

Statement of ADM Tom Fargo, U.S. Pacific Fleet Commander

Good afternoon. I have a rather lengthy statement here that has been provided to you, and then I'll be happy to take some of your questions.

On 13 April, Vice Admiral Nathman and the Court of Inquiry forwarded to me the Court of Inquiry's report of the investigation into the circumstances surrounding the collision between the USS GREENEVILLE (SSN 772) and the Japanese M/V EHIME MARU.

As you know, the Court was directed to look into all aspects of the collision, including:

- the cause of the collision and the responsibility for it,
- the impact of the civilians on board and the embarkation program.
- the propriety of GREENEVILLE's assigned operating area,
- and the role of CAPT Robert Brandhuber, a senior officer embarked that day.

In addition, I intend to address:

- the accountability of the Commanding Officer, CDR Waddle and other members of his crew,
- the Search and Rescue,
- and throughout, our actions to preclude incidents like this in the future.

The Court of Inquiry was unanimous in its findings and conclusions. This is a comprehensive report that we have released in total to the public today. It includes...

- A summary of the collision itself, a complete graphic reconstruction and a timeline of events.
- The 119 page report of the Court of Inquiry and the memorandum which details my conclusions and actions after reviewing the report. The more than 2000 pages of supporting documentation and testimony will be available on our web site.
- Additionally, I have provided this statement to you today as well.

In addition to the Court of Inquiry's report, I also reviewed the unsworn statements given to the National Transportation Safety Board by the civilian guests who were embarked in GREENEVILLE on 9-10 February. The Court did not feel it necessary to subpoena them to testify given the evidence produced during the Court, but I felt their observations were worthy of review. After reviewing their statements, there is nothing that sheds new light or context on the evidence produced by the Court that would change my conclusions.

COLLISION

Let me start with the collision. There were two fundamental causes for this collision:

1. First was the inadequate acoustic and visual search conducted by USS GREENEVILLE in preparation for surfacing on 9 February. In short, GREENEVILLE completed only an abbreviated sonar and periscope search that did not conform to standard operating procedures or the Commanding Officer's own Standing Orders.
2. Second was the failure of the ship's watch team to work together and pass information to each other about the surface contact picture. The team utilized an unqualified sonar watchstander, failed to compensate for the loss of a video display (AVSDU), failed to identify important information that would have made it clear the EHIME MARU was close and did not adequately update the contact picture to provide sufficient backup to the Commanding Officer.

As you read this report, the reason for these two causes is quite clear. The Commanding Officer, USS GREENEVILLE created an artificial sense of urgency in preparation for surfacing on 9 February when prudent seamanship, the safety of his submarine and good judgment dictated otherwise. In doing so, he marginalized key contact management and Control Room personnel, cut corners on prescribed operational procedures, and inhibited the proper development of the contact picture.

GREENEVILLE was aware of three surface sonar contacts as she prepared to surface on 9 February. Managing these three contacts was well within the capability of any ship. And ultimately, an adequate periscope search of the proper duration, at a higher elevation and with due consideration for the white, hazy background would have precluded this accident.

The collision summary I have provided you shows this all in great detail.

Let me be clear. There was no fault or neglect on the part of the EHIME MARU's captain or crew. There was no equipment or system failure onboard the EHIME MARU that contributed to the collision.

This collision was solely the fault of USS GREENEVILLE. This tragic accident could and should have been avoided by simply following existing Navy standards and procedures in bringing submarines to the surface.

ACCOUNTABILITY

The responsibility of the Commanding Officer for his ship in this regard is clearly stated in U-S Navy Regulations. It is absolute. And it starts with the safe navigation of the ship. Today, I found CDR Scott Waddle, the former Commanding Officer of USS GREENEVILLE, guilty of committing two violations of the Uniform Code of Military Justice at Admiral's Mast. These were Article 92 - Dereliction in the Performance of his Duties and Article 110 - Negligent Hazarding of a Vessel. As punishment, I issued a Punitive Letter of Reprimand and directed him to forfeit one-half his pay for 2 months and also directed that

action be taken to detach CDR Waddle “for cause” from his previous duties as Commanding Officer, USS GREENEVILLE. I suspended the forfeiture. These actions will effectively terminate his career.

