# EXECUTIVE SUMMARY: RESULT OF ADMINISTRATIVE INVESTIGATION INTO THE DEATH OF MSST ANCHORAGE (91111) CREWMEMBER

## Overview

- On 25 March 2007, CG 25501, a 25-ft Defender Class Boat from Maritime Safety and Security Team Anchorage (MSST 91111), operating under the Tactical Control (TACON) of Commander, Sector Seattle was escorting the Washington State Ferry (WSF) TILLICUM. During a hard, high speed turn to starboard, Petty Officer Gill was ejected and struck by the boat's propellers, suffering fatal injuries.
- This tragic death was preventable. This mishap was caused by a combination of gaps in doctrinal guidance, inadequate oversight and direction at key levels, and human error in the exercise of judgment. The administrative investigation found a failure to follow proper procedures and a lack of appropriate supervision and risk management.
- The Coast Guard continues its review of this mishap and expects there will be additional insights and further internal policy / procedural revisions upon conclusion of the safety investigation process.
- Subsequent to this incident, the Coast Guard took the following actions:
  - The Deployable Operations Group was established in July 2007. One of the DOG's primary responsibilities is to improve and standardize the training, tactics and procedures of deployable, specialized forces.
  - All Level 1 and Level 2 Ports, Waterways and Coastal Security (PWCS) units (which includes Maritime Safety and Security Teams) are now equipped with gunner restraint systems. The device being used is a single point harness that allows for easy release.
  - The Coast Guard is fielding a boat crew communications system to ensure coxswains and crew members can easily and effectively communicate. All MSSTs, and approximately one quarter of Level 1 PWCS units have received the equipment. The remaining units that will receive the equipment are scheduled to have it by July 2008.

## Key Facts

- CG 25501 was an element of MSST Anchorage's forces deployed to Seattle conducting Ports, Waterways and Coastal Security (PWCS) operations.
- MSST Anchorage Detachment Two (DET 2) was supporting waterside operations under the supervision of a Detachment Leader (DTL). The Commanding Officer verbally deemed the officer as qualified and certified to serve as DTL for DET 2.
- The small boat crews received a pre-brief for the escort mission from the DTL that outlined patrol tasking, weather conditions, and a risk assessment using the Green Amber Red (GAR) scoring system.
- Both MSST Anchorage coxswains involved in the escort mission believed power turns were to be conducted for deterrent effect and to demonstrate officer presence. The DTL understood that the boats conducting escorts would conduct an average of two power turns per escort.
- A power turn is an informal term used to describe a boat maneuver involving a hard turn to port or starboard utilizing acceleration through the turn to provide a change of course in a short time and distance.
- PS3 Gill assumed the gunner position on the forward M240B gun mount onboard CG 25501. There was no restraining device on board CG 25501 to secure PS3 Gill to the boat. No Coast Guard-wide policy required gunners be secured to the boat. Pacific Area

Instruction 3530.1, MSST Response Boat Tactics Training Guidelines, and MSST Anchorage's Navigation Standards mandated the use of gunner restraints during training but not during actual operations.

- The Commanding Officer made use of restraining devices for the forward gunner discretionary due to boat egress concerns in the event of a capsizing and no quick release mechanism on restraining devices.
- At the time of the incident, the Coast Guard had completed testing and evaluation of several restraint configurations in an effort to mitigate egress concerns and use with existing personal protective equipment. Selection of the servicewide restraint standard had been completed, but the selected restraint and method of wear had not been announced or fielded at the time of the mishap.
- During previous escort operations, the coxswain of CG 25501 had executed several power turns without incident. While escorting WSF TILLICUM, CG 25501 performed its first power turn to port. CG 25501 transited the length of the ferry and executed a second power turn to starboard. Prior to the first turn to port, PS3 Gill held up his hand and gave what the coxswain described as a "whirly bird signal." The hand signal given by PS3 Gill was not a form of standard communication. There was no form of communication prior to the second power turn to starboard.
- No Coast Guard-wide or unit generated standardized communication procedures had been developed for use between the boat coxswain and the boat gunner.
- During the second power turn, CG 25501 heeled sharply to starboard. The crew in the cabin of CG 25501 observed PS3 Gill lose grasp of the weapon and fall head first over the port side of the boat.
- PS3 Gill was promptly recovered from the water with a very faint pulse, but he quickly became quiet and unresponsive. CG 25501 immediately proceeded to shore where PS3 Gill was transferred to an ambulance and transported to Harborview Memorial Hospital.
- PS3 Gill was pronounced dead at the hospital at approximately 1500 local time.

## Key Findings

- The death of PS3 Gill occurred in the line of duty.
- CG 25501 was ready for operations and fully mission capable.
- The crew of CG 25501 were qualified and certified to execute assigned missions.
- The death of PS3 Gill was preventable. This was a tragic death which resulted from system shortcomings and human error, anyone of which, had it not occurred, may have prevented PS3 Gill's death.
- The power turns conducted by CG 25501 risked ejection and injury to personnel, and were unnecessary for the low threat mission at the time of the mishap.
- The lack of knowledge, skills and abilities at the key MSST leadership positions precluded interventions that may have averted this mishap.
- Additional oversight and direction by the command authority assigned tactical control of the MSST detachment may have averted this mishap.
- Existing gaps in policy, doctrine, training, tactics, techniques and procedures may have indirectly contributed to this mishap.

## Directed Actions:

- Conduct top-to-bottom review of PWCS mission requirements to identify gaps in policy,

doctrine, training capabilities, tactics, techniques and procedures.

- Develop policy for tactical maneuver training, including high speed maneuvers, with a clear distinction between training and operations.
- Promulgate standard PQS for personnel assigned to MSSTs.
- Review unit organizational structure to ensure knowledge, skills, and abilities exist in key leadership positions, including commands assuming TACON of these units.
- Develop unit level guidance addressing a range of responses/actions from officer presence through deadly force in the application of PWCS missions.
- Develop a Ready for Operations and Standardization program for tactical operations.
- Review external unit inspection/visit requirements to ensure compliance with established policy and procedures.
- Promulgate service-wide doctrine for the certification, integration, acceptance, and employment of deployable forces by officers exercising tactical control over Deployable Operations Group forces.
- Expedite the fielding of the Gunner Restraint and Boat Crew Communications System.
- Conduct a joint review and analysis of the Defender Class boat to determine if there are reasonable solutions to reduce violent and unexpected motions during high speed maneuvers.
- Commander, Coast Guard Pacific Area, Commander, Coast Guard Atlantic Area and Commander, Deployable Operations Group shall review this FAM and take actions as they deem appropriate in light of this final action. Commander, Pacific Area, and Commander, Deployable Operations Group, shall also assess the culpability and accountability of persons in the chain of command who were involved in or who contributed to this incident, and take any action if and to whatever extent they deem appropriate.