 to reference (c), and this and similar mishaps are briefed. The safety stand-downs for Pacific Fleet units shall be completed by 30 May 2014. CNAP and CNSP shall also coordinate with Commander, Naval Air Force, Atlantic (CNAL) and Commander, Naval Surface Force, Atlantic (CNSL).

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167985, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
- (2) CNSP shall forward a redacted copy of this investigation, including endorsements, to the WPL's Officer of the Deck and Conning Officer who were on watch during the mishap, and their present Commanding Officer[s], for constructive counseling regarding my findings of fact and opinions.
- b. On 14 February 2014, Commander, Naval Air Systems Command (NAVAIR) issued interim change² 11 to reference (c), which addressed the particular risks associated with helicopter operations on low-freeboard vessels. Before that interim change, the Helicopter Operating Procedures for Air-Capable Ships NATOPS Manual cautioned to use "special care", but did not expressly restrict ship maneuvering when a helicopter was operating on deck.³ By copy of this endorsement, I request the following actions:
- (1) NAVAIR, Naval Sea Systems Command (NAVSEA), and the Naval Safety Center coordinate with CNSP and CNAP to review all previous documented occurrences of seawater intrusions associated with flight operations aboard DDG 51/79 Class ships. Use those results to review and expand upon reference (k) and to codify changes to reference (c). Define more explicitly the safe-operating parameters that shall govern helicopter operations on air-capable ships, including the risks posed by platform-specific characteristics and associated risk-mitigation measures. Incorporate those changes into all applicable training syllabi.
- (2) NAVAIR and NAVSEA conduct joint modeling of this mishap and other occurrences of seawater intrusions in order to refine current ship handling procedures during air-capable ship helicopter evolutions.
- (3) NAVAIR and NAVSEA review wind, sea state, pitch, roll, ship's speed, and wave height/period parameters governing helicopter operations aboard DDG 51/79 Class ships and other low-freeboard vessels. Validate the restrictions and warnings contained in reference (k); issue detailed changes to reference (c) that address

² Reference (k).

³ Reference (c) at page 7-4 (version in effect 22 Sep 2013).

specific wind, sea, and maneuvering restrictions that affect take-off, landing, and on-deck-engaged-rotor operations (including at "red deck") across a broad range of expected operating conditions.

8. Accountability

a. I will direct appropriate administrative action for CDR Jana A. Vavasseur.

9. Conclusion

- a. The WPL Commanding Officer's actions contributed to the loss of life, loss of an aircraft, and damage to the ship. While conducting flight operations, she maneuvered at flank speed and did not fully assess the environmental factors. She unnecessarily assumed increased risk during the helicopter evolution, which was unwarranted given the operational circumstance, and she did not communicate with the HEC. In this instance, the Commanding Officer did not exercise the highest degree of judgment, seamanship, or prudence.
- b. A Commanding Officer has absolute responsibility and accountability for the conduct of her unit's mission; Article 802 of Navy Regulations addresses this. Her responsibility to execute operations and to manage risk across the full range of environmental conditions is ever-present. These environmental conditions are both naturally occurring (the wind, seas and weather in which our units operate) as well as operationally induced (the mission at hand, and the circumstances in which we are employing the unit, from peace through crisis and into war). The management of risk is a comprehensive calculus, an enduring requirement, and an integral element for successful command. Commanding Officers have an enduring responsibility to manage risk, which requires the finest sense of judgment.
- c. Commanding Officers must execute this most serious responsibility through a continuous assessment of all factors that affect our operations whether at sea, in the air, or ashore. We achieve success by drawing from our experience, expertise, and operational traditions, all of which value seamanship and airmanship;

and by developing a finely tuned understanding of the physical environment in which we operate. These factors combine in our assessment of risk, both risk to mission and risk to force, and how this assessment relates to safety -- foremost for our Sailors, our most valued of all resources, and for our ships and aircraft. A Commanding Officer is trusted to get this balance right.

- d. The tragic events of 22 September 2013 unfolded in the following manner:
- Prior to the mishap, WPL observed true winds from northwest to northwest-by-north at 25-30 knots and combined seas running with the wind at 5-6 feet with a 4-5 second period.
- At 1237, INDIAN 617 was recovered. WPL's course was 130° true, which placed the seas directly astern. Immediately after recovery, WPL turned to starboard seeking course 190° true.
- WPL rolled moderately during the course change from 130° to 190°, but at course 190°, rolls became excessive with increasing magnitude.
- · At 1242, WPL rolled 12° to starboard.
- · At 1243, WPL changed course from 190° to 195°, and rolls got worse.
- At 1244, WPL rolled 16.6° to starboard and a thick "wall" of water enveloped INDIAN 617, which was still turning on deck.
- · At 1245, a crash on deck was reported.
- · At 1247, there was a report of INDIAN 617 going overboard.
- e. When viewed in isolation, at every moment, CDR Vavasseur's maneuvering was within the envelope:
- DDG110INST 3750.1A (written before NAVAIR promulgated Change 11 to reference (c)) places no restrictions for maneuvering the ship while at red deck with chocks and chains installed;
- At the time of the incident, reference (c) only restricted maneuvering in high sea states, which was not technically the situation at the time of the mishap; and,
- At the time of the incident reference (c) also stated that, "once chocks and chains are installed, ship is free to maneuver."
- f. But I expect more from my Commanding Officers than simply the ability to stay within the written operating parameters. I expect

Commanding Officers to exercise independent thought and sound judgment. In this case, the risks assumed by proceeding at 30+ knots and turning into quartering seas with a helicopter on deck with rotors engaged, did not correlate to the environment in which the ship was operating. The Commanding Officer failed to factor in the totality of the physical conditions (wind, sea state, course steered, etc.) and the perceived operational necessity to return to station at an ordered flank bell, given the mission at hand. There was time to rectify the situation by simply reducing speed after taking INDIAN 617 aboard; a significant reduction in speed, thereby creating a more stable platform, could have been achieved in seconds.

- There are those who will contend that my conclusion is unreasonable, perhaps even harsh and uncompromising; they might say that it fails to recognize the challenges of Commanding Officers' positions and the factors beyond their immediate control; and that my conclusions will breed timidity instead of aggressiveness in our Commanding Officers. On the contrary, I believe that the missions we are regularly asked to perform -- and must be ready to perform in conditions of extreme adversity while in conflict -- together with the lives of those we are charged to lead, demand a trust in our leadership to employ every means available to make the right decisions. This means factoring in the totality of conditions affecting any given operation, and fully employing one's skills and experience to draw the right conclusions. No single set of operating procedures, instruction manuals, guidelines, or checklists -- while essential contributing tools -- relieves this enduring responsibility. This highest of all standards is demanded in the naval profession all the time.
- h. Equally incumbent on the naval profession is an institutional obligation to provide the necessary foundation to support our Commanding Officers. WPL's Commanding Officer was ill served by us, who did not provide her all necessary information and training for a thorough operational risk management calculus. Specifically, there is no systematic process in the surface warfare community for disseminating a pattern of known hazards and incorporating them into refined operating parameters beyond the most general of notes, warnings, and cautions in NATOPS. Accordingly, and as noted by

Commander, Destroyer Squadron TWO THREE in the SECOND ENDORSEMENT, the event warrants further review of wind, sea state, pitch, roll, ship's speed, and wave height/period parameters governing H-60 aircraft operations aboard DDG-51 Class ships. This analysis should address take-off, landing, and on-deck rotor operations across a broad range of expected operating conditions; and it must be jointly conducted by both the Naval Aviation and Surface Warfare enterprises.

i. In the case of the WPL's helicopter mishap, the Commanding Officer did not do all that should have been done. While she did not exceed published procedures and operating parameters, she failed to accurately evaluate the totality of the combined effects of ship's speed together with winds, sea state, and course. While procedural compliance is essential, the full scope of responsibilities in our profession extends beyond simple compliance and blind obedience -- we require more.

