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United States Coast Guard

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MEMORANDUM

From: J. P. CURRIER, VADM
VCG

To: Distribution

Subj: FINAL ACTION ON THE ADMINISTRATIVE INVESTIGATION INTO THE COLLISION OF CG-33118 AND RECREATIONAL VESSEL CF2607PZ IN SAN DIEGO HARBOR ON 20 DECEMBER 2009

1. **Overview:**

On the evening of 20 December 2009, a 33-foot Coast Guard vessel (a Special Purpose Craft – Law Enforcement (SPC-LE)), with hull number CG-33118, collided with a 24-foot Sea Ray recreational vessel, registration number CF2607PZ, carrying 13 persons, in San Diego Harbor, California. The collision occurred during the San Diego Bay Parade of Lights marine event. CG-33118 overran the Sea Ray's stern, causing fatal injuries to an eight-year-old boy, serious injuries to four persons, and minor injuries to six persons, all of whom were on board the Sea Ray. The five CG-33118 crewmembers were not injured.

Three CG-33118 crewmembers were tried and found guilty of violations of the Uniform Code of Military Justice (UCMJ) at varying levels of courts-martial. The coxswain was convicted by general court-martial of dereliction of duty for not completing a risk assessment or designating lookouts prior to getting underway. The Officer-in-Charge of Coast Guard Station San Diego was tried and found guilty of violations of the UCMJ at a special court-martial. Although the conduct for which the Officer-in-Charge was held accountable was not directly related to the primary cause of this mishap – CG-33118's coxswain's failure to operate the vessel in a safe manner consistent with standard navigation and operating procedures – it nonetheless contributed to a poor command environment that in turn contributed to the mishap. Because of the UCMJ actions previously taken, this Final Action Memorandum includes no directed actions with regard to the discipline of these members.

This Final Action Memorandum concludes a comprehensive investigation, sets forth the facts that led to this incident, states my conclusions, and orders certain actions intended to prevent similar mishaps in the future. The UCMJ proceedings and the investigation by the National Transportation Safety Board (NTSB) were reviewed and considered in preparing this Final Action Memorandum.

2. **Findings of Fact and Opinion:**

The following narrative provides the key findings that inform my conclusions and actions:

Parade of Lights

The San Diego Bay Parade of Lights is an annual parade of boats decorated in Christmas-themed, white and multi-colored lights held on successive Sunday nights on San Diego Bay. The 2009 Parade of Lights was held on 13 and 20 December 2009. The events on 20 December 2009 featured a fireworks display at 1730 hours followed by a parade of decorated recreational vessels led by a Coast Guard cutter. The parade commenced immediately following the end of the fireworks display, along a route starting near Shelter Island, north of the main ship channel, and finished downtown at the Seaport Village.

Operating Environment for 20 December 2009

Sunset was at 1646 hours (all times local) with civil twilight occurring at 1713. Nautical twilight was at 1744 and moonrise at 2045. Maximum visibility in the harbor was 10 miles but affected by the presence of background lights. Maximum tidal ebb was at 1507 at 0.5 knots and slack water was at 1856. The wind was from the south-southeast at about 2.5 knots and the bay was calm.

There was a significant amount of background lighting from the parade, vessels watching the parade, and the city, making it difficult to distinguish the different vessels on the water. There was a large number of vessels on San Diego Bay, with the largest concentration located along the southwestern side of Harbor Island and the basin area between Harbor Island and Shelter Island. Spectator vessels ranged from unlit kayaks to recreational vessels and larger commercial passenger vessels.

The Mishap

At approximately 1723 hours, CG-33118 got underway for a law enforcement patrol. CG-33118 did not have any specific tasking. The five member crew included a coxswain (third class boatswain's mate), two qualified boat crewmembers (third class boatswain's mate and third class machinery technician), a crew member in training (third class machinery technician), and the crew's section leader (second class boatswain's mate) who was also serving as Station San Diego Officer of the Day (OOD), although not qualified in that position. The only mission pre-brief given by the coxswain or any other crewmember was a statement that the parade would be occurring during their patrol.

