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PLYMOUTH HARBOR PORT CONTROL

VHF RADIO RECORDING

29 DECEMBER 2006

(ENCL(15))

ENCL (16)

MILITARY INTERDEPARTMENTAL PURCHASE REQUEST

2. FSC	3. CONTROL SYMBOL NO.	4. DATE PREPARED	5. MIPR NUMBER	6. AMEND NO.
		2007/01/04	N00060-07-MP-2BYRQ	BASIC

TO: GSA FTS
10 CAUSEWAY ST
BOSTON, MA 02222
ATTN: ANNE MITCHELL

8. FROM:
COMMANDER
U.S. FLEET FORCES COMMAND
1562 MITSCHER AVE., SUITE 250
NORFOLK, VA 23551-2487

9. ITEMS [ ]ARE [X]ARE NOT INCLUDED IN THE INTERSERVICE SUPPLY SUPPORT PROGRAM AND REQUIRED INTERSERVICE SCREENING [X]HAS [ ]HAS NOT BEEN ACCOMPLISHED.

ITEM NO. a	DESCRIPTION (Federal stock number, nomen.,spec.,drawing, etc.) b	QTY c	UNIT d	ESTIMATED UNIT PRICE e	ESTIMATED TOTAL PRICE f

ESTABLISH 07TAV3-051 GSA BOSTON CONTRACT FOR LCE TO PERFORM IN-PLACE REFURBISHMENT OF DIESEL GENERATOR ONBOARD USS MINNEAPOLIS ST. PAUL (SSN 708) TO REMOVE SALT WATER CONTAMINATION TO INCLUDE INSPECTIONS OF ROTOR AND STATOR ASSEMBLY, INSULATION RESISTANCE MEASUREMENTS, REMOVAL/REPLACEMENT OF COVERS AS REQUIRED TO FACILITATE DETERGENT AND FRESH WATER CLEANING OF THE D/G, SLIP RING STONING AND POLISHING, INSULATION RESISTANCE VALUES AT WORK COMPLETION AND FINAL REPORT FOLLOWING COMPLETION. FUNDS ARE ISSUED UNDER PROPERTY ACT 295X FOR TASK R1PNS05003. GSA PROJECT MANAGER IS [redacted] FAX IS [redacted] ($118,674 for LCE and $4,747.00 for GSA fee)

FUNDS AUTHORIZED ONLY FOR USE IAW CINCLANTFLT INST 7303.8Q

For non-DOD Transactions:
If applicable to severable services, "These funds are available for services for a period not to exceed one year from the date of acceptance of this order. All unobligated funds shall be returned to the

Please See Attached Continuation Sheet(s) for Further Description

10. SEE ATTACHED PAGES FOR DELIVERY SCHEDULES, PRESERVATION AND PACKAGING INSTRUCTIONS, SHIPPING INSTRUCTIONS AND INSTRUCTIONS FOR DISTRIBUTION OF CONTRACTS AND RELATED DOCUMENTS.

11. GRAND TOTAL 123,421.00

12. TRANSPORTATION ALLOTMENT
(Used if FOB Contractor's plant)

13. MAIL INVOICES TO
DFAS-CLEVELAND,
NORFOLK ACCTS PAYABLE
P.O. BOX 998022
CLEVELAND, OH 44199

14. FUNDS FOR PROCUREMENT ARE PROPERLY CHARGEABLE TO THE ALLOTMENTS SET FORTH BELOW. THE AVAILABLE BALANCES OF WHICH ARE SUFFICIENT TO COVER THE ESTIMATED TOTAL PRICE.

ACRN	APPROPRIATION	LIMIT/ SUBHEAD	SUPPLEMENTAL ACCOUNTING CLASSIFICATION	AMOUNT
AA	1771804	60BA	000 00060 R 068732 2D P2BYRQ 208847B1DR4P	123,421.00

15. AUTHORIZING OFFICER (Type name and title)	16. SIGNATURE	17. DATE
ICHAEL F. LEE FINANCIAL MANAGEMENT ANALYS		2007/01/04

FORM 448

ENCL (17)

CONTINUATION SHEET	MIPR NUMBER N00060-07-MP-2BYRQ
	AMENDMENT NO BASIC

CRIPTION OF WORK TO BE PERFORMED AND OTHER INSTRUCTIONS (Contd.)

ordering activity no later than one year after the acceptance of the order or upon completion of the order, whichever is earlier." If applicable to goods, "I certify that the goods acquired under this agreement are legitimate, specific requirements representing a bona fide need of the fiscal year in which this order is placed."

"THESE FUNDS ARE AVAILABLE FOR SERVICES FOR A PERIOD NOT TO EXCEED ONE YEAR FROM THE DATE OF ACCEPTANCE OF THIS ORDER. ALL UNOBLIGATED FUNDS SHALL BE RETURNED TO THE ORDERING ACTIVITY NO LATER THAN ONE YEAR AFTER THE ACCPETNCE OF THE ORDER OR UPON COMPLETION OF THE ORDER, WHICH EVER IS EARLIER."

"I CERTIFY THAT THE GOODS ACQUIRED UNDER THIS AGREEMENT ARE LEGITIMATE, SPECIFIC REQUIREMENTS REPRESENTING A BONA FIDE NEED OF THE FISCL YEAR IN WHICH THIS ORDER IS PLACED."

ACCEPTANCE OF MIPR

1. TO (Requiring Activity Address)	2. MIPR NUMBER	3. AMENDMENT NO.
COMMANDER U.S. FLEET FORCES COMMAND 1562 MITSCHER AVE., SUITE 250 NORFOLK, VA 23551-2487	N00060-07-MP-2BYRQ	BASIC
	4. MIPR DATE 2007/01/04	5. MIPR AMOUNT 123,421.00

6. The MIPR identified above is accepted and the items requested will be provided as follows:
(Check as applicable)

a.[ ]ALL ITEMS WILL BE PROVIDED THROUGH REIMBURSEMENT (CATEGORY I).
b.[ ]ALL ITEMS WILL BE PROCURED BY DIRECT CITATION OF FUNDS (CATEGORY II).
c.[ ]ITEMS WILL BE PROVIDED BY BOTH CATEGORY I AND CATEGORY II AS INDICATED BELOW.
d.[ ]THIS ACCEPTANCE, FOR CATEGORY 1 ITEMS, IS QUALIFIED BECAUSE OF ANTICIPATED CONTINGENCIES AS TO FINAL PRICE. CHANGES IN THIS ACCEPTANCE FIGURE WILL BE FURNISHED PERIODICALLY UPON DETERMINATION OF DEFINITE PRICES, BUT PRIOR TO SUBMISSION OF BILLINGS.

7. [ ] MIPR ITEM NUMBER(S) IDENTIFIED IN BLOCK 13, 'REMARKS' IS NOT ACCEPTED (IS REJECTED) FOR THE REASONS INDICATED.

8. TO BE PROVIDED THROUGH REIMBURSEMENT CATEGORY I			9. TO BE PROCURED BY DIRECT CITATION OF FUNDS CATEGORY II		
ITEM NO. a	QTY b	ESTIMATED PRICE c	ITEM NO. a	QTY b	ESTIMATED PRICE c

ESTABLISH 07TAV3-051 GSA BOSTON CONTRACT FOR LCE TO PERFORM IN-PLACE REFURBISHMENT OF DIESEL GENERATOR ONBOARD USS MINNEAPOLIS ST. PAUL (SSN 708) TO REMOVE SALT WATER CONTAMINATION TO INCLUDE INSPECTIONS OF ROTOR AND STATOR ASSEMBLY, INSULATION RESISTANCE MEASUREMENTS, REMOVAL/REPLACEMENT OF COVERS AS REQUIRED TO FACILITATE DETERGENT AND FRESH WATER CLEANING OF THE D/G, SLIP RING STONING AND POLISHING, INSULATION RESISTANCE VALUES AT WORK COMPLETION AND FINAL REPORT FOLLOWING COMPLETION. FUNDS ARE ISSUED UNDER PROPERTY ACT 295X FOR TASK R1PNS05003. GSA PROJECT MANAGER IS DOROTHY CESTRONE, (617) 565-5751, FAX IS (207) 268-3632 PNSY POC IS BILL TREFETHAN, FAX (207) 438-4503. ($118,674 for LCE and $4,747.00 for GSA Fee)

FUNDS AUTHORIZED ONLY FOR USE IAW CINCLANTFLT INST 7303.8Q

For non-DOD Transactions:
If applicable to severable services, "These funds are available for services for a period not to exceed one year from the date of acceptance of this order. All unobligated funds shall be returned to the

Please See Previous Continuation Sheet(s) for Further Description

d. TOTAL ESTIMATED PRICE	d. TOTAL ESTIMATED PRICE 123,421.00
10. ANTICIPATED DATE OF OBLIGATION FOR CATEGORY II ITEMS	11. GRAND TOTAL ESTIMATED FOR ALL ITEMS 123,421.00

12. FUNDS DATA (Check if Applicable)
a. ADDITIONAL FUNDS AMOUNT OF $_____ ARE REQUIRED (SEE BLOCK 13)
b. FUNDS IN THE AMOUNT OF $_____ ARE NOT REQUIRED AND MAY BE WITHDRAWN

13. REMARKS

14. ACCEPTING ACTIVITY ADDRESS	15. TYPED NAME AND TITLE OF AUTHORIZED OFFICIAL	
GSA FTS 10 CAUSEWAY ST BOSTON, MA 02222 ATTN: ANNE MITCHELL	[redacted]	
	16. SIGNATURE Recorded by: [redacted]	17. DATE 2007/01/08

DD FORM 448-2

5.4m, extend up to about 2 miles S of the shore, 2.8 miles NE of St. Georges Island.

Knight Errant Patch, at the SE end of the shoals, has a depth of 6.2m and lies about 2.7 miles E of The Ranneys; a patch, with a least depth of 5m, lies near the SW end of the shoals.

Looe Harbour (50°21'N., 4°27'W.) lies at the mouth of the River Looe, about 0.5 mile N of Hannafore Point. This small drying harbor is used by fishing vessels and pleasure craft. It has depths of 4m at HWS and 3m at HWN. Vessels up to 16m in length and 2.9m draft can enter. A stone bridge spans the river about 0.4 mile above the entrance.

The roadstead off Looe affords good shelter from W winds and is exposed only to the S through E. The best anchorage is in depths of 7 to 13m, sand, between 0.5 and 1 mile SE of the river mouth.

Rame Head (50°19'N., 4°13'W.), at the W side of the entrance to Plymouth Sound, appears from seaward as a conical hill. Rising to a height of 102m close within, the headland, with an old chapel standing on its summit, is very prominent and clearly defines the position of the sound.

A prominent radio mast, 23m high, is situated 0.4 mile NE of Rame Head. A beacon stands at an elevation of 128m about 1.5 miles N of the head and is prominent from seaward.

Whitsand Bay lies W of Rame Head and is bordered by cliffs 30 to 75m high. Portwinkle, a small drying harbor, is situated 4.3 miles NW of Rame Head and is used by fishing boats.