(b)(6)

HARRY B. HARRIS, JR

Copy to:
COMNAVAIRPAC
COMNAVSURFPAC
COMNAVFORCENTCOM
NAVAIR
NAVSEA
NAVSAFECEN
COMCARSTKGRU 11
COMCARAIRWING 11
CDR (b)(3), (b)(6)
CDR (b)(3), (b)(6)



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

5830 Ser N01J/171 25 Feb 14

SIXTH ENDORSEMENT on CDR

(b)(3), (b)(6)

and CDR b 3 (b)(6)

(b)(3), (b)(6), ltr of 17 Jun 13

From:

Commander, Naval Air Force, Pacific

To: File

Subi:

COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22 34 18 E 037 25 29 RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO2 JONATHAN S. GIBSON, USN ON 22 SEP 2013

- 1. After thorough review, I close out this investigation, concurring with the recommendations in previous endorsements for further analysis of environmental impacts on ship handling during Air-Capable ship flight deck operations. The Naval Aviation Community in conjunction with the Surface Warfare Community have already taken the first important step, publishing a change to NAVAIR Publication 00-80T-122 (AIRCRAFT OPERATING PROCEDURES FOR AIR-CAPABLE SHIPS NATOPS MANUAL) that specifically addresses the hazards associated with this mishap.
- This tragic mishap highlights the importance of prudently assessing, in totality, all potential hazards of our operating environment. Naval leadership must inculcate in our Commanding Officers an expectation to apply their experience, training, and knowledge to situations that fall outside, or on the margins of, specific written guidance, identifying and appraising dangers inherent to each specific tactical or operational situation. In this evolution, a series of seemingly minor, innocuous misjudgments had a cumulative catastrophic outcome when graded by the harshness and unforgiving nature of operations at sea. The ship's crew failed to obviate the potential impacts of the environmental conditions, and did not take advantage of opportunities to break the chain of events that ultimately led to a wall of water impacting the helicopter's spinning rotor blades, resulting in unrecoverable ground resonance, violent airframe oscillations, and the death of two shipmates. I concur with the chain of command endorsements that no purposeful negligence or specific violation of published procedures took

place. However, based on the trust and confidence imbued in our selected leaders, I believe there is more that could have, and should have been done by the Commanding Officer of the USS WILLIAM P. LAWRENCE (DDG 110) in properly and thoroughly assessing the totality of risk factors present at the time of the mishap.

- 3. I concur with the opinions and recommendations contained therein, subject to the following comments:
- a. Opinion 7: I do not concur with Opinion 7 as written. Opinion 7 will be modified to read: (b)(5)

(b)(5) (b)(5) (b)(5) (b)(5) (b)(5) (b)(5) (b)(5) (b)(5) (b)(5) (b)(5)

b. Opinion 10: I do not concur with Opinion 10 as written. Opinion 10 will be modified to read: (b)(5)

(b)(5)

b 5 b 5 (b)(5)

c. Opinion 11: I do not concur with Opinion 11 as written. Opinion 11 will be modified to read: (b)(5)

> (b)(5) (b)(5) (b)(5)

b. 5.

d. Opinion 12: I do not concur with Opinion 12 as written. Opinion 12 will be modified to read: 0.5

b 5

(b)(5)

e. Opinion 16: I do not concur with Opinion 16 as written.

Opinion 16 will be modified to read: (b)(5)

(b)(5)

b 5

b, 5,

(b)(5)

(b)(5) (b)(5)

b 5

(b)(5)

(b)(5)

b 5

b 5

(b)(5)

4. I direct the following actions to be taken:

a.

b 5

(b)(5)

(b)(5)

(b)(5)

b 5

b.

(b)(5)

(b)(5)

(b)(5)

(b)(5)

C.

(b)(5)

(b)(5)

b.,5,

(b)(5)

(b)(5)

(b)(5)

(b)(5)

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22 34 18 E 037 25 29 RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO2 JONATHAN S. GIBSON, USN ON 22 SEP 2013
- 5. The findings of fact, opinions, and recommendations of the investigation as modified above are hereby approved. The recommendations contained in this investigation for perfecting our safety procedures must be vigorously implemented and methodically reviewed. Operations at sea are inherently dangerous, and require constant vigilance to identify and break a potential mishap's chain of events before a tragedy takes place. This hallmark of professional seamanship and airmanship shall be a defining characteristic of all Commanding Officers, ensuring that we only accept operational risk when the benefits far outweigh the potential cost, particularly when operating at or near the edges of the envelope.

(b)(6)

D. H. BUSS

COPY to:
COMPACFLT
COMNAVSURFPAC
COMNAVFORCENTCOM
COMCARSTRKGRU 11
COMDESRON 23
COMCARAIRWING 11
CDR (b)(3), (b)(6)
CDR b 3, (b)(6)



DEPARTMENT OF THE NAVY COMMANDER, NAVAL SURFACE FORCE UNITED STATES PACIFIC FLEET 2841 RENDOVA ROAD SAN DIEGO, CALIFORNIA 92155-5490

IN REPLY REFER TO 5830 Ser NOOJ/108 24 Jan 14

FIFTH ENDORSEMENT on CDR b 3, b 6 and CDR (b)(3), (b)(6) (b)(3), (b)(6)ltr of 23 Nov 13

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

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34' 18" E 037° 25' 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013

- 1. Forwarded concurring with the finding of fact, opinions and recommendations of the investigating officers as endorsed by Commander, Carrier Strike Group ELEVEN, Commander Carrier Air Wing ELEVEN and Commander Destroyer Squadron TWO THREE.
- 2. Specifically concurring with and reiterating CVW-11's and CDS-23's recommendations that the Surface and Aviation enterprises seek methods to prevent flight deck sea water intrusions, via both material improvements and revised maneuvering parameters during flight operations.

(b)(6)

T. H. COFEMAN

Copy to:
COMMANDER NAVAL FORCES CENTRAL COMMAND
COMDESRON TWO THREE
COMCARAIRWING ELEVEN
COMSTRKGRU ELEVEN



DEPARTMENT OF THE NAVY COMMANDER, U.S. NAVAL FORCES CENTRAL COMMAND PSC 901, FPO AE 09805-0001

NREPLYTO: 5830 Ser N013/195 23 Dec 13

FOURTH ENDORSEMENT on CDR

(b)(3), (b)(6)

and CDR (b)(3), (b)(6)

(b)(3), (b)(6) ltr of 23 Nov 13

From:

Commander, U.S. Naval Forces Central Command

To:

Commander, Naval Air Force, U.S. Pacific Fleet

Via:

Commander, Naval Surface Force, U.S. Pacific Fleet

Subj:

COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34' 18" E 037° 25' 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN

AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013

1. Forwarded, concurring with the findings of fact, opinions, and recommendations of the investigating officers, as endorsed by Commander, Carrier Strike Group ELEVEN, Commander, Carrier Air Wing ELEVEN, and Commander, Destroyer Squadron TWO THREE.