After observing the fireworks display near Harbor Island, CG-33118 took position off the Coast Guard Cutter (CGC) HADDOCK's starboard side as the parade began. The CGC HADDOCK is an 87-foot patrol boat. At 1737, CG-33118 asked permission to follow CGC HADDOCK along

the parade route. CGC HADDOCK instructed CG-33118 that they could help by keeping the parade route clear of traffic, but they should request permission from the Patrol Commander if they wanted to join the parade. CG-33118 never contacted the Patrol Commander who was onboard the Coast Guard Auxiliary vessel TUXEDO RIDE.

At 1738, Sector San Diego issued a Marine Assistance Request Broadcast (MARB) on VHF Channel 16 for a 25-foot sailboat that had run aground in the vicinity of the Harbor Island Sheraton Hotel. A MARB is a relay request for assistance made by Coast Guard units for vessels requesting non-emergency assistance. After hearing the MARB, CG-33118 contacted the Sector to ask if assistance was needed for the sailboat. Sector informed CG-33118 that the grounded vessel was not in danger and that Sector was not tasking them to assist the sailboat. In the same dialogue, CG-33118 told Sector that CG-33118 wanted to conduct what CG-33118 called a "welfare check" on the grounded vessel to ensure that its passengers were safe. Sector repeated that CG-33118 was not tasked to do so, but was free to "take a look."

CG-33118 immediately proceeded toward the presumed location of the grounded sailboat without first conducting the necessary preparations, as required by the Boat Crew Seamanship Manual, Commandant Instruction M16114.5C. The crew did not conduct a mission brief or risk assessment for the new mission to locate the grounded vessel. Additionally, CG-33118 did not inform CGC HADDOCK or the Patrol Commander of their intentions to depart the parade area to check on the status of the grounded sailboat.

At 1740, CG-33118 proceeded in an easterly direction at a high rate of speed with its running lights and blue light energized in search of the grounded sailboat. At 1744, after not locating the sailboat, CG-33118 came to a stop to confirm the location of the grounded vessel with Sector San Diego. CG-33118 then got underway on a westerly course toward the Harbor Island west basin at a high rate of speed, estimated to be between 19 and 40 knots.

The Sea Ray was underway with 13 persons onboard to view the fireworks and parade. The Sea Ray was traveling on a westerly course in the bay at clutch speed (about 2 to 4 knots), with its port and starboard navigation lights illuminated. Although there is conflicting evidence as to whether its stern all-around white light was illuminated prior to the collision, NTSB post-accident forensic analysis indicates it was functioning at the time of the accident.

At 1745, approximately one minute after changing course, CG-33118 overran the Sea Ray with the CG-33118's bow striking the Sea Ray's starboard quarter. Upon impact, CG-33118 rose up out of the water and traveled in a diagonal direction across the Sea Ray's stern from starboard to port. CG-33118 continued its forward motion, coming to rest approximately 100 feet away from the Sea Ray. CG-33118 immediately returned to the Sea Ray to provide assistance.

After CG-33118 conducted an initial assessment, the most seriously injured passenger from the Sea Ray, an eight-year-old boy, was brought aboard. The crew of CG-33118 administered first

aid while proceeding to the Harbor Island fuel dock to transfer the passenger to ashore medical services.

There is no evidence that CG-33118, which was engaged in rendering assistance, made any radio calls immediately after the collision. A civilian boater broadcast a "Mayday" call on VHF Channel 16, which Sector San Diego heard. Upon hearing the Mayday, CGC HADDOCK proceeded to the scene of the collision, and relayed information to Sector San Diego on VHF Channel 23A. Sector San Diego directed EMS paramedics to the Harbor Island fuel dock and implemented its Sector Briefing Matrix to alert the Sector chain of command. At 1757, CGC HADDOCK launched its cutter boat (CG-171182) to provide assistance. CG-171182 was directed to assist boats ferrying injured passengers to the Bali Hai dock on Shelter Island for emergency care. CG-171182 disembarked two Coast Guard members at the Bali Hai dock to provide first aid and returned to the CGC HADDOCK to retrieve additional Coast Guard crew to assist. CGC HADDOCK crew members provided emergency medical care until 1842, when the last injured passengers were transferred to the hospital by EMS personnel.