Caution.—A submarine exercise area lies in the approaches to Looe Harbor and Whitsand Bay.

A spoil ground and disused explosive dumping area lies centered 1.5 miles W of Rame Head and may best be seen on the chart.

A small arms firing range is situated on the shore of Whitsand Bay, about 1.5 mile E of Portwinkle. Red lights and red flags are displayed from flagstaffs in its vicinity when firing is in progress.

1.20 Eddystone Rocks (50°11'N., 4°16'W.), lying 8 miles S of Rame Head, do not completely cover. They are fairly steep-to outside a radius of 0.3 mile, but vessels are recommended to give them a wide berth. A main light (Eddystone) is shown from a prominent granite tower, 49m high and surmounted by a helicopter platform, standing on the rocks. This tower is radar conspicuous. A racon is situated at the light.

Eddystone Light

Hand Deeps, located about 3.5 miles NW of Eddystone Rocks, consists of a group of rocky shoals with a least depth of 7m. In bad weather the position of this shoal area is indicated by a short breaking sea in its vicinity, and in good weather usually by tide rips.

Plymouth (50°20'N., 4°10'W.)

World Port Index No. 35370

1.21 The port of Plymouth is entered between Penlee Point and the island of Great Mew Stone, 3.2 miles ESE. The commercial facilities, including a ro-ro ferry terminal, are situated in the areas of Mill Bay Docks and Cattewater. HM Naval Base, Devonport, a large naval dockyard, is situated in the W part of the port. It stands on the E bank of an area known as Hamoaze.

Winds—Weather

During the summer and winter the sea breeze is primarily from the SW during the day, the land breezes at night shifting mostly from NW or W. Gales obtain the highest incidence during the months of December and January, possibly reaching 3 to 4 days a month, but in summer they are rare.

Fog occurs on the average of 2 to 4 days a month in the spring and fall, but haze with visibility reduced to 2 to 6 miles may occur about four times in as many days.

Tides—Currents

The tides rise about 5.5m at springs and about 4.4m at neaps.

The tidal currents in the narrow channels can be irregular. Strong S winds usually prolong the flood current and delay the ebb by about 15 minutes. Strong N winds usually prolong the ebb current and delay the flood by about 15 minutes. Freshets after heavy rain have the same effect as a strong N wind and long summer droughts can prolong the flood current up to 30 minutes.

The flood current sets through Western Channel toward Asia Pass, and through Eastern Channel toward Smeaton Pass at a velocity of 1.2 knots at springs. The ebb current sets outward from the passes toward the respective channels at the same rate.

The tidal currents in Drake Channel, the Narrows, and Hamoaze set generally in the direction of the channels, with a spring velocity of 2.5 knots in the Narrows and about 1.5 knots in Hamoaze.

Depths—Limitations

Penlee Point, dark and rocky, is located 1.5 miles ENE of Rame Head. Draystone, a shallow reef, fronts the SE side of this point and is marked by a lighted buoy.

Great Mew Stone (50°18'N., 4°06'W.) lies about 0.5 mile S of Wembury Point to which it is connected by a drying rocky reef. This island is 57m high, conical, and prominent.

Plymouth Sound, entered between the above point and island, has general depths of 26 to 5.5m. However, several

Courtesy of M. J. Wilson, Brantag Inc, Wiltshire, UK

Plymouth

shoal areas lie in the approach and may best be seen on the chart.

Plymouth Breakwater, about 0.8 mile long, is detached. This breakwater lies at the E side of the sound with its W end situated about 1.5 miles NE of Penlee Point.

The Knapp extends up to about 0.6 mile S from the W end of the breakwater. This shoal area has depths of 5 to 8m and is marked on the SW side by a lighted buoy.

Tinker, with a least depth of 3.3m, lies at the S end of a shoal area extending up to about 0.8 mile S from the E end of the breakwater. This shoal patch is marked by two lighted buoys.

Two approach channels, which may best be seen on the chart, lead through the sound to the port.

Eastern Channel lies between the E end of Plymouth Breakwater and Staddon Point, about 0.4 mile ENE. It is not recommended for use by small craft during strong W winds due to a dangerous sea. The least depth in the approach is 6.2m over a width of about 100m. However, vessels are recommended to maintain an underkeel clearance of at least 2m due to scend and inequalities of the rocky bottom.

Western Channel, the main approach channel, rounds the W end of Plymouth Breakwater. It is maintained at a dredged depth of 11m as far as a position about 0.5 mile NW of the E end of Plymouth Breakwater.

An entrance fairway, dredged to a depth of 8.6m, then leads NE and N from the inner end of Western Channel to the outer ends of Smeaton Pass, Asia Pass, and Cobbler Channel.

A recommended deep-water track, which may best be seen on the chart, leads through Western Channel, the entrance fairway, and Smeaton Pass. Its outer end lies about 0.8 mile SE of Penlee Point.

Cobbler Channel leads NE and E to the commercial berths of Cattewater and Sutton Harbour.

Smeaton Pass, with a least depth of 25m, and Asia Pass, with a least depth of 7.6m, lead NW between the shoals lying ENE of Drake's Island to Mill Bay Docks and the outer end of Drake's Channel.

The naval facilities along Hamoaze are accessible via Drake's Channel and The Narrows. Hamoaze is formed by the lower portion of the River Tamar. A railroad bridge and a road bridge, close N, span the river at the N end. They have vertical clearances of 30m and 35m, respectively.

Drake Channel is reported (1995) to have a least charted depth of 10.7m. Recommended tracks, which may best be seen on the chart, lead through the fairways to the Hamoaze.

Vessels intending to berth at the naval facilities are recommended to contact the local authorities for the latest information concerning depths, regulations, etc., prior to arrival.

The main berths at the E side of Hamoaze include Rubble Jetty, 130m long, with a depth of 10m alongside; and No. 1 Jetty, 145m long, with a depth of 9.8m alongside. No. 5 Basin is the largest and deepest. It is maintained at depths of 9 to 9.5m and may best be seen on the chart. The seawall extending S of the entrance to this basin provides the deepest berths. There is 508m of total quayage with a depth of 11.9m alongside. Weston Mill Lake Jetty, close N of No. 5 Basin, provides 503m of quayage with depths of 8.5 to 9.2m alongside.

The largest drydock at the naval base is 242m long with a depth of 14.7m on the sill at HWS. Its length can be increased by 12m by using a caisson. The dock is entered from No. 5 Basin, which has a maximum entrance width of 37.7m at HWS.

Yonderberry Point oil jetty is situated at the W side of Hamoaze. It has a berthing head, 61m long, with a depth of 11.6m alongside.

Ernesettle Pier is situated at the NE end of Hamoaze, close N of the bridges. It provides a berth, 100m long, with a depth of 6.1m alongside.

An extensive marina fronts the NW entrance point of Stonehouse Pool, at the N side of the channel, at the N end of The Narrows.

Mill Bay Docks has a ro-ro ferry and cruise ship terminal situated at the W side of the outer basin. The inner basin is only used by small craft. A marina lies at the E side of the outer basin. There are two berths with depths up to 9m alongside. Vessels up to 200m in length and 8.5m draft can be accommodated.

Cobbler Channel is maintained at a dredged depth of 5.5m as far as the entrance to Sutton Harbour. The fairway in Cattlewater has a dredged depth of 5m (1995).

Sutton Harbor has a non-tidal basin, which is entered via a small lock with a width of 12m. It provides two quays, with depths of 3.5m alongside, for fishing vessels and facilities for small craft and yachts.

Victoria Wharves, on the NW side of Cattlewater, provide two berths, 145m and 103m long, with depths of 6.5m alongside. Vessels up to 5,000 dwt, 130m in length, and 7m draft can be handled at HW. Vessels are generally limited to a maximum beam of 15m.

Cattledown, on the N side of Cattlewater, provides facilities for general cargo, bulk, and tanker vessels. The berth is 216m long with a depths of 6.5 to 7.4m alongside (1995).

Aspect

A main light is shown from a prominent granite tower, 23m high, standing on the W end of Plymouth Breakwater. A lighted beacon is situated at the E end.

The entrance channels are indicated by directional sector lights and ranges which may best be seen on the chart.

An orange flashing light is shown from all principal directional lights when the main power supply at the port is interrupted. Special high intensity fog lights are shown on request from several positions within the harbor and sound.

Two special lighted buoys (OSR North and OSR South) are moored about 1.2 miles SSW of the W end of Plymouth Breakwater, at the E side of the recommended approach track.

Within the sound the coast extending N of Staddon Point, located 2 miles NNW of Great Mew Stone island, is formed by high, steep cliffs. Two conspicuous radio towers stand at elevations of 175m and 173m on Staddon Heights, 0.7 mile NE of Staddon Point.

Picklecombe Point is located 0.7 mile NW of the W end of Plymouth Breakwater. An old fort, which has been converted into a prominent block of apartments, stands on this point.

Drakes Island, prominent and cliffy, lies 1 mile NE of Picklecombe Point and is fronted by drying rocky ledges. A signal station is situated on this island.

Within the harbor Mountbatten Tower stands on a small peninsula, 1.3 miles N of Staddon Point. A short breakwater extends W from the W side of this peninsula.

A conspicuous silo, 61m high, stands at the W side of Mill Bay Docks outer basin. It is surmounted by a tower and a flagstaff. A prominent hotel and the conspicuous Civic Center building are situated 0.3 mile and 0.6 mile, respectively, NE of the entrance to this dock basin.

Ocean Court is a long, white block of apartments standing on the N side of the channel at the N end of The Narrows. It is prominent and fronted by an extensive marina.

Smeaton Tower, 28m high, stands on The Hoe, a park area, about 0.5 mile E of the entrance to Mill Bay Docks outer basin. This historic monument, a former lighthouse, is conspicuous and easily identified by its white and red bands. The tower was erected on Eddystone Rocks in 1759 and moved to its present location in 1882 when the foundation was discovered to be unsafe.

The Naval War Memorial consists of a stone column, 30m high, surmounted by a copper sphere. It stands about 200m N of Smeaton Tower and is prominent.

The city of Plymouth is radar conspicuous.

Pilotage

Pilotage is compulsory for the following vessels:

1. All vessels over 50m in length proceeding to or from an alongside berth or buoy berth within the port.
2. All vessels over 100m in length proceeding within the areas lying N of lines extending from Maker Point Light (50°20.5'N., 4°10.9'W.) to the West Breakwater Light and from the East Breakwater lighted beacon to Staddon Point (50°20.2'N., 4°07.6'W.).
3. All vessels over 125m in length proceeding to an anchorage in Cawsand Bay (50°20'N., 4°11'W.).
4. All vessels carrying hazardous, noxious, or polluting cargo proceeding to or from a berth in the port, including vessels not gas-free from a previous cargo.
5. All vessels over 150m in length proceeding N of a line extending from Penlee Point to Shag Stone.
6. All vessels over 50m in length not having navigational charts showing all numbered anchorages of Plymouth (1:12,500 or larger) on board.