I determined Admiral’s Mast to be the appropriate forum for determining his accountability because the Court of Inquiry’s report indicated CDR Waddle’s actions on 9 February represented a serious departure from the high standards expected of officers in command. At the same time, the Court’s report did not produce any evidence of criminal intent or deliberate misconduct on CDR Waddle’s part. I think this is an important point. Additionally, CDR Waddle upheld the principle and tradition of accountability and took full responsibility for his actions. Prior to this accident, CDR Waddle’s career and record for superior performance in the service of this nation were excellent.

Additionally, I did not refer CDR Waddle’s case to a General Court Martial because the facts related to the cause of the collision are well understood as a result of the Court of Inquiry and its comprehensive report. CDR Waddle is responsible for this accident under Navy Regulations and he has publicly accepted that responsibility. He has been held formally accountable by both this process and my actions at Admiral’s Mast.

With respect to accountability for other GREENEVILLE personnel, the Court of Inquiry recommended that accountability for the Officer of the Deck, LTJG Michael Coen be dealt with by the Commanding Officer of USS GREENEVILLE. Instead, I elected to convene Admiral’s Mast for him because his responsibilities are just as clear under Navy regulations. At that hearing, I counseled him to ensure he fully understood his obligation with regard to the safe navigation of the ship and the proper supervision of personnel on watch in the Control Room, despite the presence of the Commanding Officer.

The Court recommended Fire Control Technician First Class (SS) Patrick Seacrest be taken to Captain’s Mast by the Commanding Officer, USS GREENEVILLE to answer for his actions for failing to report a closing sonar contact (the EHIME MARU) in accordance with the CO’s Standing Orders. I noted this recommendation and have forwarded it to Commander, Submarine Force Pacific for action as he deems appropriate.

The Court of Inquiry also recommended the following GREENEVILLE personnel be admonished for their performance on 9 February:

- the Executive Officer, LCDR Gerald Pfeifer, for lack of administrative oversight and execution of the enlisted watchbill
- the Chief of the Boat, MMCM(SS) Douglas Coffman for lack of administrative oversight and execution of the enlisted watchbill,
- the Sonar Supervisor, STS1(SS) Edward McGiboney for permitting an unqualified Sonar Operator on watch.

I noted these recommendations as well and have forwarded them to Commander, Submarine Force Pacific for action as he deems appropriate..

The Court determined and I concurred that CAPT Brandhuber had no official authority over the GREENEVILLE's Commanding Officer or the situational awareness with the contact picture to actually intervene, assume command of the ship and prevent this accident.

At the same time, I do feel that an officer of CAPT Brandhuber's experience and position - even as an embarked passenger, should have played a more forceful role on board GREENEVILLE. He provided little assistance as an escort when it was in fact his purpose to do so and he should have questioned the CO when he believed the submarine was preparing to surface too quickly. Additionally, he failed to ensure the integrity of the COMSUBPAC chain of command in the absence of the Commander as he prepared to go to sea that day.

The Court recommended that Captain Brandhuber be admonished for failing to professionally carry out his duties on 9 February and I have noted and forwarded that recommendation to SUBPAC as well.

VISITORS

With respect to the implementation of the Distinguished Visitor Embarkation program on GREENEVILLE, I concur with the Court's opinion that none of the embarked civilians onboard GREENEVILLE on 9 February directly contributed to this collision. The three civilian guests who participated at controls in the emergency surfacing maneuver were properly supervised at all times and did not contribute to this accident. The remaining guests were quiet and attentive to instruction. They did however, prove to be a distraction to the Commanding Officer, hindered the normal flow of contact information in the moments leading up to the collision and as such, affected the performance of his Control Room watchstanders. It was CDR Waddle's responsibility to prevent this from occurring.

Commanding Officers are charged as a matter of policy and regulation with the control of visitors on their ships. 16 guests is a manageable number if they are properly organized and escorted throughout the ship. Our Commanding Officers are expected to operate their ships – and in fact routinely do operate their ships under conditions considerably more stressful and complex.