CG-33118 returned to Station San Diego mooring at 1857. CG-171182 returned to CGC HADDOCK at 1921 and CGC HADDOCK moored at 2015. The CG-33118 crew members were relieved of their underway duties and submitted to drug and alcohol testing. Drug and alcohol test results were negative.

The eight-year-old boy was fatally injured as a result of the mishap. Ten others on the Sea Ray were injured, several seriously.

Training

The CG-33118 coxswain was trained and currently certified in accordance with Coast Guard policy. The coxswain successfully completed the Coast Guard's twelve-week Boatswain's Mate Basic Training and Basic Seamanship Course in June 2007 before reporting to Station San Diego. In March 2009, he was qualified as a coxswain on another platform and on the 33-foot SPC-LE. His on-the-job training on the 33-foot SPC-LE consisted of 231 daytime hours and 44 nighttime hours since July 2009. At the time, there were no boat-handling or operator courses available to Coast Guard personnel specific to, or which used, the 33-foot SPC-LE platform. He had more underway hours than any other coxswain at Station San Diego during the period of 1 July to 20 December 2009.

Planning

Captains of the Port are responsible for port safety and security in their respective areas (33 CFR § 1.01-30). The Commander of Coast Guard Sector San Diego, as the Captain of the Port, was involved in planning for the Parade of Lights and issued a notice of enforcement for the special local regulation governing the Parade of Lights.

The Sector Commander approved an Incident Action Plan (IAP) drafted by his staff in preparation for the event. The IAP stated the general objectives for managing the event and identified operational resources and assignments. The IAP estimated that 80 to 85 recreational vessels would be in the parade with an additional 60 to 100 vessels observing. The CGC HADDOCK was assigned to lead the parade. The Coast Guard Patrol Commander, a petty officer, was assigned to be on board the Coast Guard Auxiliary vessel TUXEDO RIDE, which would keep position relative to the middle of the parade for oversight. By federal regulation, the Patrol Commander acts as the Sector Commander's official representative and his or her duties include controlling the movement of vessels in the regulated area. Pursuant to the IAP, San Diego Harbor Police were responsible for maintaining law enforcement presence in the bay. The IAP did not assign any Station San Diego vessels to support the parade, but the IAP said station assets might be called to support law enforcement activity as requested by the Patrol Commander through the Joint Harbor Operations Center (JHOC). The "command emphasis" section of the IAP included "Ensure safety of the public."

Boat crews have a defined role in mission planning. The Boat Crew Seamanship Manual, Commandant Instruction M16114.5C, mandates the use of team coordination, risk management, and crew briefing (and debriefing) as part of standard boat operations. The Manual warns that "human error has been and continues to be a significant cause of boat mishaps." It further states that "technical knowledge and skill alone cannot prevent mishaps. It also takes teamwork that recognizes, minimizes, and corrects human errors and a systematic process to continuously assess and manage safety risks."

With regard to team coordination, the coxswain's duties include discussing mission objectives and hazards with the mission coordinator before getting underway and understanding the level of risk the coxswain is authorized to take. The coxswain is responsible for understanding the mission objectives, the known risks, and plan of action prior to getting underway. The coxswain must also ensure that the crew understands the mission plan and assigned tasks.

The Boat Crew Seamanship Manual requires risk management to be performed during the planning and execution of missions. The Boat Operations and Training (BOAT) Manual, Volume I, Commandant Instruction M16114.32B, requires unit commanding officers (COs) and officers-in-charge (OICs) and boat coxswains to utilize Operational Risk Management (ORM) tools in evaluating mission risk. The Coast Guard's ORM policy and procedures are contained in the Operational Risk Management Instruction, COMDTINST 3500.3, and include the use of the GAR model (green, amber, red), which assists crews evaluate a mission's risk.