Pilotage of the following vessels will be at the discretion of the Queen's Harbor Master Plymouth, using an Admiralty Pilot when required:

1. HM ships.
2. Government owned ships/auxiliaries and foreign warships/auxiliaries navigating in port for the purpose of securing to or departing an anchorage or Ministry of Defence owned berth, dock or mooring.
3. Any vessel enroute between the Sound and a Ministry of Defence owned berth, dock or mooring.

Pilots board vessels of 150m in length and less within 0.75 mile of the W entrance to the Sound and vessels over 150m in length in position 50°18.5'N, 4°10.5'W (about 0.9 mile SE of Penlee Point). The pilot vessel is black with orange upperworks.

The call sign for commercial pilots is "Plymouth Pilots" and the call sign for Ministry of Defence pilots, for the naval berths, is "Long Room Port Control."

All vessels over 25m in length must send an ETA to the "Long Room Port Control" at least 24 hours in advance of

arrival or on leaving the last port, if later. The message should include name; nationality; draft; and berthing, anchorage, pilotage, or tug requirements.

Vessels carrying hydrocarbons or dangerous cargo must send an ETA at least 48 hours prior to arrival. The message must include a description, quantity or weight, and classification of the cargo.

All arriving vessels must contact "Long Room Port Control" when within VHF range to confirm pilotage requirements or report any serious defects.

Vessels are required to maintain a continuous VHF watch while underway or at anchor.

All vessels must report their position to "Long Room Port Control" when passing a line joining Penlee Point and Shag Stone (50°19.0N., 4°08.1W.) and attain permission to enter the sound. They must then report when passing Plymouth Breakwater and when berthed.

Commercial vessels should use VHF channel 16 or 4. Ministry of Defense vessels should use VHF channel 16, 8, 11,12, or 13.

The Devonport Dockyard and Hamoaze signal station, call sign "Flagstaff Port Control," may be contacted on VHF channels 13 and 73. This station controls movements of vessels N of The Narrows.

Reporting vessels will be advised of traffic movements in the approaches. Tidal and wind speed information is available on request. Information on fog conditions is available on VHF channel 13, 14, or 16 from "Longroom Port Control" or "Flagstaff" stations.

Vessels may obtain information on the Traffic Signals displayed at Drake's Island from "Longroom Port Control" or "Flagstaff" stations.

When the Port Control Traffic Light System displays no lights there are no restrictions in force unless notified on VHF channel 13, 14, or 16.

Plymouth pilots may be contacted by e-mail, as follows:

pilot @plymouthport.org.uk

Regulations

Submarines frequently operate within the sound and the approaches with equipment extending up to 800m astern. Vessels should not pass within 200m of any submarine or cross astern within 800m. If in doubt, vessels should contact the submarine directly on VHF channel 13 or 16 to seek advice. If contact with the submarine cannot be established, vessels should call "Longroom Port Control."

The Dockyard Port of Plymouth is a naval port under the control of the Queen's Harbour Master. Special rules and regulations concerning navigation within the port are in force. Mariners are urged to consult the pilot for information on such regulations, and to obtain a copy on arrival.

A speed limit of 10 knots is in force N of latitude 50°20'N (Plymouth Breakwater). A speed limit of 8 knots is in force E of a line joining Fisher's Nose and Mount Batten Breakwater. A speed limit of 8 knots is also in force within the bathing areas of Crawsand Bay, Firestone Bay, Tinside East, and Bovisand Bay.

When two power-driven vessels proceeding in opposite directions are about to meet one another in any narrow channel of the Dockyard Port, the power-driven vessel navigating against the tidal current shall give priority of passage through such narrow channel to the vessel navigating with the current.

When, within the limits of the Dockyard Port, power-driven vessels underway (including a tug with a tow) are about to turn round at night or by day, such vessels shall signify their intention by sounding five short blasts of the whistle in rapid succession, followed after a short interval, if turning to starboard, by one short blast, and if to port, by two short blasts. While turning, vessels shall repeat such signals for any approaching vessel. These sound signals are only to be used by vessels in sight of one another.

All vessels over 60m in length, shall, when leaving the Outer basin of Millbay Docks and prior to entering the main channel, sound one prolonged blast in order to warn other traffic of their movement in accordance with Rule 34 of the Collision Regulations.

Signals

Visual traffic signals to control the movement of all vessels over 20m in length, which are required to use or cross the charted recommended track for deep-draft vessels, are displayed by day and at night from a lattice mast at Drake's Island for vessels to seaward of a line extending S from Mutton Cove (outside Hamoaze). The signals are also displayed at the Flag Port Control Signal Station in the naval base for control of vessels within the Hamoaze.

When the signal lights are unlit, there are no restrictions unless broadcast by VHF.

The following signals are shown:

1. Three red flashing lights indicate a serious emergency. All traffic movements are suspended throughout the port unless specifically directed by "Longroom Port Control" of "Flagstaff Port Control".
2. One red light over two green lights, all occulting, indicate outgoing traffic only may proceed on the recommended track. Crossing vessels must request approval.
3. Two green lights over one red light, all occulting, indicate incoming traffic only may proceed on the recommended track. Crossing vessels must request approval.
4. Two green lights over one white light, all occulting, indicates vessels may proceed in either direction but shall give a wide berth to any Ministry of Defence vessels using the recommended track.

When any traffic light signal specified above is displayed, no vessel shall enter the main channel except in the direction indicated by that signal. Any vessel already in the channel and proceeding in a contrary directional must clear the channel. Vessels less than 20m in length may proceed in a contrary direction so long as they navigate with caution and do not impede the passage of a vessel for which the signal is being shown.

Wind strength warning lights are exhibited from the mast on Drake's Island by day when there is no traffic light signal in force. One white occulting light indicates wind at force 5 to 7; two white occulting lights disposed vertically indicate wind greater than force 7.

Anchorage

Anchorage can be obtained in Cawsand Bay to the W of the W end of Plymouth Breakwater. The roadstead is sheltered from all but SE winds and has depths 5.6 to 10.5m. The berths are numbered 11 to 17 and may best be seen on the chart.

An anchorage area for vessels with drafts of less than 7.5m lies close S of Drake's Island. The berths are numbered 3 to 5 and may best be seen on the chart. Another anchorage for these vessels, which may best be seen on the chart, lies E of the entrance channel and 0.3 mile S of Mount Batten Tower.

The quarantine anchorage lies in the S portion of Jenny Cliff Bay, about 0.7 mile S of Mount Batton Tower.

An anchorage area for vessels with drafts of 7.5m and over lies N of Plymouth Breakwater and on the NW side of the entrance channel. The berths are numbered 1, 2, 6, and 7 and may best be seen on the chart.

Anchorage berths, numbered 21 to 23, lie S of the W end of Plymouth Breakwater and may best be seen on the chart.

Four main mooring buoy berths are situated N of the breakwater and may best be seen on the chart. Buoy C, 0.4 mile ENE of the W end of the breakwater, has a maintained depth of 12m; Buoy D, 0.7 mile ENE of the W end of the breakwater, has a maintained depth of 11.6m; Buoy E, 0.8 mile NE of the W end of the breakwater, has a maintained depth of 9.7m; and Buoy F, 1.2 miles NE of the W end of the breakwater, has a maintained depth of 8.6m.

Special anchorage rules apply to vessels carrying hydrocarbons, hazardous liquid chemicals, and liquefied gases. Also to vessels in ballast but not gas-freed after carrying such cargo.

Directions

If approaching from seaward, vessels should pass about 3 miles E of Eddystone Light, and steer for the light on the W end of Plymouth Breakwater bearing N. When Maker Light (50°20.5'N., 4°10.9'W.) is in sight, steer for it on a bearing of 350°; this course will bring the vessel to the pilot boarding ground.

Approaching from the W, pass about 1 mile S of Rame Head, with the summit of Great Mew Stone ahead bearing 080°. When Plymouth Breakwater Light bears about 020°, change course for the boarding ground, with Maker Light ahead bearing 350°.

From the E, steer to pass not less than 1 mile offshore, with Rame Head bearing 290°. When Maker Light bears 350°, steer for it and the boarding ground.

From the boarding ground, follow the recommended track, which may best be seen on the chart. through Western Channel.

In certain portions of Hamoaze, light-draft and deep-draft recommended tracks have been established. Vessels should consult the pilot before selecting one of these tracks.

Caution

Strong tidal currents may be encountered within the narrow channels.

Submarine cables extend across the channels at several places within the harbor limits and may best be seen on the chart.

Diving training areas are situated within the port and may best be seen on the chart.

Small boat training by naval craft is carried out within an area lying on the SW side of Hamoaze. The area is marked by buoys and may best be seen on the chart.

Several small craft mooring areas and groups of mooring buoys are situated within the port and may best be seen on the chart.

Local ferries cross the channel in a number of places within the port and may best be seen on the chart.

Degaussing ranges are situated within the port limits and may best be seen on the chart.

Several prohibited anchorage areas lie within the port and may best be seen on the chart.

Submarines may be frequently encountered in the sound and the approaches (see Signals).

High speed craft may be encountered in the approaches to the sound.

A navy shore establishment, HMS Cambridge, situated in the vicinity of Wembury Point (50°19'N., 4°06'W.), occasionally conducts gunnery training. The firing area extends up to 13 miles seaward between the bearings of 130° and 210°, and 12.5 miles between the bearing of 210° and 245°. When the range is operational, information may be obtained on VHF channel 16 from "Wembury Range."

Warships and auxiliary vessels, carrying out training exercises, may be encountered in the approaches and N of the breakwater. In addition, ships may carry out minelaying exercises in an area lying 3 miles S of the entrance to the sound. Such vessels may not follow the regular traffic patterns.

Warships frequently enter the port via both channels to transfer personnel to and from support craft. These transfers are usually carried out 0730 to 0830, Monday to Friday except in August, in the vicinity of C, D, and E mooring buoy berths. Information regarding these operations may be requested from "Longroom Port Control."

Plymouth to Start Point

1.22 Yealm Head (50°18'N., 4°04'W.), located 1.2 miles E of Great Mew Stone, is the W extremity of a hilly peninsula. It forms the E entrance point of Wembury Bay and the S side of the mouth to the Yealm River.

Wembury Bay, with irregular depth of less than 15m, is used by small craft as an anchorage. The Yealm River, a yachting center, has a bar which dries.

The coast E of Yealm Head is craggy and reef strewn, with numerous dangers lying within the 20m curve. Stoke Point, located 2 miles E of Yealm Head, is the SE extremity of the above peninsula. Conspicuous cliffs stand about 0.5 mile NNE of this point.

Bigbury Bay lies between Stoke Point and Bolt Tail, 6.5 miles ESE. The mouth of the Erme River, located near the head of the bay, can be identified by clumps of trees just within the W entrance point. The river dries and can only be entered by small craft with local knowledge.

Wells Rock, with a depth of 1.2m, lies about 0.5 mile S of the E entrance point of the river.