(b)(6)

J. W. MILLER

Copy to: COMDESRON TWO THREE COMCARAIRWING ELEVEN COMSTRKGRU ELEVEN

DEPARTMENT OF THE NAVY

COMMANDER CARRIER STRIKE GROUP ELEVEN UNIT 25066 FPO AE 96801-4703

5830 Ser N00J/312 20 Dec 13

THIRD ENDORSEMENT on CDR (b)(3), (b)(6) and CDR (b)(3), (b)(6) (b)(3), (b)(6) 1tr of 15 Nov 13

From: Commander, Carrier Strike Group ELEVEN

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

Via: (1) Commander, U.S. FIFTH Fleet

(2) Commander, Naval Surface Force, U.S. Pacific Fleet

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013

- 1. Forwarded, concurring with the findings of fact, opinions, and recommendations of the investigating officer, as endorsed by Commander, Carrier Air Wing ELEVEN and Commander, Destroyer Squadron TWO THREE.
- 2. I specifically find that AWS1 $_{(b)(3),\,(b)(6)}$ USN, sustained his injuries while in the line of duty and not due to his own misconduct. By copy of this letter, Commanding Officer, Helicopter Sea Control Squadron SIX is directed to make appropriate medical record entries.
- 3. I am satisfied that negligence was not a contributing factor by anyone within HSC-6 or USS WILLIAM P LAWRENCE (DDG 110). Therefore, I do not believe any disciplinary action or administrative corrective measures are warranted in this case.
- 4. My point of contact for this case is my Staff Judge Advocate, CDR (b)(3),(b)(6) , JAGC, USN. He may be reached by telephone or email at b,6, or b,3,(b)(6) @ccsgll.navy.mil.

(b)(6)

M. S. WHITE

Copy to: COMDESRON TWO THREE COMCARAIRWING ELEVEN



DEPARTMENT OF THE NAVY COMMANDER, DESTROYER SQUADRON TWO THREE UNIT 25073 FPO AP 96601-4722

IN REPLY REFER TO 5800 Ser N00/250 15 Dec 13

SECOND ENDORSEMENT on CDR

(b)(3), (b)(6)

and CDR

(b)(3), (b)(6)

ltr of 23 Nov 13

Commander, Destroyer Squadron TWO THREE

Commander, Naval Air Force, Pacific

Via:

(1) Commander, Carrier Strike Group ELEVEN

(2) Commander, U.S. FIFTH Fleet

(3) Commander, Naval Surface Force, U.S. Pacific Fleet

(4) Commander, Naval Air Forces, U.S. Pacific Fleet

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34' 18" E 037° 25' 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN

AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 13.

- 1. The subject investigation is respectfully forwarded with concurrence regarding the Investigating Officers' findings of fact, opinions, and recommendations.
- 2. I respectfully recommend Finding of Fact NR 37 be updated to match the contents of Enclosures 4 and 5, which characterize USS WILLIAM P LAWRENCE making "best speed at/for split plant" vice "best speed" prior to flight operations."
- 3. Based upon a detailed review of the contents herein, I believe a thorough and impartial investigation was conducted. I concur with the Line of Duty findings cited, and respectfully submit that no punitive or non-punitive action is required for any of the parties involved.
- 4. Within the subject investigation, the existence of a safe operating climate and compliance with governing directives aboard USS WILLIAM P. LAWRENCE and within Helicopter Sea Combat Squadron SIX was well documented. Consequently, the subject event potentially warrants further review of wind, sea state, pitch, roll, ship's speed, and wave height/period parameters governing MH-60S aircraft operations aboard DDG-51 Class ships. This analysis should address take-off, landing, and on-deck rotor operation across a broad range of expected operating conditions, and be jointly conducted by the Naval Aviation and Surface Warfare Enterprises. Such will ensure timely review, promulgation, and education of any modifications to existing references that may be deemed applicable.

(b)(6)

H. T. WORKMAN



DEPARTMENT OF THE NAVY

COMMANDER CARRIER AIR WING ELEVEN UNIT 25120 FPO AP 96601-4408

> 5830 Ser 00/359 10 Dec 13

FIRST ENDORSEMENT on CDR

(b)(3), (b)(6)

and CDR

(b)(3), (b)(6)

ltr of 23 Nov 13

From:

Commander, Carrier Air Wing 11

To:

Commander, Naval Air Force, Pacific

Via:

(1) Commander, Destroyer Squadron TWO THREE

(2) Commander, Carrier Strike Group 11

(3) Commander, U.S. FIFTH Fleet

(4) Commander, Naval Surface Force, U.S. Pacific Fleet

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34' 18" E 037° 25' 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND

CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 13

- 1. The investigating officers conducted a thorough and impartial investigation regarding the subject mishap. I concur with the facts, opinions, and recommendations contained therein. Specifically, I find that the injury incurred by AWS1 b 3 (b)(6) was incurred in the line of duty and not due to the member's own misconduct. I believe no punitive or non-punitive action is required for any of the parties involved.
- 2. This tragic mishap continues to highlight the dangers of operating helicopters on DDG-51 class ships. Operations were conducted in accordance with regulations, procedures and good headwork, yet catastrophic events still occurred. While embarked aviation operations are inherently dangerous, I believe there is room for improvement. I recommend that the Naval Aviation Enterprise and Surface Warfare Enterprise jointly investigate potential material and non-material solutions to mitigate the risks of sea water intrusion on ship flight decks.
- 3. All original evidence obtained by this investigation will be maintained by the Force Judge Advocate, Naval Air Force, Pacific, (b)(6)

(b)(6)

From: CDR (b)(3), (b)(6) USN

CDR (b)(3), (b)(6) , USN

To: Commander, Carrier Air Wing ELEVEN

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
- Ref: (a) JAGINST 5800.7F, Manual of the Judge Advocate General
 - (b) OPNAVINST 3710.7U, NATOPS General Flight and Operating Instructions
 - (c) NAVAIR 00-80T-122, Helicopter Operating Procedures for Air-Capable Ships NATOPS Manual
 - (d) NAEC-ENG-7576, Shipboard Aviation Facilities Resume
 - (e) A1-H60SA-NFM-000, MH-60S NATOPS Flight Manual
 - (f) DDG110INST 3750.1A, Helicopter Standard Operating Procedures
 - (g) COMNAVSURFORINST 3700.1B, Aviation Readiness Qualification (ARQ), Aviation Facility Certification (AVCERT) and Aviation (Air) Certification of COMNAVSURFOR Ships
 - (h) HSC-6INST3710.3A, HELSEACOMBATRON SIX Standard Operating Procedures
 - (i) NAVAIR 17-1-537, Technical Manual, Aircraft Securing and Handling Procedures
 - (j) CNAFINST 13800.1A, Integrated Launch and Recovery Television Surveillance System
- Encl: (1) Command Investigation Convening Letter dated 24 Sep 2013
 - (2) Written Statements of AWS1 (b)(3), (b)(6) , HSC-6 Flight Crew Chief
 - (3) Written Statement of AWS3 (b)(3),(b)(6) , HSC-6 Flight Crew
 - (4) Written Statement of CDR Jana A. Vavasseur, Commanding Officer, USS WILLIAM P. LAWRENCE (DDG 110).
 - (5) Written Statement of LTJG (b)(3), (b)(6) Officer of the Deck, USS WILLIAM P. LAWRENCE (DDG 110).
 - (6) Written Statement of ENS (b)(3), (b)(6) , Junior Officer of the Deck, USS WILLIAM P. LAWRENCE (DDG 110)