Locally promulgated policy, specifically Boat Piloting and Navigation Standards, Station San Diego Instruction 3530.3D, requires the coxswain, prior to getting underway, to conduct a crew brief including the following elements: a risk assessment using ORM tools (including the GAR model); crew position assignments, including designation of a lookout; review of charts and the intended track/patrol area; safe speed for the mission/conditions; hazards to navigation; anticipated traffic; and environmental considerations, including visibility.

There was no pre-mission brief given by the coxswain (or any other member of the boat crew) of CG-33118 except for a brief statement about the boat parade. There were no designated roles or responsibilities assigned except for the coxswain. There was no assigned lookout. The crew did not use ORM tools, to include the GAR model. Although one crew member told the NTSB that a GAR risk assessment was undertaken, the evidence suggests that was not the case. There is no evidence that the CG-33118 crew reviewed the IAP. The crew's failure to conduct a pre-mission brief and to conduct a risk assessment using ORM tools was not in accordance with Coast Guard or unit policy.

OOD, Coxswain, and Crew Responsibilities

There are various Coast Guard publications that outline the specific responsibilities of Coast Guard members when they are performing assigned duties. In this case, Coast Guard members failed to meet standards for carrying out the duties of the OOD, coxswain, and boat crew.

a. The OOD

The OOD is the direct representative of the unit's CO or OIC. In accordance with the BOAT Manual, Volume I, Commandant Instruction M16114.32B, the duties of the OOD include "operations planning or execution oversight for SAR and other missions for the Station CO/OIC." Prior to qualifying as an OOD, the Station San Diego SOP requires a member to demonstrate the ability to effectively use ORM tools, to include the GAR risk assessment model. The second class boatswain's mate assigned as the duty section leader on 20 December 2009 had not achieved his OOD qualification, but was acting in that capacity because the qualified duty section OOD was on temporary additional duty (TAD) elsewhere. It is not evident that the duty section leader serving as OOD adequately fulfilled prescribed duties on 20 December 2009.

b. The Coxswain

Coast Guard Regulations, Commandant Instruction M5000.3B, Chapter 5-1-8-B, state that the coxswain is responsible for the safety and conduct of passengers and crew, the safe operation and navigation of the boat assigned, and the completion of the sortie or mission(s) assigned or undertaken pursuant to Coast Guard policy and regulations.

The BOAT Manual, Volume I, Chapter 3, Section G.1, obligates all personnel operating Coast Guard boats to abide by Inland and International Navigational Rules, promulgated to Coast Guard personnel via Commandant Instruction M16672.2D. Rule 6 of the Navigation Rules requires every vessel to proceed at a safe speed at all times to take proper and effective action to avoid collision and be stopped within a distance appropriate to the prevailing circumstances and conditions. Factors to be considered in determining safe speed include visibility; traffic density (including concentration of vessels); maneuverability of the vessel with special reference to stopping distance and turning ability; the presence of background lights at night; wind, sea and

current, and the proximity of navigational hazards; and the draft in relation to the available depth of water.

The Station San Diego Boat Piloting and Navigation Standards, which add local direction to the Navigation Rules, warn coxswains to use additional caution during nighttime navigation because of reduced ability to observe vessel traffic, hazards, and navigation reference points. The unit policy states that reduced visibility at night usually dictates the need for reduced speed, even when responding to a potential life threatening case. Additionally, the policy requires that special consideration must be given to the fact that background lights on shore will make the identification of vessel traffic more difficult and may be disorienting when looking for navigational references. The policy also requires the coxswain to conduct a mandatory crew brief, perform a risk assessment (GAR model), designate crew positions, including a lookout, and discuss anticipated traffic and safe speed for the mission or conditions.