The River Avon, used only by small craft, enters the bay 2.3 miles NNW of Bolt Tail. Burgh Island, 47m high, lies close off the N entrance point of the river. It is connected to the shore by a drying sandy neck and a small ruined chapel stands on the summit. A church, with a conspicuous spire, stands at Bigbury, 1.8 miles NE of the island.

Thurlestone Rock, 10m high and resembling the hull of a stranded vessel, lies close offshore, 1 mile N of Bolt Tail.

From a distance the coast in this vicinity appears as a line of even topped hills backed by the irregular mountainous outline of Dartmoor Hills, which rise to heights of over 500m, about 10 miles inland.

Bolt Tail (50°14'N., 3°52'W.) rises to a height of 87m about 0.3 mile within its extremity and is prominent from seaward.

Anchorage, according to draft, can be taken by small vessels in Hope Cove, on the N side of the point. It is only safe in offshore winds and local knowledge is required.

East Rutts (50°13'N., 3°59'W.), a steep-to isolated shoal, lies about 4.5 miles WSW of Bolt Tail and has a least depth of 8.9m. Two special lighted buoys (NGS West and NGS East) are moored about 2.3 miles S of the shoal.

Caution.—A spoil ground area. the limits of which may best be seen on the chart, lies 3.4 miles SSW of Stoke Point.

A continuous area of sandwaves, about 9 miles wide, lies with its centerline extending between 4.5 and 16.5 miles S of East Rutts.

The sand waves in this area attain an average height of 2 to 3m with isolated peaks of 5m. The distance between crests varies from 100m to 300m. The waves usually form in a N to S direction.

1.23 Bolt Head (50°13'N., 3°47'W.), a prominent headland, is located 3.8 miles SE of Bolt Tail. The coast between consists of a prominent succession of dark rugged cliffs rising abruptly to a height of about 120m. Large vessels are recommended to keep at least 1.5 miles off this part of the coast.

Several prominent radio masts, each 50m high, stand at an elevation of 180m near the coast, about 2.5 miles NW of Bolt Head. A fairly conspicuous notch in the cliffs exists about 0.8 mile SE of the masts.

A coast guard station stands on Bolt Head and a conspicuous radio tower is situated about 1 mile NNW of it. The headland is fronted by two small islands, known as The Mewstones.

Salcombe Harbour (50°14'N., 3°46'W.) (World Port Index No. 35380), approached between Bolt Head and Prawle Point, 2.5 miles E, is a small, well-sheltered inlet. The harbor is primarily an extensive yachting center. Vessels up to 30m in length and 5.5m draft can enter at HW. The entrance is obstructed by a bar with a least depth of 1m. A heavy sea breaks on this bar during S gales.

A range and a directional light indicate the channel across the bar; however, local knowledge is recommended. The harbor can be contacted on VHF channel 14 by day. Anchorage is available within the harbor, in depths of 5 to 8m. Anchorage is also available outside the bar, in a depth of 11m.

The town of Salcombe stands along the W side of the harbor. A ferry crosses the river between the town and Portlemouth, on the E bank. Local pilots may be obtained from Plymouth.

Start Point (50°13'N., 3°38'W.), described in paragraph 2.2, is located 3.3 miles ENE of Prawle Point.

DEPARTMENT OF THE NAVY
USS MINNEAPOLIS-SAINT PAUL (SSN 708)
FPO AE 09578-2388

5830
30 DEC 06

From: Commanding Officer, USS MINNEAPOLIS-SAINT PAUL (SSN 708)
To: [redacted]

Subj: PRELIMINARY INQUIRY INTO EVENTS OF 29 DECEMBER 2006

Ref: (a) JAG Manual (Chapter 2)

1. In accordance with reference (a), you are appointed to conduct a Preliminary Inquiry into the events on 29 December 2006.

2. You are specifically directed to make a Line of Duty/Misconduct determination for the deaths of ETCS(SS) Higgins and STS2(SS) Holtz.

3. Report your determination using reference (a) Chapter 2, Appendix A-2-h.

[redacted]

Encl (21)

31 DEC 06

From: LCDR Kevin P. Schultz, USN,
To: Commanding Officer, USS MINNEAPOLIS-SAINT PAUL (SSN 708)

Subj: PRELIMINARY INQUIRY INTO EVENTS OF 29 DECEMBER 2006

Ref: (a) JAG Manual
(b) COMNAVSUBFORINST 5400.39 (SSORM)

1. This reports completion of the preliminary inquiry conducted in accordance with Article 0203 of reference (a) into the deaths of ETCS(SS) Thomas Higgins and STS2(SS) Michael Holtz on 29 December 2006. This preliminary inquiry was conducted with the specific intent of making a Line of Duty determination for the deaths of ETCS Higgins and STS2 Holtz.

2. Personnel Contacted:

a. LCDR Brian Hogan, USN, Officer of the Deck
b. ETC(SS) James Wilson, Bridge JA Phone Talker
c. ETCS(SS) Robert May, Small Boat Handling Party
d. MMCS(SS) Richard Cherland, Crew's Mess Man-in-Charge

3. Material Reviewed:

a. USS MINNEAPOLIS SAINT PAUL (SSN 708) Maneuvering Watchbill for 29 December 2006.
b. USS MINNEAPOLIS SAINT PAUL (SSN 708) Deck Log for 29 December 2006.
c. USS MINNEAPOLIS SAINT PAUL (SSN 708) position log for 29 December 2006 as recorded in the Voyage Management System (VMS).

4. Summary of Findings:

a. ETCS Higgins and STS2 Holtz were both assigned to the Small Boat Handling Party on the 29 December 2006 maneuvering watchbill.
b. ETCS Higgins and STS2 Holtz were wearing appropriate safety gear (Kapok life jackets and safety harnesses) in accordance with Article 4318 of reference (b).
c. The Officer of the Deck gave the Small Boat Handling Party a lawful order over to proceed topside via the Forward Escape Trunk in preparation for a personnel transfer.

d. Through no fault of their own, ETCS Higgins and STS2 Holtz were swept overboard by a wave washing over the main deck and were unable to climb back aboard the ship due to heavy seas.

5. Recommendations:

a. In accordance with Article 0236d of reference (a), the investigating officer recommends finding the deaths of ETCS Higgins and STS2 Holtz "in the line of duty and not due to the members' own misconduct."

/S/

K. P. SCHULTZ

FIRST ENDORSEMENT

X Concur with recommendation.

____ Other: _____

/S/

E. J. RUFF, JR.

11 Jan 07

From: JAGMAN Investigation Team
To: Commander, Submarine Group EIGHT

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. On 8 January 2007, the JAGMAN investigation team met with Commander Ian Hugo, Queen's Harbor Master, Plymouth, England. He briefed the team about his knowledge of the facts and circumstances surrounding the subject investigation. In addition to providing the team with a hard-copy of his PowerPoint brief, he provided the following relevant information:

a. Movement of ships in Plymouth harbor is based on slack high tide at narrow portions of the channel, due to funneling of currents through this area.

b. [redacted] is a civilian Ministry of Defence employee.

c. A submarine will normally be escorted out of Plymouth Harbor with three police boats, two tugboats and the pilot boat.

d. Only one other ship was scheduled to move on 29 December 2006, a merchant vessel later in the day.

e. United Kingdom vessels usually disembark the [redacted] on the 169 leg.

f. Foreign vessels usually disembark [redacted] on the 250 leg, sometimes outside of the Plymouth breakwater.

g. Typically, [redacted] transfers will take place at approximately 4-5 knots, but can adjust as needed.

h. Sea conditions on 29 December 2006 at the time of the incident beyond the breakwater were exactly as expected by local authorities.

i. The Harbor Master believes the ship made a distinction between "inside the breakwater" and "inside the lee of the breakwater."

j. While [redacted] can each independently call off a transit in or out of Plymouth Harbor, the [redacted] retains sole authority for allowing a vessel's movement in or out

ENCLOSURE (22)

of the harbor.

k. Surface ships' transits in or out of Plymouth Harbor are restricted when wind speeds are greater than 30 knots.

l. [redacted] are not required to inform submarine commanding officers of restrictions on surface ship movements.

[redacted]

USS Minneapolis-Saint Paul (SSN 708)

Commander Naval Submarine Forces
Commander, Submarine Force U.S. Atlantic Fleet
7958 Blandy Road•Norfolk, VA 23551-2492•(757) 836-1650•Fax (757) 836-1355

Twice As Good

USS Minneapolis-Saint Paul (SSN 708) has been at the forefront of submarine operations and training since being commissioned in 1984. This has included eight major deployments of significance to the national defense of the United States. USS Minneapolis-Saint Paul's exceptional performance during these missions resulted in the ship being awarded five Meritorious Unit Commendations in 1985, 1986, 1987, 1988, and most recently 1991 for the ships operations in support of Desert Shield/Desert Storm.

The ship has excelled in many other areas during her years of commissioned service, earning the Battle Efficiency "E" five times for 1986, 1988, 1989, 1996 and 2003. In January 1992, USS Minneapolis-Saint Paul was awarded the Southwest Asia Service Medal with two Bronze Stars for her deployment to the Mediterranean Sea and was the first submarine to carry Tomahawk Missiles specifically designated for use in strike warfare in support of Operation Desert Shield/ Desert Storm.

Following a shipyard availability in the Spring of 1992, the ship completed four highly successful deployments to the North Atlantic Ocean.

USS Minneapolis-Saint Paul will continue to be a leader among her peers and a formidable threat to those opposed to the people and ideals of the United States of America.

SSN 708 Facts and Figures

- **Builders:** Newport News Shipbuilding Co. and General Dynamics Electric Boat Div.
- **Powerplant:** One nuclear reactor, one shaft
- **Length:** 360 feet (109.73 meters)
- **Beam:** 33 feet (10.06 meters)
- **Displacement:** Approx. 6,900 tons (7010.73 metric tons) submerged
- **Speed:** 20+ knots (23+ miles per hour; 36.8+ KPH)
- **Crew:** 20 officers, 132 enlisted
- **Armament:** Tomahawk cruise missiles and MK48 ADCAP torpedoes, delivered from four torpedo tubes

ENCL (23)

REROUTE DETECTED ATTENTION INVITED TO
ADMINISTRATIVE MESSAGE

ROUTINE

ZOV RUFNSAA0702 REROUTE OF RUCBCLF5066 2861722
ZUI RHHMMCB0962 2980702
ZUI RUCOMCA0322 2902042

R 131721Z OCT 06 ZYB PSN 045217H19

FM COMUSFLTFORCOM NORFOLK VA//N00//

TO ALFLTFORCOM
ALPACFLT

INFO CNO WASHINGTON DC//N00/N09/DNS/N4//
CNO WASHINGTON DC//N00/N09/DNS/N4//
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COMNAVSAFECEN NORFOLK VA//N00//
COMNAVSPECWARCOM CORONADO CA//N00//
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BT
PERSONAL FOR COMMANDERS, COMMANDING OFFICERS, AND OFFICERS IN CHARGE FROM ADMIRAL NATHMAN

MSGID/GENADMIN/COMUSFLTFORCOM//

SUBJ/FLEET RISK MANAGEMENT POLICY//

REF/A/DOC/OPNAVINST 3500.39B/30JUL2004//

ENCL (24)

AMPN/REF A IS THE OPERATIONAL RISK MANAGEMENT (ORM) INSTRUCTION//

RMKS/THIS IS A COORDINATED COMMANDER, U.S. FLEET FORCES/COMMANDER, U.S. PACIFIC FLEET MESSAGE.