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
 - (7) Written Statement of LTJG (b)(3), (b)(6) , Conning Officer, USS WILLIAM P. LAWRENCE (DDG 110)
 - (8) Written Statement by QMC (SW/AW) (b)(3),(b)(6) III, Quartermaster of the Watch, USS WILLIAM P. LAWRENCE (DDG 110)
 - (9) Written Statement of SN (b)(3),(b)(6) , Helmsman, USS WILLIAM P. LAWRENCE (DDG 110)
 - (10) Written Statement of SN (b)(3), (b)(6) , Helmsman, USS WILLIAM P. LAWRENCE (DDG 110)
 - (11) Written Statement of PSC (b)(3),(b)(6) , Helo Control Officer, USS WILLIAM P. LAWRENCE (DDG 110)
 - (12) Written Statement of BM1 (b)(3),(b)(6) ,
 Flight Deck Officer, USS WILLIAM P. LAWRENCE (DDG 110)
 - (13) Written Statement of BM2 (b)(3),(b)(6) , Landing Signalman Enlisted, USS WILLIAM P. LAWRENCE (DDG 110)
 - (14) Written Statement of SN (b)(3),(b)(6) , Chock and Chainman, USS WILLIAM P. LAWRENCE (DDG 110)
 - (15) Written Statement of LS3 (b)(3),(b)(6) , Chock and Chainman, USS WILLIAM P. LAWRENCE (DDG 110)
 - (16) Written Statement of AT2 (b)(3), (b)(6) , Working Party, HSM-75 Combat Element 3
 - (17) Written Statement of ATAT (b)(3), (b)(6) , Working Party, HSM-75 Combat Element 3
 - (18) Written Statement of AD3 (b)(3), (b)(6) Working Party, HSM-75 Combat Element 3
 - (19) Written Statement of AE3 (b)(3), (b)(6) , Working Party, HSM-75 Combat Element 3
 - (20) Written Statement of AM2 b 3, b 6) , Working Party, HSM-75 Combat Element 3
 - (21) Written Statement of LT (b)(3),(b)(6) , Tactical Action Officer, USS WILLIAM P. LAWRENCE (DDG 110)
 - (22) Summary of interview statements of OS1 b 3,(b)(6) (b)(3),(b)(6), Surface Warfare Coordinator, USS WILLIAM P. LAWRENCE (DDG 110)
 - (23) Written Statement of CDR (b)(3), (b)(6) , Commanding Officer, HSC-6
 - (24) Written Statement of HM3 (b)(3), (b)(6) , USS NIMITZ (CVN 68), Passenger
 - (25) Written Statement of CTI2 b 3.b 6 , Flight Deck Phone Talker, USS WILLIAM P. LAWRENCE (DDG 110)
 - (26) USS NIMITZ (CVN 68) Weather Forecast for 22 Sep 13
 - (27) Summary of interview statements of OS1 b 3. b 6

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34′ 18″ E 037° 25′ 29″ RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
 - (b)(3),(b)(6) Anti-Submarine Tactical Air Controller, USS WILLIAM P. LAWRENCE (DDG 110)
 - (28) Summary of interview statements of LCDR (b)(3), (b)(6) , HSM-75 Combat Element 4 Officer-in-Charge
 - (29) Copy of USS WILLIAM P. LAWRENCE (DDG 110) 22 Sep 13 Ship's Deck Log, OPNAV 3100/99
 - (30) USS WILLIAM P. LAWRENCE (DDG 110) MISHAP Site Survey
 - (31) USS WILLIAM P. LAWRENCE (DDG 110) Underway Watch Bill
 - (32) Aviation Life Support Systems Inspection Records and Maintenance Action Forms for LCDR Jones' and CWO3 Gibson's flight gear
 - (33) Copy of HSC-6INST 3710.3A Risk Assessment Form from 22 Sep 13
 - (34) Copy of DDG-110 Weather Observations for 22SEP13, 3141-3
 - (35) Flight Deck Witness Locations
 - (36) Copy of Designation as Level 3 Anti-Submarine Tactical Air Controller letter for OS2 (b)(3), (b)(6) b 3, b 6
 - (37) Copy of Designation as Officer of the Deck (U/W) letter for LTJG (b)(3), (b)(6)
 - (38) Copy of Designation as Tactical Action Officer (TA) letter for LT b.3. b.6.
 - (39) Aviation HSC-6 Pilot Deck Landing Qualification Currency tracker dated 21 Sep 2013
 - (40) OPNAV 3710/4 Naval Aircraft Flight Records (NAVFLIR) for HSC-6 Det 1
 - (41) Copy of HSC-6 Flight Schedules for 17 -22 Sep 2013 signed by Det Officer in Charge
 - (42) Copy of BUNO 167895 Daily Inspection / Turnaround Inspection Records
 - (43) Copy of AWBS Form F, Tactical Weight and Balance Clearance Form for HSC-6 MH-60S
 - (44) Copy of BUNO 167895 OPNAV 4790/141 Aircraft
 Inspection and Acceptance Record for 22 Sep 2013
 - (45) Copy of Medical Up-Chit ICO CWO3 Jonathan S. Gibson
 - (46) HSC-6 Pilot Designation Letter for CWO3 Jonathan S. Gibson
 - (47) Copy of NATOPS Evaluation Report and Instrument rating ICO CWO3 Jonathan S. Gibson
 - (48) Copy of Medical Up-Chit ICO LCDR Landon L. Jones
 - (49) HSC-6 Pilot Designation Letter for LCDR Landon L. Jones

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
 - (50) Copy of NATOPS Evaluation Report and Instrument rating ICO LCDR Landon L. Jones
 - (51) NASTP Training Qualification letter for LCDR Landon L. Jones
 - (52) NASTP Training Qualification letter for CWO3 Jonathan S. Gibson
 - (53) Copy of Medical Up-Chit ICO AWS1 (b)(3), (b)(6)
 - (54) Copy of NATOPS Evaluation Report ICO AWS1 (b)(3), (b)(6)
 - (55) Copy of Medical Up-Chit ICO AWS3 (b)(3), (b)(6)
 - (56) Copy of NATOPS Evaluation Report ICO AWS3 (b)(3), (b)(6) (b)(3), (b)(6)
 - (57) Written Statement of PR2 (b)(3), (b)(6) , HSC-6 Det 1
 - (58) USS WILLIAM P. LAWRENCE Personnel Qualification Standards sheets
 - (59) USS WILLIAM P. LAWRENCE Aviation Facility Certification msg 221819Z APR 12
 - (60) USS WILLIAM P. LAWRENCE Ship's Inertial Navigation System Data
 - (61) Investigators' Opinion of Sequence of Events
 - (62) Weather Data from NIMITZ Strike Group Oceanography Team (SGOT) for 22 Sep 2013
 - (63) Flight Log Book entries for LCDR Landon L. Jones and CWO3 Jonathan S. Gibson
 - (64) Flight Deck Chain Inventory & Maintenance Records
 - (65) Personal Observations of the crash site from the JAGMAN Investigating Officers
 - (66) Transcription of USS WILLIAM P. LAWRENCE LAND/LAUNCH Frequency
 - (67) Line of Duty investigation ICO, LCDR Landon L. Jones, DTD 10 October 2013
 - (68) Line of Duty investigation ICO CWO3 Jonathan S. Gibson, DTD 10 October 2013
 - (69) Copy of BUNO 167895 NALCOMIS OMA Scheduled
 Inspections Report and Aircraft/Equipment Workload
 Report
 - (70) Written Statement of CDR (b)(3), (b)(6) , Combat Direction Center Officer, USS NIMITZ (CVN 68)
 - (71) Command Investigation Extension Letter dated 24 Oct 2013