The Boat Crew Seamanship Manual, Chapter 1, Section C.4, requires the coxswain to post lookouts so they have the best possible chance of seeing and hearing an approaching vessel. The Manual also requires the coxswain to choose a boat speed that enables lookouts to effectively and safely perform their duties. The coxswain of CG33118 did not assign lookout duties during this patrol.

c. The Crew

Rule 5 of the Navigation Rules require all vessels to "at all times maintain a proper lookout by sight and hearing as well as by all means appropriate in the prevailing circumstances and conditions, so as to make a full appraisal of the situation and of the risk of collision." The Boat Crew Seamanship Manual, Chapter 1, Section C.1, requires the entire crew to "perform lookout duties unless directed otherwise," even when not specifically assigned or designated as a lookout.

Speed

CG-33118's exact speeds during its search for the grounded sailboat and at the time of the collision are unknown. According to the crew, CG-33118 was not on plane and was traveling in semi-displacement mode with the bow raised in the air. The NTSB report indicates that CG-33118 may have been traveling at speeds of about 42 knots during its easterly leg, before the collision, and traveling at least 19 knots at the time of the collision. Crew and witness accounts, along with engine data, estimated CG-33118's speed of travel at between 19 and 40 knots at the time of the collision. Data recorded by the engines indicate an RPM associated with a higher speed at the time of the collision, but that RPM rate was likely a result of the propellers coming out of the water upon collision. The speed was excessive for safe operation of the vessel and did not allow time for effective action to be taken to avoid collision, or to stop within a distance appropriate under the prevailing circumstances. The speed may also have obstructed the ability of the coxswain and crew to observe the Sea Ray, whose stern white light may have been the

only part of the boat visible to CG-33118 prior to the collision given the 33' bow high attitude when transitioning between approximately 2000-3500 RPMs, (10-27 knots).

Ready for Operations Evaluations, Standardization Team Evaluations, and Command Oversight

The Coast Guard assesses boat unit readiness and compliance with Coast Guard standards through Ready for Operations (RFO) and Standardization (STAN) team evaluations. RFO evaluations are conducted annually by the Sector. STAN team evaluations are conducted every two years by Boat Forces & Cutter Operations (BFCO) based at Training Center Yorktown. The RFO and STAN evolutions evaluate boat crew performance, training, survival systems, and personal protective equipment for compliance with Coast Guard policy and procedures. Both evaluations include equipment inspections and underway exercises. The RFO provides the Sector Commander with a snapshot of that local unit's readiness to conduct safe and effective operations. Station San Diego had completed its most recent RFO on 2-3 December 2009 and was found to be ready for operations. The STAN visit prior to this mishap was conducted in early 2008 and the unit was found in compliance. The STAN evaluation conducted by BFCO from 11-14 January 2010 (which had been scheduled prior to this mishap) determined that Station San Diego was ready for boat operations in accordance with the BOAT Manual, Volume I, Commandant Instruction M16114.32B.

Although the results of the evaluations indicated that Station San Diego was ready for operations, certain areas of training were highlighted for additional attention. While the coxswains averaged a score of 90.3 percent on the RFO knowledge-based written tests, the Station San Diego SPC-LE coxswains averaged 58.6 percent on navigation rules testing. There is no STAN pass rate.

The Sector San Diego Safety Program requires the Sector Commander to oversee the unit safety program in accordance with the Coast Guard Sector Organization Manual, Commandant Instruction M5401.6. The Sector Organization Manual assigns the Deputy Sector Commander to serve as the Sector Safety Officer and requires commanders to incorporate ORM concepts into daily operational, maintenance, and support activities. The San Diego Sector Commander assumed the duties of the Sector safety officer from the Deputy Sector Commander, who served as his assistant in this area. There is evidence that prior Sector Commanders performed the same role. The Sector Commander did not attend Safety Board meetings and was unaware that Station San Diego did not adequately incorporate ORM concepts in its activities and operations.