2. EXPERIENCE HAS PROVEN THAT SAFETY IN GENERAL AND ORM IN PARTICULAR NEEDS CONSISTANT ATTENTION ACROSS THE FLEET. IN ORDER TO ENSURE A MORE STANDARDIZED APPROACH TO INSTILLING A CULTURE OF RISK MANAGEMENT IN ALL THAT WE DO (ON AND OFF DUTY), IT IS NECESSARY TO REFINE OUR METHOD OF AND RENEW OUR COMMITMENT TO BUILDING A STANDARDIZED AND WELL-IMPLEMENTED ORM PROCESS.

3. THE NAVY EXECUTIVE SAFETY BOARD, CHAIRED BY VCNO, IS FOCUSED ON RESTRUCTURING THE CURRENT ORM IMPLEMENTATION PROCESS. IN TURN, CFFC/CPF INTEND TO REVITALIZE AND STANDARDIZE ORM SO THAT ALL LEVELS, E-1 TO O-10, CONTRIBUTE TO A CULTURE WHERE RISK MANAGEMENT, BOTH OPERATIONAL AND NON-OPERATIONAL, IS INCULCATED INTO EVERY ASPECT OF OUR LIVES. EFFORTS CURRENTLY UNDERWAY, FOR EXAMPLE, INCLUDE THE IMPLEMENTATION OF RISK MANAGEMENT CONCEPTS INTO SEVERAL TRAINING PIPELINES, AS WELL AS RESEARCH AT THE HUMAN PERFORMANCE CENTER FOCUSED ON ENHANCING IMPLEMENTATION METHODS. GUIDANCE BASED ON THE RESULTS OF THESE INITIATIVES WILL BE COMMUNICATED SEPCOR.

4. IN THE INTERIM, COMMANDING OFFICERS WILL ENSURE THAT THE REQUIREMENTS ALREADY DELINEATED IN REF A ARE IMPLEMENTED. AS A FUNDAMENTAL FIRST STEP IN ALIGNING THE ORM PROGRAM FLEET WIDE:

A. FORMALLY DESIGNATE THE EXECUTIVE OFFICER AS THE ORM PROGRAM MANAGER IN WRITING AT EACH COMMAND. XO IS RESPONSIBLE FOR ENSURING ORM PROGRAM IMPLEMENTATION IAW REF A.

B. ENSURE AT LEAST ONE OFFICER AND ONE SENIOR ENLISTED RECEIVE TRAINING TO BECOME QUALIFIED RISK MANAGEMENT ASSISTANTS.

C. COMMAND ORM MANAGERS WILL ENSURE COMMAND INDOCTRINATION/TRAINING INCLUDES A REVIEW OF BOTH OPERATIONAL AND NON-OPERATIONAL/OFF-DUTY RISK MANAGEMENT TRAINING (IAW THE APPROVED EXECUTIVE LEVEL "ORM-101" PRESENTATION FOUND ON THE NAVAL SAFETY CENTER WEBSITE HTTP:/SAFECEN.NAVY.MIL/ UNDER THE ORM PORTAL). INCORPORATION INTO COMMAND INDOC TO BE COMPLETED FLEET-WIDE NLT 30 NOVEMBER 2006, AND IN PRACTICE, THIS TRAINING WILL BE GIVEN BY A RISK MANAGEMENT ASSISTANT WHEN SUCH ASSISTANTS COMPLETE TRAINING.

D. ALL COMMANDS WILL INCORPORATE RISK MANAGEMENT INTO COMMAND INSTRUCTIONS AND STANDARD OPERATING PROCEDURES; WILL APPLY RISK MANAGEMENT PRINCIPLES DURING ALL TRAINING, PLANNING AND OPERATIONAL EVOLUTIONS; AND WILL ENCOURAGE AND REINFORCE RISK MANAGEMENT DECISIONS BEING MADE AT THE APPROPRIATE LEVELS FOR MISSION ACCOMPLISHMENT.

E. ALL COMMANDS WILL INFORM ALL PERSONNEL OF THEIR ROLES AND RESPONSIBILITIES IN THE RISK MANAGEMENT PROCESS, ON AND OFF DUTY, IAW REF A. COMMANDS WILL ALSO ENSURE THAT THOROUGH TRAINING IS PROVIDED THAT ENABLES ALL PERSONNEL TO EFFECTIVELY UTILIZE ORM PRINCIPLES AS A MATTER OF BOTH THEIR PROFESSIONAL AND PERSONAL LIVES.

4. THE FLEET CAN NOT, AND WILL NOT, ACCEPT LOSS OF LIFE, HEALTH AND PROPERTY RESULTING FROM POOR RISK MANAGEMENT. REMEMBERING THAT WE ARE ALL LEADERS AND THAT OUR PEOPLE EXPECT AND DESERVE SAFETY LEADERSHIP, EACH OF YOU SHOULD RENEW YOUR COMMITMENT TO THE SAFETY OF THOSE WHO MAKE OUR NAVY GREAT. ADMIRALS NATHMAN AND ROUGHEAD SEND.//

BT
#0702
NNNN

DEPARTMENT OF THE NAVY
USS MINNEAPOLIS-SAINT PAUL (SSN 708)
FPO AE 09578-2388

3500
7 Nov 06

From: Commanding Officer, USS MINNEAPOLIS-SAINT PAUL (SSN 708)
To: [redacted]

Subj: DESIGNATION LETTER AS COMMAND OPERATIONAL RISK MANAGEMENT (ORM) PROGRAM MANGER

Ref: (a) COMUSFLTFORCOM NORFOLK VA 131721Z Oct 06
(b) OPNAVINST 3500.39B

1. Per reference (a), you are hereby designated as the ORM Program Manager for USS MINNEAPOLIS-SAINT PAUL (SSN 708). As such you are to become familiar with the duties and responsibilities prescribed in references (a) and (b) and other pertinent instructions regarding ORM.

/S/
[redacted]

ENCL (25)

USS MINNEAPOLIS-SAINT PAUL (SSN 708) CHECK-IN SHEET

NAME: _____ SPONSOR: _____
DATE REPORTED: _____ PREVIOUS COMMAND: _____

Welcome aboard! This check-in sheet is designed to assist you in getting acquainted with your chain of command. The goal is to have this check-In completed within two weeks. You will muster with the Personnel Officer in the Ship's Office every morning and prior to your departure until your check-in is complete. Your sponsor will assist you in this process.

PART I (COMPLETE *IN ORDER* WITHIN 24 HOURS OF REPORTING)

1. **SDO/DCPO:** _____

_____ Inform the XO/COB of new crewmembers arrival.
_____ Urinalysis within 24 hrs of reporting onboard (if work day). If it is a weekend or holiday, complete on next working day. Inform Urinalysis Program Coordinator (UPC).

2. **Ship's Yeoman:** [redacted]

_____ Verify Temporary Service Record from NSSC
_____ Verify Pg. 2/PNOK's Phone
_____ Provide Welcome Aboard Handout
_____ Introduce to CO, XO, COB
_____ Obtain copy of most Recent eval/fitrep
_____ Issue free command ball cap and command patches
_____ Verify temp Service Record
_____ Witness signing of all page 13s (enclosure (2))
_____ POD Note
_____ Add to Database
_____ Provide Command Policy Letter
_____ Identify personal/family issues requiring immediate attention and assist with filling out enclosure (8)

Meet: CO_____ XO _____ COB_____ DH_____ DO_____ LCPO_____

Date/Time Completed: _____ Initials: _____

3. **Security Officer:** [redacted]

_____ Verify JPAS printout is current.
_____ Explain security regulations and responsibilities including the safeguarding of Naval Nuclear Propulsion Information.
_____ Issue Security Brief/Debrief Statement and have members sign.
_____ Provide investigation package for personnel requiring special clearances. Date Due: _____

Date/Time Completed: _____ Initials: _____

4. **Chemistry Radiological Controls Assistant:** _____
(NOTE: Must complete Security Officer Check-in prior to CRA check-in.)

_____ Introduction to Nuclear Propulsion Plant (EDM Art. 4.9.b/Non-nuclear trained only).
_____ Indoc to Vital Ship's Equipment (SSORM 4252.2H) (CSL/CSP 5400.39).
_____ Sign Art. 212 Acknowledgement. Ensure Security Brief statement is signed (EDM 4.9.c).
_____ Explain RCLIV Remote Operability and Maintenance Precautions (EDOM 3.8.8.a/ENG Dept only).

_____ Fire in Radioactive Material Indoc (RAD Health Manual 3.2.7.b).
_____ Containment Requirements (EDM 4.9.a).
_____ Article 212 and 208 Training (for Non-Radiation workers) Article 106.1 and 212 training (for Radiation workers). Article 212 is retained indefinitely. Article 208 and 106.1 is retained until member departs.

Date Completed: _____ Initials: _____

5. **Medical Department Representative:** [redacted]

_____ Ensure the individual is properly trained and medically screened to allow the issuing of personal dosimetry.
_____ Ensure valid submarine/Radiation worker physical.
_____ Issue LiF TLD to Non Radiation workers (Verify Article 208/212 Training Complete).
_____ Train on basic first aid.
_____ Conduct Heat stress (JTM 1803), Hearing Conservation, Back Injury, and Atmosphere Monitoring Training.
_____ Ensure TRICARE medical and dental training is provided
_____ Explain sick call procedures and local dependent medical procedures

Date Completed: _____ Initials: _____

6. **LELT:** [redacted]

_____ (Radiation workers only) Issue CAF TLD (after verifying Article 106.1 and 212 training complete).

PART II (TO BE COMPLETED WITHIN ONE WEEK OF REPORTING)

1. **Leading Chief Petty Officer:** _____

_____ Introduce individual to Division.
_____ Explain divisional responsibilities, ship/department Chain of Command and ship's organization.
_____ Conduct the Basic Damage Control Indoc. (include proper donning of an EAB (within 24 hours), and how to flush toilet. Emphasize importance of not operating equipment without proper training and qualification.
_____ Check "Temp Service Record" and fill out division officer's record form. Maintain a copy of last 3 evals in Div Off. Notebook.
_____ Provide folder with complete set of qualification cards and qualification goals to be routed via the chain of command.
_____ Discuss the individual's career goals, identify items that need to be completed for advancement to next pay grade.
_____ Discuss how to route leave/special request chits.
_____ Discuss civilian court appearance policy.
_____ Review Personal Information Sheet (enclosure (7)).

Date Completed: _____ Initials: _____

2. **Division Officer:** _____

_____ Review service record and accuracy of division officer's record form.
_____ Explain advancement and evaluation procedures, individual career goals and retention.
_____ Review and forward qualification goals.
_____ Review Personal Information Sheet (enclosure (7)).