Preliminary Statement

- 1. Pursuant to enclosure (1) and in accordance with reference (a), a command investigation was conducted to inquire into the circumstances surrounding a Class Alpha Mishap involving the loss of an MH-60S aircraft Bureau Number (BUNO) 167895 in the Red Sea on 22 September 2013.
- 2. In accordance with Title 10 USC 2255 and section 0241c(2) of reference (a), one of the Investigating Officers, CDR (b)(3), (b)(6), is a graduate of the Naval Aviation Safety Course and is qualified to conduct the inquiry into the facts surrounding the mishap.
- 3. Per reference (a), an extension for submission of this report was requested and granted by the Convening Authority to expire on 23 November 2013, enclosure (71). Extensions were necessary to ensure receipt and analysis of critical enclosures.
- 4. CDR $_{(b)(3),\,(b)(6)}$, JAGC, USN, Staff Judge Advocate, Carrier Strike Group ELEVEN assisted the Investigating Officers with legal advice during the course of this investigation.
- 5. Line of Duty investigations were performed previously for LCDR Landon L. Jones and CWO3 Jonathan S. Gibson (enclosures 67 and 68). A Line of Duty determination for AWS1 (b)(3), (b)(6) is included in this report.
- 6. All reasonably available and relevant evidence was collected. There were no difficulties encountered during the conduct of this investigation. In cases where several documents show the same qualification, only one document is enclosed. However all documents were reviewed and verified as consistent.
- 7. The Aviation Mishap Board will maintain all original evidence.

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34′ 18" E 037° 25′ 29" RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
- 8. There were several eye witnesses to this mishap. Enclosure 35 is a graphical depiction of where each individual at the scene was standing.
- 9. The Investigating Officers have met each of the Convening Authority's directives. They have investigated the cause of the accident and provided opinions as to any fault, neglect or responsibility. Investigating Officers have also provided recommendations to mitigate the possibility of this type of mishap happening in the future.

Findings of Fact

- 1. MH-60S Aircraft BUNO 167895, INDIAN 617 (IN 617) and USS WILLIAM P. LAWRENCE (DDG 110) (WPL) were involved in a Class A Flight Mishap on 22 September 2013. [Enclosures 29, 41, 70 and 65]
- 2. LCDR Landon L. Jones, USN and CWO3 Jonathan S. Gibson, USN were onboard BUNO 167895 when the mishap occurred. All crewmembers were active duty US Navy Personnel assigned to HSC-6 deployed with NIMITZ Carrier Strike Group and embarked on USNS RAINIER (AOE 7) during the mishap. [Enclosure 41]
- 3. The mishap occurred on the flight deck of WPL on 22 September 2013. [Enclosures 29, 41 and 65]
- 4. The mishap resulted in complete destruction of the Aircraft and substantial damage to the WPL flight deck. [Enclosures 30 and 65]
- 5. Both pilots perished in the mishap. [Enclosures 23]
- 6. AWS1 (b)(3),(b)(6) , USN, assigned to HSC-6 deployed with NIMITZ Carrier Strike Group and embarked on USNS RAINIER (AOE 7) was injured during the mishap. [Enclosure 2]
- 7. According to Naval Aviation Logistics Command Management Information System (NALCOMIS) Organizational Maintenance

Activity (OMA) and the aircraft discrepancy log book (ADB) summary report, BUNO 167895/INDIAN 617 (IN 617) was in compliance with all periodic maintenance inspections and applicable technical directives. The aircraft had 1012.2 total flight hours. 143.6 flight hours had occurred since the last intermediate phase inspection. The aircraft's 364 Day Special inspection was completed on 29 August 2013. [Enclosure 69]

- 8. Daily and Turnaround inspections were conducted on BUNO 167895 on 21 September 2013. No discrepancies were noted. [Enclosure 42]
- 9. According to NALCOMIS OMA, the ADB summary report, and the OPNAV 4790/141 Aircraft Inspection and Acceptance Record, BUNO 167895 was fully mission capable for mission assigned. [Enclosures 44 and 69]
- 10. BUNO 167895 was within all weight and balance limitations. [Enclosure 43]
- 11. The mishap flight was properly scheduled per applicable directives (references (b) and (h)). The flight was authorized by HSC-6 Detachment 1 Officer-in-Charge LCDR L. L. Jones. [Enclosure 39 and 41]
- 12. LCDR Landon L. Jones's last flight was 16 Sep 2013. [Enclosures 40 and 63]
- 13. CWO3 Jonathan S. Gibson's last flight was 20 Sep 2013. [Enclosures 40 and 63]
- 14. LCDR Jones and CWO3 Gibson were current for day landings on air capable ships in accordance with reference (e). [Enclosure 39]
- 15. LCDR Landon L. Jones was the HSC-6 Det 1 Officer-In-Charge. He was a Helicopter Aircraft Commander (HAC) and was Assistant NATOPS Instructor qualified. He had 3800.9 total flight hours with 1961.2 flight hours in H-60 model aircraft. [Enclosures 49 and 63]

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- 16. CWO3 Jonathan S. Gibson was HSC-6 Det 1 Training Officer. He was a Helicopter Second Pilot (H2P). He had 436.9 total flight hours with 225.6 flight hours in H-60 model aircraft. [Enclosures 46 and 63]
- 17. IN 617 Flight Crew clearances, qualifications, and designations were current and appropriate for the assigned mission including Naval Air Training and Operating Procedures Standardization (NATOPS), Instrument, Egress Training, Naval Aviation Survival Training, Aircrew Coordination Training and a current Medical up-chit. [Enclosures 45-56]
- 18. LCDR Jones' and CWO3 Gibson's Aviation Life Support Systems were in compliance with all periodic maintenance inspections. No flight gear for LCDR Jones or CWO3 Gibson was found onboard USNS RAINER (AOE 7). [Enclosure 57 and 32]
- 19. The crew of IN 617 completed a pre-mission Crew Risk Assessment Form IAW reference (h) and discussed ORM issues and mitigation techniques during the brief conducted prior to the flight. The Crew Chief, AWS1 (b)(3),(b)(6), received approximately 5-6 hours of sleep the night prior to the mishap and was experiencing some personal stress due to family issues. The only noted stress factor was the fast pace of scheduled events for the mission. [Enclosure 2 and 33]
- 20. The Officer of the Deck (OOD), Tactical Action Officer (TAO) and Anti-Submarine Tactical Air Controller (ASTAC) aboard WPL were designated and qualified per applicable directives. [Enclosures 31 and 36-38]
- 21. The Helicopter Control Officer (HCO), Flight Deck Officer (FDO), Landing Signalman Enlisted (LSE), Helmsmen, and starboard Chock and Chainman aboard WPL were qualified per applicable Personnel Qualification Standards (PQS). [Enclosure 58]
- 22. The port Chock and Chainman was not qualified in 43219-DCH1 (Helicopter Operations for Air Capable Ships) 302 Flight Deck Crewman in his PQS. This qualification is not required per reference (c). [Enclosure 58]