Command Climate

Station San Diego coxswains were supervised by the Station's OIC, who in-turn was overseen by the Commander of Sector San Diego, through the Sector's Response Department.

A lack of consistency in Station San Diego's command cadre and marginal oversight by the OIC resulted in a weak command climate at the Station. The two previous permanent OICs had been relieved for cause, resulting in five different permanent or temporary OICs or COs in the nine-year period leading up to this mishap. The Station permitted duty section members to go home when there were more than the minimum number of watch standers required for a ready crew. The section leader of duty section A-1, of which the CG-33118 crew was part, had a reputation for taking advantage of this practice more than others. The effect was that the A-1 section leader became detached from active oversight of the duty section, resulting in the more junior members assuming responsibilities for running the section.

The OIC's involvement in an inappropriate relationship with the A-1 section leader likely enabled the section leader to withdraw from daily management responsibilities and further contributed to the Station's overall poor command climate. This led to the OIC's relief for cause on 11 December 2009, just nine days before the mishap; he was replaced by the Sector San Diego Enforcement Division Chief. Moreover, the only qualified OOD in the A-1 duty section was not standing watch on 20 December 2009 because of a temporary assignment.

Additionally, personnel from both Station San Diego and Sector San Diego reported inconsistent approaches to what should have been standard ORM processes. ORM was practiced by some Station personnel but not by others, and when conducted, the level of assessment changed from one person to the next. There was confusion at the Sector over the level of ORM that was required, what had to be recorded, and what ORM was being employed at the unit level.

Characteristics of 33-foot SPC-LE

All 33-foot SPC-LEs are equipped with three 300-horsepower outboard engines. They are designed to conduct the following missions: Defense Operations, Port Safety and Security, Recreational Boating Safety, Marine Environmental Protection, Enforcement of Laws and Treaties, Marine Safety and Security, and Search and Rescue.

The design and operating characteristics of the 33-foot SPC-LE may impede the coxswain's visibility off the bow at certain speeds of operation. Specifically, when operating the 33-foot SPC-LE at transition speeds between approximately 2000 and 3500 RPMs (10-27 knots), the vessel's bow rises, potentially obstructing the coxswain's field of view forward. The crew's visibility on a 33-foot SPC-LE is impeded under certain circumstances because of the cabin design and structure. There are several line of sight restrictions within the cabin for both the coxswain and the crew caused by aluminum framing between windows. Additionally, crew members in the raised rear seats may be required to bend down in order to look out the side windows because their line of sight is typically level with or higher than the window frame. The coxswain and crewmembers failed to compensate for these well known characteristics when operating the vessel.

3. **Findings and Directed Action:**

A. I find that the failure of the coxswain to operate CG-33118 in a safe manner consistent with standard navigation and operating procedures was the causal factor in the mishap.

I base this finding on the following facts:

1. The coxswain is responsible for safe operation and navigation of the boat assigned.

2. The coxswain failed to maintain an adequate lookout as required by the Boat Crew Seamanship Manual, Station San Diego Boat Piloting and Navigation Standards, and Rule 5 of the Navigation Rules.

3. The coxswain failed to operate CG-33118 at safe speed as required by Rule 6 of the Navigation Rules. In determining the appropriate speed to operate CG-33118, the coxswain failed to take into account the traffic density, the presence of background lights at night, and the effect of bow rise on his field of vision. Conditions during the San Diego Bay Parade of Lights were such that vessels participating in and observing the parade were decorated with white and multi-colored holiday lights. The additional non-standard lighting distorted the crew's ability to discern aspects of other vessels operating on the water. These factors clearly required slow speed operation for safety.

4. The coxswain failed to operate CG-33118 in accordance with the Station San Diego Boat Piloting and Navigation Standards that direct coxswains to employ additional caution during nighttime navigation, and advises coxswains that reduced visibility at night usually dictates the need for reduced speed, even when responding to a potential life threatening case. The Standards further advise that the reduced ability to see vessel traffic, hazards, or navigation reference points at night adds extra risk, and special consideration must be given to the fact that background lights on shore will make the identification of vessel traffic more difficult, and may be disorienting when looking for navigational references.