Date Completed: _____ Initials: _____

3. **Department Leading Chief Petty Officer:** _____

_____ Review Temp Service Record and accuracy of Div Off's record form.
_____ Explain role of Departmental LPO and individual's career goals.
_____ Review and forward qualification goals.
_____ Review Personal Information Sheet (enclosure (7)).

Date Completed: _____ Initials: _____

4. **Department Head:** _____

_____ Review service record and approve qualification goals.
_____ Explain Department goals for a new crew member.
_____ Discuss individual's career goals and retention
_____ Review Personal Information Sheet (enclosure (7)).

Date Completed: _____ Initials: _____

PART III (TO BE COMPLETED WITHIN TWO WEEKS OF REPORTING)

1. **Fleet Hometown News Coordinator:** [redacted]

_____ Initiate "Fleet Hometown News Release" (with member's concurrence).

Date Completed: _____ Initials: _____

2. **Assistant Qualification Officer:** [redacted]

_____ Explain Qualification/Requalification program, issue card.
_____ Explain LPO involvement with qualification program.
_____ Qualification goals are as follows:

Completed Phase I _____ Completed Phase IV _____
Completed Phase II _____ Completed Phase V _____
Completed Phase III _____ Completed Submarine Qualified _____

Date Completed: _____ Initials: _____

3. **Command Career Counselor:** [redacted]

_____ Establish NKO Account at www.NKO.navy.mil
_____ Complete Argus Survey at www.NPC.navy.mil
_____ Initiate/Review Career Development Plan for appropriate pay grade: E1-E8.
_____ Provide information on Educational Benefits, Incentive Programs, Officer Programs, Command Programs, Sea/Shore Rotation.

_____ Complete new Duty Preference Card (NAVPERS 1306/63)
_____ Complete Electronic Duty Preference Card at www.NPC.navy.mil

Date Completed: _____ Initials: _____

4. **Educational Services Officer:** _____

_____ Explain course requirements and procedures for ordering courses.
_____ Explain training and educational opportunities available.
_____ Verify preparation for next advancement examination.

Date Completed: _____ Initials: _____

5. **Drug and Alcohol Program Advisor:** [redacted]

_____ Explain Drug/Alcohol Abuse Program (including underage drinking laws) and review PG 13 on Drug and Alcohol Abuse.
_____ Screen and complete Command Screening Sheet and pass to MDR.
_____ Add to Prevent and Adams training status.

Date Completed: _____ Initials: _____

6. **Command Fitness Coordinator:** [redacted]

_____ Obtain individual's PFA Sheet. Date last PFA conducted: _____
_____ Measure and record body fat percentage.
_____ Complete risk factor screening.

Date Completed: _____ Initials: _____

7. **Schools Coordinator:** [redacted]

_____ Enter completed schools on master schools list. Verify against STMPS run.

Date Completed: _____ Initials: _____

8. **Ship's 3M Coordinator:** [redacted]

_____ 3M/PQS indoctrination.
_____ Tagout Procedure indoctrination (SOMS). (JTM 1813)

Date Completed: _____ Initials: _____

9. **Combat Systems Officer:** [redacted]

_____ Personnel Reliability Program (PRP) Screening.
_____ Force Protection Threat and Personal Security Briefing.

Date Completed: _____ Initials: _____

10. **Small Arms Petty Officer:** _____

_____ Initiate Small Arms Training Record.
_____ Sign Deadly Force Statement.
_____ Reaction Force Qualification.

11. **Safety Officer:** _____

_____ Ships Safety Briefing.
_____ Operational Risk Management Briefing.
_____ Review motorcycle safety requirements and review page 13.

Date Completed: _____ Initials: _____

12. **Electrical Officer:** _____

_____ Electrical Safety Briefing. (JTM 1808)

Date Completed: _____ Initials: _____

13. **ELCPO:** [redacted]

_____ Review proper operation of the laundry.

Date Completed: _____ Initials: _____

14. **Quality Assurance Officer:** _____

_____ QA Awareness training.

Date Completed: _____ Initials: _____

15. **LAN Coordinator:** [redacted]

_____ Enter member into SNAP.
_____ Provide LAN account.
_____ Ensure member is enrolled in NKO.

Date Completed: _____ Initials: _____

16. **Supply Officer:** [redacted]

_____ Hazmat & Atmosphere Containment training.
_____ Plastics waste training.

17. **Chief of the Boat:** [redacted]

_____ Assign Bunk and Locker.
_____ Ensure member has been issued organizational clothing by NSSC.
_____ Explain Food Service Attendant Policies, Watchstanding Organization, the Watch, Quarter and Station Bill, and SORM.
_____ Explain Proper Grooming Standards and Barracks Procedures.
_____ Explain OMBUDSMAN program. Review Ombudsman Information Sheet (enclosure 6). Provide Wife's name to Ombudsman.
_____ Discuss "Command Philosophy Letter" and Owner's Manual.
_____ Explain Grievance Procedures, Suicide Awareness, Drug/Alcohol Policy.
_____ Ensure Sexual Harassment/Orientation training has been completed.
_____ Explain items such as teamwork, sanitation, watchstanding, and Submarine Life.
_____ Review Personal Information Sheet (enclosure (7)).

Date Completed: _____ Initial: _____

18. **Executive Officer:** [redacted] **(SCHEDULED VIA POD)**

_____ Welcome Aboard Interview.
_____ Discuss ORM
_____ Review Pay/Travel issues

(Report with the below in temporary service record and approved qualification goals).

_____ Mission Statement
_____ Check-in Package
_____ SGLI Certificate
_____ Last 2 Evals
_____ Qual Goals
_____ Personal Information Sheet (enclosure (7)
_____ Page 2
_____ Review page 13s.

Date Completed: _____ Initials: _____

19. **Commanding Officer:** [redacted] **(SCHEDULED VIA POD)**

_____ Interview.

(Report with the below in temporary service record and approved qualification goals).

_____ Check-in Package
_____ SGLI Certificate
_____ Last 2 Evals
_____ Personal Information Sheet
_____ Page 2
_____ Mission Statement

Date Completed: _____ Initials: _____

ENCL (27)

Out-of-Commission Log

Equipment	Entered By	Date	JSN	Cleared By	Date
BDF Mast	[redacted]	4/30/05	OC01 - 2223		05OCT06
OOC LOG AUDIT COMPLETED SAT. NO DISCREPANCIES NOTED			- 2/28/06		—
#1 Torpedo Tube	WEPS	8/5/06	WI01 - 2253		8/16/02
OOC LOG Audit completed SAT NO DISCREPANCIES NOTED			- 8/9/06		—
#4 TT RAMMER	[redacted]	9/13/06	WI01 - 2274/2276		10/6/02
OOC LOG Audit	[redacted] SAT - NO DISCREPANCIES NOTED		10/20/06		—
SUBMARINE ID BEACON	[redacted]	11/2/06	NE01 - 01475		
OOC LOG Audit	Complete SAT NO Discrepancies		Noted	11/05/06	
~~TOTALIZER COUNTER INDICATOR~~	ETC. LINE	~~11/27/06~~	~~NE01 - 2180~~		
#1 Burner OOC	[redacted]	12/31/06	EA01 - 7520		

WASERE 12/1/0

ENCL (28)

Reduced Status Log

Equipment	Entered By	Date	JSN	Cleared By	Date
BAD -7	[redacted]	8-28-05	0001 - 2223		26OCT06
Reduced Status Conducted.			CANCEL 7/12/06		
REDUCED STATUS LOG AUDIT		ERO PANELS NOTED	7/28/06		
REDUCED STATUS LOG AU		AT NO DISCREPANCIES NOTED	8/8/06		
REDUCED STATUS LOG AUD		O DISCREPANCIES NOTED	8/20/06		
TYPE-18 EW RCUR		25OCT06	0001 - 2527		11/2/06
W/C8 BAND 6		25OCT06	0001 - 2528		11/2/06
Reduced STATUS LOG AUD		NO DISCREPANCIES NOTED		11/3/06	
AN/BQH-9 TAPE DRIVE		11/27/06	WD01-3484		
EXTERNAL HYDRAULICS		11/27/06	EA01-7482		
AN/URT-23C		11/27/06	0001-2528		11/1/07
AN/URT-23D		11/27/06	0001-2527		
BQH-1 (LOWER SOUND HEAD OOC)		11/27/06	WD01-3477		
WHISTLE (DOOR BROKEN)		11/27/06	EA01-7464		
TOTALIZER COUNTER INDICATOR		12/1/06	NE01-2180		
DIESEL GENERATOR		12/31/06	EE01-7521		

5800
Ser 00J/
14 Nov 99

From: [redacted]
To: Commander, Submarine Group SEVEN

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE LOSS OVERBOARD OF SEVEN CREWMEMBERS OF THE USS OLYMPIA (SSN 717), AND THE SUBSEQUENT RECOVERY OF THESE MEN ON 4 NOVEMBER 1999 WHILE GETTING UNDERWAY FROM BERTH 30, PORT RASHID, DUBAI, UAE

Ref: (a) JAG Manual

Encl: (1) Convening Order
(2) Statement of [redacted]
(3) Interview of [redacted]
(4) Interview with Bridge Maneuvering Watchstanders
(5) Maneuvering Watchbill
(6) Maneuvering Watch
(7) Excerpts fm Ship Systems Manual
(8) Piloting Brief
(9) Statement of [redacted]
(10) Statement of [redacted]
(11) Weather messages
(12) Email statement of [redacted]
(13) Navigation Division Pre-underway Checklist
(14) Article, The Gulf Times
(15) Statement of [redacted]
(16) Statement of
(17) Statement of
(18) Statement of
(19) Email statement of [redacted]
(20) Statement of [redacted]
(21) Statement of
(22) Statement of
(23) Excerpts fm Ship's Deck Log
(24) Excerpts fm Engineer's Bell Book
(25) Statement of [redacted]
(26) Statement of
(27) Statement of
(28) Statement of
(29) Statement of
(30) Statement of
(31) Statement of

ENCLOSURE (29)

(32) Statement of [redacted]n
(33) Statement of [redacted]
(34) Statement of [redacted]
(35) Excerpt fm COMSUBLANT/COMSUBPACINST 5400.39
(36) Statement of [redacted]
(37) Statement of [redacted]
(38) Statement of [redacted]
(39) Statement of [redacted]
(40) Statement of [redacted]
(41) Statement of [redacted]
(42) Statement of [redacted]
(43) Statement of [redacted]
(44) Statement of [redacted]
(45) Statement of [redacted]
(46) Statement of [redacted]
(47) Statement of [redacted]
(48) Statement of [redacted]
(49) Statement of [redacted]
(50) Statement of [redacted]
(51) Statement of [redacted]
(52) Medical records of [redacted]
(53) Medical records of [redacted]
(54) Medical records of [redacted]
(55) Statement of MMC [redacted]
(56) Chart with overlay [redacted]
(57) Statement of ETC [redacted]

Preliminary Statement

1. As directed by enclosure (1) and in accordance with reference (a), a command investigation was conducted into the loss overboard and subsequent recovery of seven crewmembers of the USS Olympia (SSN 717) on 4 November 1999. An extension was neither requested nor granted. All reasonably available evidence has been gathered and each directive of enclosure (1) has been met. I found that the statements of [redacted] (enclosure 2) and [redacted] (enclosure 3) conflicted. [redacted] claimed that he never discussed conditions outside the breakwater with the pilot, while [redacted] stated that he warned [redacted] of big swells outside of the breakwater and informed him that the tug and pilot boat could not go outside the breakwater. Based on my interview with the bridge maneuvering watchstanders (enclosure 4) I found the

statement of [redacted] more credible. All times, unless otherwise stated, are Delta time zone. In conducting this investigation I was assisted by [redacted] evidence are either attached to this report or are maintained onboard USS Olympia (SSN 717).

