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APR 18 2011

MEMORANDUM

From: M. J. TEDESCO, RADM
CG-11

Reply to Attn of: CG-1134
Mr. George Borlase
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To: CG-751

Subj: FINAL SUMMARY LETTER – CGC SPAR CLASS "C" HIPO OD BOX FAILURE, 14 APR 2010

Ref: (a) Safety and Environmental Health Manual, COMDTINST M5100.47 (series)

1. SYNOPSIS. At approximately 0910 on April 14, 2010, CGC SPAR was approaching Bechevin Bay buoy number 8 in maneuvering mode and joystick/dynamic positioning (DP). The Conning Officer (CONN) noticed unrequested strong astern propulsion; the Engineer of the Watch (EOW) received an Main Propulsion Control and Monitoring System (MPCMS) program control failure alarm. CONN shifted from port station DP control to center DP control, could not regain pitch control, and attempted to shift to transit mode. MPCMS would not shift to transit. Upon direction from CONN, EOW/Engineer Casualty Response Team (ECRT) took control in the engineering control center and attempted to provide ahead propulsion; pitch control could not be provided. Indicated propeller pitch was 110% astern. CONN ordered ECRT to declutch both Main Diesel Engines (MDEs); MDEs would not declutch. CONN reported that SPAR was making 9 knots astern. ECRT secured both MDEs under full load at the local control station. CO ordered the anchor detail to let go the starboard anchor. ECRT restarted both MDEs and attempted to adjust pitch at the local control station on the Oil Distribution Box (OD Box) to meet permissive of zero thrust for clutching in the reduction gear. The potentiometer arm on the oil tube extension rod then ejected from the front of the OD Box. Anchor fetched up at 4 shots in approximately 100 feet of water with cutter 165 yards from shore and land inside the swing circle. SPAR was able to use both small boats to reposition cutter in safer water. A tug was dispatched from Dutch Harbor, AK. On the morning of April 16, TUG REDEEMER took SPAR in a side tow and towed the cutter out of Bechevin Bay. Tow was passed to CGC ALEX HALEY and SPAR was towed home.

2. Corrective Action. After review of the mishap analysis report, per ref (a), I have recommended corrective action via an internal Final Summary Message (FOUO) to prevent similar future mishaps. A number of corrective actions have already been completed.

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