5. The coxswain self-dispatched CG-33118 on a "welfare check" for a vessel which the Sector had determined required no Coast Guard on-scene presence. There was neither urgency nor emergency response associated with CG-33118's operation.

Action:

As a result of this finding, I direct:

All COs and OICs of boat stations to personally review this Final Action Memorandum with the coxswains and boat crews assigned to their units, and discuss the importance of

maintaining adequate situational awareness of the operating environment, positioning proper lookouts, and operating at safe speeds.

B. I find that the failure of the crew members of CG-33118 to carry out their duties consistent with standard navigation and operating procedures was a contributing factor in the mishap.

I base this finding on the following facts:

1. The Boat Crew Seamanship Manual provides that even while not specifically assigned, the entire crew must perform lookout duties unless directed otherwise. Additionally, the Manual directs that "[l]ookouts must report what they see, smell, or hear with as much detail as possible. Object type is immediately important (vessel, buoy, breaking waves), but additional details may help the coxswain in decision-making . . . at night, lookouts must identify the color of all lights."

2. No member of the CG-33118 crew was performing lookout duties, or reporting what they saw to the coxswain.

Action:

As a result of this finding, I direct:

All COs and OICs of boat stations to personally review this Final Action Memorandum with the boat crews assigned to their units, and discuss the responsibility of the entire crew to perform lookout duties while underway consistent with standard navigation and operating procedures.

C. I find that the failure of the CG-33118 crew to follow standard ORM practices was a contributing factor in the mishap.

I base this finding on the following facts:

1. The crew of CG-33118 did not conduct a pre-mission brief or risk assessment prior to getting underway as required by the Boat Crew Seamanship Manual, the BOAT Manual (Volume I), and the Station San Diego Boat Piloting and Navigation Standards.

2. The crew of CG-33118, through an adequate pre-mission brief or risk assessment should have assessed and elected a mode of operation suitable to mission requirements and existing conditions. Each platform has well known operational characteristics that must be compensated for. The rise of the 33-foot SPC-LE bow at moderate speeds or while in transition from displacement to planing can impair crew visibility during operations in congested areas and requires mitigating actions.

3. The absence of an adequate pre-mission brief resulted in the crew's failure to: review charts and the intended track/patrol area; consider safe speed for the mission and/or conditions; consider hazards to navigation; consider the impact of anticipated traffic; and consider the operating environment including tides, currents and weather. On the night of the mishap, the operating conditions included confused vessel and background lighting and a crowded harbor. As a result, the Coxswain had poor situational awareness of the operational hazards. The employment of ORM tools would have increased the likelihood of the crew recognizing, accounting for, and/or mitigating the increased risks associated with the operating environment.

4. The crew of CG-33118 failed to employ ORM tools to evaluate the changing risk level and mode of operation when deciding to divert and respond to the reported 25-foot sailboat in the vicinity of Harbor Island.

Action:

I note that the coxswain of CG-33118 was tried by General Court-Martial and found guilty of dereliction of duty under Article 92 of the Uniform Code of Military Justice for failure to complete a risk assessment.

1. As a result of this finding, I direct DCO and the Deputy Commandant for Mission Support (DCMS) to review existing ORM policy and update to enhance the practical application of risk management tools, including setting guidelines for the sharing of risk management information and mitigation strategies up and down the chain of command, and for the dynamic application of ORM. We must establish operational doctrine that requires the application of ORM principles whenever mission tasking to environmental conditions change significantly. ORM must be enculturated as an ongoing process, not just a mission prerequisite.

D. I find that the poor command climate at Station San Diego contributed to the mishap.

I base this finding upon the following facts and opinions:

1. There was an abnormally high level of turn-over in the Station OIC position. The previous two permanent OICs had both been relieved for cause. Station San Diego had five permanent or temporary COs or OICs in the nine-year period leading up to this mishap. This led to inconsistency in the leadership at the unit.