Findings of Fact

Prior to 0600, 4 November 1999, the following conditions were in existence aboard USS Olympia (SSN 717).

1. The posted and approved maneuvering watchbill did not list all watchstanders listed by the SSM (Navigation watch, OIC of anchor detail, line-throwing gun standing by in crews mess not specified). Additionally some watchstanders were assigned communications circuits contrary to the SSM (Torpedo Room watch and crews mess were assigned to JA vice UV, and anchor watch was assigned UV vice JA). Diesel operator and Reactor Technician (RT) were not specified as being on the 2JV. The pre-underway checklist was not completed or reviewed. [encl (5), (6), (7), (12)]

2. The piloting brief for the inbound leg to Dubai was actually done for Jebel Ali vice Dubai due to a late change in the port visit location. No piloting brief was conducted for the outbound transit from Dubai. [encl (8), (9)]

3. The ship received METOC Arabian Gulf weather forecasts (DTGs 021212ZNOV99 and 030012ZNOV99). These messages predicted seas of 1-2 feet in the southern Arabian Gulf 26 hours prior to scheduled underway. [encl (11), (12)]

4. The ship, however, did not receive METOC Arabian Gulf weather forecast 03 2122Z because it was screened off the broadcast by the Broadcast Control Authority (BCA) which was COMSUBPAC. This message predicted building seas of 2-4 feet 14 hours prior to underway. [encl (11), (12)]

Observed weather conditions:

5. Strong northwesterly winds of up to 34 knots brought about a sudden change to the weather on 4 November 1999. [encl (14)]

6. Within the protected breakwaters of the harbor wave height of 2-3 feet with whitecaps and winds estimated at 25 knots were observed. [encl (9), (16)]

7. Spray was observed breaking over the 20-foot high breakwater. [encl (9), (15), (17)]

8. The submarine was noted to be surging and rocking while moored to the pier. [encl (9), (15)]

Material condition of safety equipment.

9. The ship had 16 harnesses and lanyards with the shock mitigators, but only 2 properly knotted spinaround lines per the SSORM. [encl (19), (33)]

10. The ship has a portable ladder, capable of reaching from the bridge to the main deck, stored in the Forward Trim Tank. This ladder was not broken out and available for the Maneuvering Watch. [encl (10)]

11. The man overboard bag was not initially staged in the crew's mess for the maneuvering watch. Upon a report of water on deck, the bag was broken out and brought to the crew's mess [encl (20),]

Timeline.

12. 2300, 03 November [redacted] on the Maneuvering Watchbill as the OOD, retired to bed. [encl (21)]

13. 0400, 04 November: The Engineer woke up for the 0430 reactor startup brief. [encl (21)]

14. 0430 Reactor Startup Brief. [encl (21)]

15. 0730 The Engineer went forward to prepare to assume Maneuvering Watch OOD. [encl (21)]

16. 0815 [redacted] who was the designated JOOD and the Navigator [redacted] in his stateroom about piloting issues outbound. During this meeting the decision was made to keep the pilot aboard until clear of the breakwater requiring personnel to remain topside to support pilot transfer. They discussed the strong current and wind that would be present for the underway in addition to how to handle the tug and line handling for the underway. There was no discussion of conditions outside the breakwater. A formal piloting brief did not take place. [encl (2), (9), (10), (21), (22)]

17. Around 0813, [redacted] informed [redacted] that he would be topside during maneuvering watch due to the higher sea state he noted earlier in the day. [redacted] noted about a two to three foot wave height at the pier. [encl (9)]

18. 0845 The Engineer relieved the [redacted] as the Ship's Duty Officer. [encl (21)]

19. 0900 [redacted] warned the crew over the 1MC not to rush or make mistakes now that they had effectively completed their assigned tasking and were heading home. The maneuvering watch was stationed. [encl (2), (24), (10)]

20. The Engineer went to the bridge and noted a heavy southeasterly current of approximately one-knot with 2-3 foot waves inside the harbor. [encl (21)]

21. The [redacted] was never stationed. [encl (22)]

22. 0916 The outboard was lowered and tested satisfactorily. The shaft was tested on the EPM and main engines satisfactorily. [encl (23)]

23. 0945 [redacted] went topside. Lines were already being pre-staged to assist in rapidly getting personnel belowdecks once the ship was cast off in anticipation of rough seas. [encl (9)]]

24. [redacted] received a report from the Navigator of a vessel under sail expected to enter the breakwater at 1000. [encl (10), (21)]

25. 0950 [redacted] arrived on the bridge. The Pilot reported the sailing vessel to the OOD. The OOD looked at the sailing vessel and noticed heavy waves on the breakwater. The Pilot did not discuss the conditions outside the breakwater with the OOD or CO. [encl (2), (3), (4), (21)]

26. 0956 The tug arrived alongside forward port with single sternline. The Navigator reported an inbound tug in tow headed for the breakwater. The pilot arranged, via bridge to bridge radio, for the tug in tow to stop outside the breakwater and remain clear. [encl (21), (23)]

27. 0959 Ship underway. The ship used the tug and outboard to turn around and steadied on course 295 at all-ahead one-third to head for outbound track. The tug-and-tow decided to enter the breakwater anyway, and the pilot arranged a port to port passage via bridge to bridge. [encl (21), (23), (56)]

28. 1006 1/3 bell (25 turns) ordered. [encl (24)]

29. 1012 to 1017 The ship conducted various maneuvers to effect port passage with tug in tow with a general heading of 325 degrees true. The [redacted] agreed to conduct a personnel transfer 800 yards north of the breakwater. [encl (2), (23), (56)]

30. 1018 Ship was steady on course 005. Soon thereafter the OOD noticed the ship was taking water over the bow. [encl (21), (23), (56)]

31. All lines and linehandlers for lines three and four were down from topside. All non-essential personnel were ordered below by the CO. [encl (21)]

32. At the mouth of the breakwater the tug was ordered cast off by the CO. Tug is cast off and personnel forward of sail began trying to rig the forward cleats. Personnel managed to get one cleat rolled before water came over the bow [redacted] realized that the seas were unsafe for personnel topside and ordered all remaining personnel below. [encl (2),(21), (56)]

33. Approximately 1020 to 1022. Waves came over the port side of ship resulting in large amounts of water going down the forward escape trunk into the ship, wetting the mess decks and various equipment in the machinery room. [encl (2), (16), (17), (21)]
34. Both burners were secured and their breakers opened. The trim pump breaker at 1B was opened by [redacted] [encl (25), (26), (27), (28), (29), (30), (31), (32)]

35. Life preservers on personnel topside began to auto inflate as they got wet from surging seas. [encl (9)]

36. 1022 to 1028. The forward escape trunk lower hatch was ordered shut due to continued waves coming at the ship [redacted] shut the hatch. The forward escape trunk rapidly filled with water as waves came over the side. Twelve (12) people were trapped topside, seven by the forward escape trunk upper hatch – [redacted] and five on the aft starboard side of the sail – the [redacted] [encl (33), (34), (36)]

37. Those personnel whose life preservers did not auto inflate attempted to manually inflate their life preservers using the CO2 cartridge pull strings. All inflated with the exception of LT Johnson's life preserver. [encl (9), (37)]

38. The [redacted] decided to return to the harbor. The [redacted] noticed that the tug and pilot boat have already returned to the harbor. [encl (2), (21), (56)]

39. The order to get men below was again passed via phones to control. The lower hatch of the forward escape trunk was repeatedly ordered opened by [redacted] on the 7MC. However, the hatch was unable to be opened due to the forward escape trunk being full of water. The hatch was being drained via the drain valve. [encl (2), (21), (27)]

40. Harnesses were passed down to personnel topside from the bridge. The [redacted] ordered [redacted] into a harness [redacted] put the harness (with lanyard but no deck traveler) on [redacted] harness. [encl (9), (37), (38), (39)]

41. Topside personnel attempted to request the bridge to rig the long ladder from the bridge to topside to evacuate personnel through the bridge. This was unsuccessful due to communications difficulties caused by wind and noise topside. [encl (9)]

42. The ship remained at 1/3 bell to clear channel. The ship remained outbound from the channel due to the limited maneuvering room in the channel. [encl (2), (21)(24), (56)]

43. The [redacted] requested that the pilot boat remain close in the event personnel are swept over the side. [encl (23)]

44. 1025. The SPM is trained in preparation for turning the ship around. [encl (23)]

45. 1028. The ship turns right with full rudder and the SPM assistance to re-enter the harbor. Speed is increased to 30 turns to maintain steerageway through the turn. [encl (23), (56)]

46. 1031. The OOD ordered all-back two-thirds to avoid being set into the southeast shoal and shifted the rudder. He used the SPM to continue to turn the ship. The OOD estimated an approximate sea-state of four with 5-7 foot waves outside breakwater. [encl (21), (23), (56)]

47. 1034. As the ships head passed through course 100 to 120 degrees true to the right, men were washed overboard on the port and starboard sides as waves hit the boat from astern. The SPM is secured. All stop is ordered. [encl (2), (21), (23), (56)]

48. Seven men total washed overboard. [illegible] in the water away from the boat in life jackets [redacted], and three were attached to the boat by harnesses – [redacted] [encl (2), [illegible], (40), (41), (42), (43), (44), (45), (46)]

49. The escape trunk was being drained by a drain valve and a two-and-a-half inch hose to the machinery room bilge. After equipment in the machinery room was covered, an attempt was made to open the hatch using a jack but was stopped when it was determined that water has not stopped coming into the forward escape trunk. [encl (2), (9).