GREENEVILLE's original schedule had properly aligned this particular civilian embark with a scheduled underway training period for the submarine. While ships are not to be underway exclusively for the embarkation of civilians, a late modification to GREENEVILLE's schedule requested by the Commanding Officer had them underway for a single day for the express purpose of conducting the embark. While the Court stated this accommodation may have been appropriate,

it nevertheless should have been reviewed for its propriety and utility given the stated policy.

I believe modifications to the distinguished visitor program are necessary. By this action:

- I have directed our numbered fleet commanders in coordination with our submarine, surface and aviation type commanders to personally approve all individual ship and squadron training agendas in support of civilian embarks.
- I have directed the Pacific Fleet Deputy Commander to coordinate a review of this guidance to the Pacific Fleet and I have forwarded a recommendation to the CNO for a thorough review of the associated Navy-wide instructions to achieve consistent policy direction throughout the Navy.
- Lastly, it is my recommendation for the future that civilians not be at key watch stations during any critical evolution – obviously, that includes the emergency blow.

The Distinguished Visitor embarkation program is extremely valuable to a nation like ours. The public has a right and need to know and understand how the Navy operates and the service it provides to the country. The educators, businessmen, legislators, staff personnel, local government officials, family members and media who typically join us at sea are a cross-section of America and contribute much to the nation's understanding of the Navy's mission.

SEARCH AND RESCUE

With respect to GREENEVILLE's search and rescue response on 9 February. I can only characterize it as exceptional and immediate. There was nothing to indicate that the GREENEVILLE did not do everything they could possibly do in the Search and Rescue for EHIME MARU crewmen in the wake of this accident. From the testimony of the crew, the observations of the civilian visitors onboard, the prompt reporting and positioning of rescue personnel and materials, the reported weather conditions, the reports of the USCG and the lack of any sighting of survivors in the water, it is clear to me that GREENEVILLE responded with all dispatch. Let me add my appreciation to the USCG for their very thorough and as always, professional search and rescue effort.

OPERATING AREA

The propriety of the USS GREENEVILLE's operating area on 9 February was also found to be suitable and appropriate for independent submarine operations. It is located south of the known commercial shipping lanes and it is lightly trafficked. This is clearly evident in the fact that GREENEVILLE had only three sonar contacts on the day of the collision.

There is a bottom line here. When surfacing, submarines are always required to stay clear of other shipping - no matter where that might be.

SUMMARY

To the families of the lost, I again offer my profound sorrow and regret for this tragedy. We have expressed our apologies throughout this difficult period. It has been our objective to bring forth the facts related to the causes of this accident in a fair, just and open manner from the beginning.

The Court of Inquiry has determined the cause of the collision between the EHIME MARU and USS GREENEVILLE. Through the provisions of the Uniform Code of Military Justice, I have held CDR Waddle and members of his crew accountable for their failures in the performance of their duties. Punishment has been awarded where appropriate.

As I indicated previously, I have directed actions to ensure the proper execution of the distinguished visitors program is accomplished under the close supervision and specific approval of our senior and most experienced leaders. And I have requested a review by the chain of command of the administration of this program.

Additionally, the GREENEVILLE's performance that led to this serious accident, the removal of the Commanding Officer, the interruption of the ship's training schedule for docking repairs and the result of this investigation lead me to believe that a thorough evaluation of the watch team proficiency in GREENEVILLE is warranted. I have directed the Commander, Submarine Force Pacific to conduct this evaluation after the new permanently—assigned Commanding Officer reports for duty. Successful demonstration of GREENEVILLE's watchstanders as a team, under new leadership, is a prerequisite to GREENEVILLE's certification for deployed operations.

But ultimately, we will prevent accidents of this nature by respecting the importance of our responsibilities and the value of well-honed and time-tested operating procedures. As such, I have directed the Commander, Submarine Force Pacific to prepare a case study of this accident and its lessons. It will be briefed to every Commanding Officer and each Prospective Commanding Officer and then used to train the officers of each ship of the force. Initial action will be completed in 60 days, but this will remain a standing requirement. It will serve to remind all that no matter how apparently routine the mission, there is nothing about going to sea that is forgiving.

I'm happy to take some of your questions...