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- 23. The LSE and port Chock and Chainman were not listed on the watchbill. [Enclosure 31]
- 24. WPL had a current Aviation Facility Certification for H-60S aircraft in accordance with reference (g). [Enclosure 59]
- 25. IN 617 took off from USNS RAINIER at approximately 1045C and stopped at USS NIMITZ (CVN 68) en route to WPL. [Enclosure 41]
- 26. Weather forecast by the NIMITZ Strike Group Oceanography Team (SGOT) for 1200-1600L called for wind from the northwest at 25-30 knots gusting to 35 knots; swell of 3-5 ft from the northwest with a period of 4-6 seconds; combined seas of 5-7 ft; sea state of 4. [Enclosure 26]
- 27. Observed weather for the mishap area was reported by the NIMITZ SGOT as 30.6 degrees Celsius; sea surface temperature 30.6 degrees Celsius; sea height 2-3 ft with a period of 2-3 seconds; swell of 2-4 ft from 330T with a period of 4-6 seconds; altimeter setting of 29.77; surface winds 320 degrees true at 28 knots; sky clear; visibility 6 nautical miles with haze; no thunderstorms; no turbulence, icing or precipitation. (At 1256C USS NIMITZ was 9nm from WPL). [Enclosures 62]
- 28. The WPL Surface Weather Observations log recorded seas of 3 feet or less for the entire day and swell of 4 to 5 feet throughout the day, with swell from 250 to 320 degrees true for a calculated combined sea height of 5.0 to 5.8 feet. [Enclosure 34]
- 29. The ship OOD stated seas during that time were 5-7 feet with a 4-5 second period. [Enclosure 5]
- 30. According to the National Weather Service, and consistent with consultations with the CCSG-11 METOC Officer, significant wave height is the average of the highest one-third (33%) of waves (measured from trough to crest) that occur in a given period and, as a general rule, the largest individual wave one may encounter is approximately twice as high as the Significant Wave Height (or Seas). For a significant wave height of six

feet, approximately one in every one hundred waves will be greater than 10 feet; and one in every 1000 waves will be greater than 12 feet.

- 31. True winds (TW) as observed by the OOD and Conning Officer were 320 to 325 degrees true at 25-35 knots. [Enclosures 5 and 71
- 32. Reference (c) defines "Green Deck" as winds and ship movement within specified limits for a particular type of aircraft and ship. Green Deck is required for launching and recovering aircraft. "Red Deck" is defined as the condition when an aircraft is secured to the flight deck with rotors turning or stopped.
- 33. Per reference (c), allowable pitch is 2° and allowable roll is 8° degrees for Green Deck. There is no ship motion or maneuvering limitations for Red Deck.
- 34. Winds were in the envelope for Green Deck per reference (c). [Enclosures 4 and 6]
- 35. The OOD, JOOD and CONN ship pitch was indicated at 1 degree and ship roll was indicated at 3 to 6 degrees. [Enclosures 5, 6 and 71
- 36. Ship's Inertial Navigation System data for WPL indicted ship pitch varied from $+0.6^{\circ}$ to -0.9° degrees and ship roll varied from $+4.2^{\circ}$ to -6.3° degrees between 1230C and 1240C. Positive values are defined as bow up for pitch and starboard roll. [Enclosure 60]
- 37. Prior to flight operations, WPL completed an Underway Replenishment and had been ordered to make "best speed" to take station on USS NIMITZ (CVN 68), which was 30 nm to the south, in order to relieve USS STOCKDALE (DDG 106) (STK) so that STK could conduct Underway Replenishment. [Enclosures 4 and 5]
- 38. The following sequence of events occurred during IN 617 flight operations with WPL:

1130C: IN 617 checks in with WPL [Enclosure 66]

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 - 1225C: HCO passes environmental information to IN 617 in preparation for landing. The information passed was true winds at 335° at 22 knots, relative winds 80° to port at 10 knots, ship's pitch 1°, ship's roll 5° [Enclosure 66]
 - 1226C: IN 617 acknowledges information and requests Green Deck for landing [Enclosure 66]
 - 1226C: Foxtrot Corpen (ship's true course and speed during flight operations) was 130° at 27 knots when Green Deck given [Enclosure 29]
 - 1228C: WPL waved off IN 617 due to winds fluctuating out of limits [Enclosures 4, 5, 11, 22 and 66]
 - 1235C: CONN ordered: All Ahead Flank, indicate 160rpm (30-31 kts) [Enclosures 4, 5 and 29]
 - 1236C: HCO passes environmental information to IN 617 in preparation for landing. The information passed was true winds at 330° at 30 knots, relative winds 60° to port at 10 knots, Foxtrot Corpen of 130° true at 31 knots, ship's pitch 1°, ship's roll 3° [Enclosure 66]
 - 1237C: IN 617 acknowledges information [Enclosure 66]
 - 1237C: HCO passes Green Deck to IN 617 [Enclosure 66]
 - 1237C: IN 617 landed [Enclosures 4, 5 and 11]
 - 1239C: IN 617 chocked & chained on the Flight Deck (FD) and Red Deck set [Enclosures 4, 5, 6, 11 and 66]
 - 1239C: CONN ordered: Right 3 Degrees Rudder, Steady on course 190° [Enclosure 29]
 - 1243C: CONN ordered: Right 2 Degrees Rudder, Steady on course 195° [Enclosure 29]
 - 1245C: Crash on Deck reported [Enclosure 29]
 - 1245C: CONN ordered all stop (not recorded in the deck log) [Enclosures 4 and 7-9]
 - 1247C: Report of IN 617 going overboard on the port side [Enclosures 4 and 6]
 - 1247C: CONN ordered Left 30 Degrees Rudder, All Engines Ahead Full for 20 knots [Enclosure 29]
 - 1247C: Ship began SAR efforts [Enclosure 4]
- 39. The CO and OOD stated that increasing speed to 160 rpm (30-31 knots) on course 130° resulted in winds stable and in the envelope for Green Deck. [Enclosures 4 and 5]
- 40. The CO entered the bridge at 1228C. The CO personally monitored the winds during IN 617's second approach and

monitored the Helmsman's inputs during ship maneuvering after IN 617 landed. [Enclosures 4 and 29]