2. The Station San Diego OIC was relieved for cause nine days prior to the accident for engaging in an inappropriate relationship with the section leader of the Station's duty section A-1.

3. The section leader of A-1, of which the crew of CG-33118 was part, had functionally withdrawn from active oversight of the duty section. This was likely tolerated by the OIC as a result of the inappropriate relationship between the two. More junior and less experienced members assumed leadership and management responsibilities for which they were not suitably prepared.

4. Standard ORM processes were not followed at Station San Diego as required by Coast Guard and unit policy.

Action:

As a result of this finding, I direct the Office of Boat Forces to incorporate this case study into the Boat Forces Command Cadre School curriculum, reinforcing with current and prospective OICs the relationship between command climate and crew performance.

E. The Sector San Diego Commander and staff failed to exercise sufficient oversight and awareness of the operational readiness and command climate of Station San Diego.

I base this finding on the following facts:

1. Three Station OICs were relieved for cause between 2001 and 2009. Nevertheless, Sector San Diego was unsuccessful in adequately addressing the poor command climate that persisted at its subordinate unit, illustrated by lack of engagement by senior station leaders with junior personnel. Sector leaders did not actively examine or monitor the Station's internal climate, or exercise active leadership where necessary.

2. Sector San Diego conducted an annual Ready for Operations (RFO) evaluation of Station San Diego on 2-3 December 2009 and was found to be ready for operations. While the Station may have met those requirements, Sector San Diego exercised limited safety oversight of Station San Diego. The Sector Commander did not ensure that ORM concepts and practices were incorporated into daily operational, maintenance, and support activities, and was unaware that Station San Diego was deficient in its ORM practices.

Action:

As a result of this finding, I direct:

1. DCO to evaluate the requirements for training for Sector Department Heads, Division Chiefs, and others who are charged with overseeing Boat Forces units, specifically on proper operational and administrative management practices.

2. Force Readiness Command (FORCECOM) to incorporate this case study in the curriculum of the Sector Command Cadre Course and the Sector Department Head Course (for Response and Prevention Department Heads), including command oversight and leadership responsibilities in the application of risk management and ORM tools in all mission areas at operational units.

F. Additional Comments and Directed Actions.

Sound leadership could have averted this mishap. Instead, there were leadership compromises at several levels. The coxswain failed to adhere to established policy, tactics, techniques and procedures. Common sense would dictate low speed operation under these circumstances. OICs and COs must establish clear expectations, both in writing and through their actions and direct engagement. They must be active coaches and mentors; one of their essential tasks is the development of junior members – that was not the case at this unit. The Sector did not adequately oversee all aspects of their subordinate operating units. Indicators of substandard unit performance were evident, but not explored. On occasion, intrusive leadership is required; it was not evident here.

FORCECOM conducted a Boat Operations Safety Review in the aftermath of this mishap. This review, completed on 4 October 2010, made a number of recommendations concerning risk management, sensors, training, qualifications, doctrine, and mishap reporting. The Coast Guard continues to assess and implement these recommendations. I am aware that the Coast Guard has begun using the 33-foot SPC-LE to train coxswains at the Non-Compliant Vessel Pursuit Course and at the Special Missions Training Center to increase coxswain familiarity with the operating characteristics of these vessels.

The Coast Guard is our Nation's premiere maritime lifesaving and law enforcement organization. Our crews are trained and equipped, and often risk their lives, to prevent the loss of life at sea. This case is a tragic anomaly, yet clearly demonstrates the need for both organizational and operational discipline. No words can atone for the loss of this young life, or for the pain and injuries caused others; we can only affirm our resolve to ensure that nothing like this happens again.

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Dist: CG-09, CG-01
CG-092, CG-094
CG-1, CG-2, CG-4, CG-5, CG-6, CG-7, CG-9, CG-DCO
All Area and District Commanders
FORCECOM (FC-T)