- 41. The bridge team made a conscious effort to limit the rudder used based on ship's speed to minimize heel of the ship.
 [Enclosures 4 and 5]
- 42. According to multiple witnesses, IN 617 recovered safely at approximately 1239C and was secured to the FD with chocks and chains by the FD crew. [Enclosures 11-15]
- 43. IN 617 crewmen verified the chains were installed properly after landing. [Enclosures 2 and 3]
- 44. After IN 617 was chocked & chained, the CO and OOD stated they maneuvered WPL to 190° true to get to their station on NIM, then maneuvered to 195° true based on a refined maneuvering board solution. [Enclosures 4, 5 and 6]
- 45. WPL's speed was above 30 knots from 1235C until 1245C. [Enclosure 60]
- 46. During the maneuvers from 130° true to 195° true, relative winds remained in the envelope for Green Deck. [Enclosures 4, 5 and 7]
- 47. During the turn from 130° to 190°, all ship rolls were less than 6.5°. Immediately upon arriving at course 190°, the ship encountered a roll of 12° to starboard at 1242C. Subsequent rolls were smaller in amplitude and the ship retuned to equilibrium within one minute. [Enclosure 60]
- 48. As the ship turned from 190° to 195° at 1243C, the ship's rolling oscillations increased in frequency and magnitude. The rolls are more pronounced to starboard. [Enclosure 60]
- 49. At 1244:34C, the ship rolls 13.1° to port and then 16.6° to starboard. These are the largest rolls recorded by the ship's inertial navigation system since 1230C. [Enclosure 60]
- 50. The OOD and CONN observed a roll to port prior to the mishap of 12 to 13.5 degrees. [Enclosures 5 and 7]

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- 51. Multiple witnesses observed the ship take a large roll to port followed by a large roll to starboard. [Enclosures 2, 5, 10 and 12]
- 52. During the roll to port, the Flight Deck Officer noticed the chains attached to IN 617 tightened but held. [Enclosure 12]
- 53. Multiple witnesses observed a thick "wall" of water came from the starboard side which enveloped IN 617. [Enclosures 2, 3, 8, 11-16, 19-22, 24 and 27]
- 54. Multiple other witnesses described the water more as a solid jet of water that shot up vertically and then back down vice a wave that moved across the flight deck.
- 55. The flight deck phone talker saw a wave from astern hit the aft rotors immediately before the large wave. [Enclosure 25]
- 56. Multiple witnesses observed the IN 617 fuselage began to shake violently. [Enclosures 3, 6, 11, 12, 14, 15, 19 and 27]
- 57. Multiple witnesses observed the rotor blades impact the flight deck. [Enclosures 3, 5, 11, 12, 21 and 27]
- 58. Multiple witnesses observed IN 617 rotate clockwise and move starboard and forward on the flight deck after water impact. [Enclosures 3, 4, 11, 12, 15, 17-19 and 25]
- 59. Multiple flight deck witnesses ran into the starboard hangar as IN 617 moved towards the starboard side of the ship.
- 60. Several witnesses who sought shelter in the starboard hangar heard what sounded like rotors hitting the hangar door but did not hear engine noise.
- 61. Multiple witnesses observed the helicopter tail was to be either at an unnatural angle or broken off. [Enclosures 2, 4, 8, 9, 15, 21 and 25]
- 62. Immediately following the start of the mishap, there was a large roll to port. [Enclosures 4, 8, 15 and 17]

- Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING A CLASS ALPHA MISHAP INVOLVING HSC-6 MH-60S AIRCRAFT, BUNO 167895, WHICH OCCURRED AT N 22° 34′ 18″ E 037° 25′ 29″ RESULTING IN THE DEATHS OF LCDR LANDON L. JONES, USN AND CWO3 JONATHAN S. GIBSON, USN ON 22 SEP 2013
- 63. After the large roll, IN 617 then moved across the flight deck and went overboard to port. [Enclosures 2, 8, 15, 17, 21 and 27]
- 64. Multiple witnesses saw both pilots in the aircraft as it moved about the flight deck. [Enclosures 2, 3, 13, 22 and 27]
- 65. IN 617 went overboard from WPL at N22° 34′ 18″ E037° 25′ 29″. WPL was heading approximately 195° true at time of impact. Wreckage was distributed to the south of the impact down the line of set and drift at 160° true at 1.63 knots to a maximum of N22° 29.47′ E037° 22.49′. [Enclosures 29, 60 and 62]
- 66. Post-mishap photographs show indications of rotor impact with the flight deck as well as signs of damage 20 feet above the flight deck. The aircraft tail rotor was found on the aft starboard side of the flight deck. The empennage section of the aircraft was found on the forward port side of the flight deck. The empennage showed signs of breaking off the aircraft cabin by twisting to the right. The right main landing gear broke off the aircraft at the pivot point. Both pilot doors were found on the flight deck with door handles in the locked position and both emergency release handles shear wired in the closed position. [Enclosure 65]
- 67. Reference (c), on page 9-1, states: "Combined wave and swell effect can result in seawater over the flight deck of FFG 7, DDG 51, and DDG 79 class ships, resulting in helicopter damage. Additionally, the wave action created by the Venturi effect between UNREP ships can cause rotor system damage."
- 68. Reference (c), on page 7-4, states: "Special care should be exercised when maneuvering while helicopters are spinning on deck. In high sea states, only maneuvering to maintain a safe navigation course is recommended."
- 69. Reference (c), Figure 2-13, states: "Once chocks and chains are installed, ship is free to maneuver".
- 70. The chains used to secure IN 617 to the deck were unable to be identified as flight deck crew do not record which chains are

to be used before flight ops. An inventory after the incident identified two chains missing as 98313009192 and 98313009198. The chain maintenance was current in accordance with reference (i). [Enclosure 64]

- 71. The flight deck camera images were not recorded during the incident. Reference (j) requires all aircraft launch and recovery operations be televised and recorded on aircraft carriers. There is no requirement to record television operations on air capable ships.
- 72. Reference (e) states the emergency procedure for "Unusual Vibrations On Deck" are to 1) lower the collective, 2) Secure the Power Control Levers (PCLs) and 3) Apply the rotor brake. Securing the PCLs shuts down the engines.
- 73. Reference (d) states, the average height of the flight deck above the water for this class of ship is 14'10".
- 74. Reference (f) states, "Consideration must be taken prior to maneuvering the ship when the nets are down. Course and speed changes should be made as to cause minimal roll of the ship to prevent damaging the nets or injuring personnel working with the nets."
- 75. According to the HSM-75 Combat Element (CEL) 4 Officer-in-Charge, there was a strong safety culture onboard WPL. HSM-75 CEL 4 flew the morning of the incident and attempted to fly the previous night in similar conditions. The previous night's flight was not cancelled for sea state or ship motion. The conditions on 22 Sep 2013 were the roughest seas WPL had conducted flight operations in since Jan 2013 during transit across the Pacific Ocean. During that transit in Jan 2013, WPL operated helicopters with rolls up to 12°. [Enclosures 28]
- 76. Search and rescue (SAR) procedures were initiated immediately by WPL. Approximately six minutes after IN 617 went in the water, INDIAN 615, a MH-60S from HSC-6, checked in with WPL to assist in the SAR effort. For the next 26 hours, a coordinated search plan was executed by 3 destroyers, one

replenishment ship, 7 rigid hull inflatable boats (RHIBs), one P-3 aircraft, one HC-130 aircraft and multiple helicopters. Over 100 square nautical miles were searched with a 99.99% probability of success. Several pieces of debris from IN 617 were found. [Enclosure 4-10, 23, 29, 66 and 70]

- 77. A Line of Duty determination concerning LCDR Landon L. Jones was completed on 14 October 2013. LCDR Landon L. Jones died while in the line of duty and not due to his misconduct. [Enclosure 67]
- 78. A Line of Duty determination concerning CWO3 Jonathan S. Gibson was completed on 14 October 2013. CWO3 Jonathan S. Gibson died while in the line of duty and not due to his misconduct. [Enclosure 68]

OPINIONS

- 1. The injuries incurred by AWS1 $_{(b)(3),(b)(6)}$ during the IN 617 mishap were incurred in the line of duty and not due to his own misconduct. [Findings of Fact 1-3, 6]
- 2. IN 617's flight crew was fully qualified, per all known and current instructions, to perform the duties they were assigned on the HSC-6 flight schedule on 22 Sep 2013. [Findings of Fact 11, 14-17]
- 3. WPL's crew was fully qualified, per all known and current instructions, to perform the duties they were assigned on 22 Sep 2013. [Findings of Fact 20, 21 and 24]
- 4. The LSE and Port Chock and Chainman were not assigned to their positions on the current WPL watchbill, but this was not a contributing factor to the mishap. [Findings of Fact 23, 42 and 43]
- 5. The mishap aircrew was in compliance with all crew rest and currency requirements. While some stress factors were identified for the aircrew, human error is not suspected as a

casual factor for this mishap. It is highly unlikely that fatigue, use of medication or alcohol use were involved. [Findings of Fact 11-14, 19 and 25]

6. Aircraft BUNO 167895 and aircrew flight gear had no material failure that contributed to the mishap. It is most likely that both pilots were wearing all appropriate flight gear. [Findings of Fact 8, 9 and 18]

7 **.** (b)(5)

(b)(5)

- 8. While IN 617 was chocked and chained on the deck of WPL, the ship took a large roll to port followed by a larger correcting roll to starboard. This resulted in a wave of unknown size impacting the starboard aft portion of WPL's hull, which in turn resulted in a large amount of water impacting the rotor blades, pushing them down and possibly impacting the fuselage. caused the tail to break off and the helicopter to shake violently. The violent shaking, in turn, resulted in the helicopter breaking free of the chocks and chains, and also caused the left and right pilot doors to detach from the fuselage. The helicopter then moved forward and starboard while the rotor blades and other parts of the helicopter impacted surrounding structures. WPL took another strong roll to port, which resulted in the helicopter continuing the clockwise rotation while the rotor blades came apart and the empennage section rotated into the forward port corner of the flight deck. At this time, the empennage section broke off the fuselage and remained on WPL while the fuselage slid overboard off the port side of the flight deck. Enclosure 61 provides a graphical recreation of the JAGMAN Investigating Officers' opinion on the sequence of mishap events. [Findings of Fact 1-4, 25, 53, 55-58, and 61-66]
- 9. LCDR Jones and CWO3 Gibson, the only aircrew onboard IN 617 at the time of the mishap, were both likely incapacitated by the violent aircraft motion and unable to execute emergency egress. Based on witness accounts of sounds they heard, it is possible

the aircrew executed the proper emergency procedure for unusual ground vibrations. With both pilot's doors removed, emergency egress after water entry would have been simplified. Most likely, both pilots were either unconscious or injured inside IN 617's cockpit when the aircraft went over the side of WPL's flight deck, thus preventing their egress from the cockpit. [Findings of Fact 5, 56, 64, 66 and 72]

10. (b)(5)(b)(5)b 5 (b)(5)(b)(5)(b)(5)(b)(5)11. (b)(5)(b)(5)(b)(5)(b)(5)b 5 (b)(5)(b)(5)(b)(5)(b)(5)(b)(5)12. (b)(5)(b)(5)(b)(5)b 5 (b)(5)

13. Chocks and chains were installed properly, per all known and current instructions. IN 617 crew members verified the chock and chain installation. The Flight Deck Officer observed the chains holding the aircraft during the 13° roll to port. When securing helicopters to the flight deck, properly installed chains have some slack. Most likely, the violent motion of the

aircraft after water impact shook the aircraft free from the chocks and chains. [Findings of Fact 43, 52, 56 and 70]

- Ship motion as a reaction to wave motion is a factor of wave height, wave period, ship speed, ship course relative to wave direction and hull length. Based on ship inertial data and witness accounts, WPL entered conditions favorable for large rolls once on course 190° true. On this heading, one large roll occurred but damped out relatively quickly. By adjusting course to 195° true, WPL entered conditions which resulted in large, undamped rolls. The rolls alone were not enough to cause the mishap. The period of the waves and rolls were such that the ship rolled to starboard coincident with another wave. impact with the hull, the water from the wave was squeezed against the hull and redirected upward, creating a thick "wall" of water which the prevailing winds pushed over the flight deck, enveloping IN 617. The sudden impact of a considerable volume of water on IN 617's main and tail rotors caused a large imbalance in rotor stability. Most likely the unbalanced rotors began disintegrating causing significant vibrations to IN 617. This resulted in IN 617 coming unchained as well as loss of tail rotor effectiveness. Without a tail rotor to counter main rotor torque as well as no longer being secured to the flight deck, the aircraft spun freely on the flight deck. An additional roll to port resulted in IN 617 going over the side. [Findings of Fact 27-31, 47-50, 53 and 54]
- 15. The mishap was not caused by an unusually large, or "rogue", wave. A "rogue" wave is an open ocean phenomenon, caused by wave addition over hundreds of miles. The likelihood of a rogue wave forming in the Red Sea is extremely remote. Several surface units were all in the same area of operation during the incident and none, including WPL, reported any indications of a rogue wave. The largest single wave potentially encountered based on observed significant wave heights could have been 12 feet. There are no regulations on maximum wave heights or sea states for flight operations. Furthermore, the forecast conditions were accurate. [Findings of Fact 26, 27, 28, 68 and 69]

16. (b)(5)(b)(5)(b)(5)b 5 (b)(5)(b)(5)(b)(5)b 5 b 5 (b)(5)(b)(5)(b)(5)(b)(5)b 5 (b)(5)b 5 b 5 (b)(5)(b)(5)(b)(5)(b)(5)

(b)(5)

- 17. Search and Rescue operations and procedures were appropriately executed. Given the high calculated probability of success and the extremely quick response by search aircraft and ships, it is most likely that LCDR Jones and CWO3 Gibson did not survive initial water entry. [Findings of Fact 76]
- 18. LCDR Landon L. Jones and CWO3 Jonathan S. Gibson perished while in the line of duty and not due to their own misconduct. Furthermore, no supervisory negligence or malpractice was causal to this mishap. [Findings of Fact 77 and 78]

Recommendations

- While it would not have affected the outcome of this mishap, the flight deck camera must include recording capability and the requirement to record all flight operations. This would significantly improve safety and mishap prevention.
- 2. The JAGMAN Investigating Officers believe this incident was caused by water coming up the side of the flight deck and impacting the turning rotor blades of the helicopter.
 Investigation should be conducted into material modifications to DDG class ships or changes to standard operating procedures in order to mitigate risks of water impacting helicopters on deck.
 Potential solutions could include modification of flight deck nets to provide a solid barrier to deflect water, disengaging rotors, or maneuvering restrictions.

(b)(6) (b)(6) (b)(3), (b)(6) (b)(3), (b)(6)