50. The water level in Auxiliary Machinery Room was reported as one inch below the deck plates. The bilge in the machinery room was lined up to be dewatered with the auxiliary drain pump and the watch attempted to open TD-105, the bilge suction for the drain pump. The operator for TD-105 was seized and the valve could not be opened. The watch then attempted unsuccessfully to dewater the bilge with a collapsible hose connected to TD-58 and the drain

pump. A non-collapsible hose was then hooked up to TD-58 and the bilge was dewatered successfully. Note: The dewatering took place over the course of the events that follow and the specific times for hooking up and changing out hoses are not clear. [encl (48), (49), (50)]]

51. 1035 The Navigator contacted the Dubai port control to request for rescue assistance. The Pilot boat responded. [encl (10), (23)]

52. [redacted] the lookout, ordered topside to cut personnel topside in harnesses free from boat. The CO cancelled the order because ET1 Johnson did not have an operable life preserver. [encl (2), (45)]

53. 1040 The [redacted] were picked up by the pilot boat. They were then taken to the pier and checked by medical personnel. The personnel then return to the pilot boat to return to the ship. [encl (9), (10), (17), (26), (37),]

54. [redacted] pulled himself back on to the deck of the ship and attempted to pull the others in harnesses back on board. Since he could not pull [redacted] on board, he kicked their deck crawler towards the forward escape trunk hatch. [redacted] were recovered on deck due to combination of wave action and by personnel at the forward escape trunk pulling them back on to the ship by their harness and a heaveline that was thrown to [redacted] [encl (38), (39), (43)]

55. 1043 Low Pressure blow was performed on all MBT's. [encl (19), (23)]

56. The forward escape trunk lower hatch was opened and the corpsman and EMAT team went topside to tend to injured personnel. [encl (48)]

57. 1045 USS Olympia (SSN 717) crossed inside the breakwater. [encl (19), (23)]

58. 1059 The pilot boat returned personnel to the submarine and transferred [redacted] to the pier where they were taken to the hospital by an awaiting ambulance. [encl (9), (17), (25), (36), (37), (48)]

59. 1100 Secured low-pressure blow. Wipedown team in Auxiliary Machinery Room reported water coming out of panel P-7. The breaker on 5SA1 to panel P-7 was opened by EM2 Fitzgerald and verified open by EM2 Sommerlot. [encl (23), (25), (26), (27), (47)]

60. 1135 The tug pulled alongside starboard side with a single headline. [encl (23)]

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE LOSS OVERBOARD OF SEVEN CREWMEMBERS OF THE USS OLYMPIA (SSN 717), AND THE SUBSEQUENT RECOVERY OF THESE MEN ON 4 NOVEMBER 1999 WHILE GETTING UNDERWAY FROM BERTH 30, PORT RASHID, DUBAI, UAE

61. 1150. After a report that the breaker to panel P-7 was open, [redacted] entered panel P-7 without permission in order to conduct a wipedown. While wiping the inside of the panel without an electrical safety glove, he received an electrical shock. [encl (25), (26), (27), (28), (29), (30), (51)]

62. [redacted] pulled [redacted] free of panel P-7. He received a mild electrical shock as he pulled [redacted] free. [encl (27), (28)]

63. 3SA1 and 6SA1 switchboards were secured. [encl (29)]

64. 1153. Ship is moored. Engineer went to the machinery room to take charge of damage control efforts in the machinery room. [encl (21), (23)]

65. [redacted] evacuated to hospital via ambulance. [encl (2), (9)]

Status of injuries to personnel.

66. [redacted] Electrical shock. Entry and exit wound on left hand (index finger and thumb). Minor surgery to remove charred skin. Released 6 Nov 99. (Total cost of hospitalization: 7,898 dhs) [encl (52)]

67. [redacted] Suffered an asthma attack as a result of being dragged in the water along side the ship, while attached by a safety harness. He was hyperventilating when retrieved on deck. Admitted to the hospital. Released 6 Nov 99. (Total cost of hospitalization: 3019 dhs) [encl (53)]

68. [redacted] Multiple deep abrasions covering both fore arms, hands, and fingers. Transferred to the pilot boat. Returned to the pier and transferred to the hospital. Admitted. Released 7 Nov 99. (Total cost of hospitalization: 4038 dhs) [encl (54)]

69. [redacted] Transferred to the pilot boat. Transported to the hospital, treated and released. [encl (48)]

70. [redacted] Transferred to the pilot boat. Transported to the hospital, treated and released. [encl (48)]

71. [redacted] Treated and released on the pier by medical staff. [encl (9), (48)]

72. [redacted] Treated and released on the pier by medical staff. [encl (36), (48)]

73. [redacted] Treated and released on the pier by medical staff. [encl (37), (48)]

74. [redacted] Received mild electrical shock on 4 Nov 99. Treated and released by corpsman on 7 Nov 99. [encl (28)]

75. Material status and wetted equipment in the machinery room (and status 24 hours after the event) consisted of the following:

(1) Trim Pump Motor (Grounded – freshwater wash down completed with CO's permission, ground are now satisfactory)
(2) Trim Priming pump motor (not grounded)
(3) No.1 CO-H_2 Burner Heaters (grounded, dried satisfactorily)
(4) No. 2 CO-H_2 Burner (not grounded – dried)
(5) Diesel Fuel Oil Transfer Pump (not grounded – dried)
(6) External Hydraulic Oil Transfer Pump (not grounded – dried)
(7) Emergency Diesel Generator Emergency Feeder Disconnect Box (six cables from emergency feeder disconnect removed with wire removal form – not grounded – dried)
(8) Diesel Generator Stator (grounded, cleaned and dried, retested satisfactorily next afternoon)
(9) Ship's Ventilation Charcoal Filter (athwartships) – all bags wetted, replaced by the end of evening
(10) Auxiliary Power Panel P-7 – The panel that shocked EM2 Wohlferd. The panel was tagged out with breakers to 5SA1 and 6SA1 open and voltmeter was connected to panel after drying. Panel was shut and power reapplied to loads from 5SA1 and 6SA1 one at a time to determine if short existed between 5SA1 and 6SA1 that could have caused the shock to EM2 Wohlferd. No short existed and P-7 was restored and determined to be satisfactory.
(11) TD-105: Stuck and failed to operate during the casualty. Follow-on inspection revealed the valve was severely rusted, with evidence of upper-stem bearing damage. The valve was lubricated and operated satisfactorily on 5 Nov. TD-105 was not listed on any of the ship's locally generated EGL's in support of greasing PMS. A message work candidate was submitted to replace the valve.
[encl (55), (26), (29), (30), (32)]

Scene on deck (between 1018 and 1040): Although addressed in the sequence of events (above), the sequence fails to capture in detail the emotions and actions of those personnel who remained topside during this evolution. Excerpts from the statements of those personnel are highlighted in this section in order to provide the reader more insight into the actual events as they unfolded:

76. [redacted] "We were taking waves over the deck every 5 to 10 seconds....There was an initial thought to just getting people below and not worrying about de-rigging topside until later. It was soon apparent that this would not work due to the volume of water being taken down the forward escape trunk (FET)....I tried to yell up to the bridge to

get a ladder down from the sail, but my voice was hoarse and I wasn't sure they could understand me....A large wave from aft starboard came and swept over the ship. I was surprised that everyone was still on deck because that wave washed over the ship at a height of at least 2 feet. I was getting very concerned about the waves. The next wave was even higher (at least 3 feet), and I was swept off of my feet by the wave. I managed to hold onto the CO2 overboard pipe for a second, but my grasp slipped, and I went overboard. I saw at least two other people go overboard with that wave." [encl (9)]

77. [redacted] "There was three people in harnesses that were swept over the side. [redacted] As the wave passed I yelled to the bridge man overboard port and starboard side. The waves kept coming across deck, and I couldn't get word to the bridge how many went overboard. [redacted] were trying to climb back up the hull using their lines and riding the waves. After about 5 attempts [redacted] made it back on deck. [redacted] could not get back up because he was attached to [redacted] attempted to go forward but it was to much for him. [redacted] attempted to go forward but I ordered him not to move since he had no harness or lanyard and deck traveler. When [redacted] released [redacted]'s lanyard, he drifted back by the FET. We had a heaving line in the hatch and we threw it to [redacted] and got them up on deck with us. [encl (16)]

78. [redacted] "[redacted] made it topside with [redacted] still in the water getting bashed over the side of the boat with [redacted] trying to pull them up for about 5 minutes then he pushed and pulled their deck crawler towards Fwd Escape Trunk and we threw them a heavie and [redacted] grabbed it and we pulled them up topside and I wrapped my legs around the old man and my arms around [redacted] and kept his head above water then we took one real big wave and I was almost swept over but then I held on and were back in the breakwater..." [encl (33)]

79. [redacted] "I could see the ship begin to turn to the STBD and the direction of incoming waves began to shift aft. At that moment a large wave (4') swept over the boat from the port side. Immediately a huge wave (6') came over from the STBD side. I then felt [redacted] get pulled over the side. I maintained my arm around him and began being pulled off the Port side with him. I felt my grip on [redacted] failing. I decided to maintain my grip on [redacted] and released [redacted]. We both were immediately washed over the Port side. When I felt my feet on the hull I pushed myself and [redacted] away from the ship. I lost my grip on [redacted] while under water. Upon surfacing I saw I was a good distance FWD of the boat and off the port side. I still maintained my life ring and swim fins. I quickly searched for [redacted] and saw him about 20 yards from myself....I made my way to [redacted] and found he was alright." [encl (17)]

80. [redacted] "The next thing I know another huge wave came around both sides of the sail and washed us all over the STBD side. I went under water and slammed into the side of the boat. It seemed like forever before I could get a chance to take a breath. I finally came up and got a chance to take a breath before going under again. I could hear the guys at the FWD Escape Trunk yelling. I slammed into the boat again and I started to pull myself up I got about 1/2 way before another big wave came and pushed me under. I rode that wave back up and pulled myself back on deck. I then turned and started to pull [redacted] up by their safety lanyard. Another big wave came and pushed me back over the side. I pulled myself back up topside and began efforts to pull them back up again. But the seas were too rough. The people at the Hatch were yelling pull em up [redacted]. Pull. Pull. Someone in the bridge yelled cut them loose. The [redacted] I realized I couldn't them up by myself so I started hitting the deck crawler aft in hopes that the 2 still in the water could end up by the hatch. As they went AFT I pulled up and a wave washed [redacted] grabbed him and held onto him. They also threw a heavey in the water and [redacted] grabbed it. Everyone started to pull and he also rode a wave up on deck...." [encl (43)]

81. [redacted] We took a lot of waves. I mean a lot of waves. I remember telling myself, 'Whoa, this is not good, we shouldn't be here! Waves, more waves, we kept taking them as said before the lower hatch was closed. The boat was getting bombarded. There was too much water for the hatch to be re-opened. We were screaming to the bridge. "Let us down, get us out of here! Turn around! Voom - Big wave, very big wave. I grabbed real hard to the upper hatch for my life. The wave just about washed me over. Only [redacted] kept me there. After the wave washed over I looked FWD by the sail and they were all gone. [redacted] were in harnesses so they were hanging off the side getting beat up the waves smashing into the boat .... Understand now the waves were huge from my point of view. There were several times that I was going overboard and thankfully the [redacted] and [redacted] grabbed me. All throughout this ordeal we kept hanging on to survive... I've never been so scared in my life and never felt so helpless watching my friends being beaten on the waves." [encl (44)]

Circumstances surrounding the electrical shock to [redacted]

82. Power panel P7 was wetted down as a result of seawater ingestion through the forward escape trunk. [encl (25)]

82. [redacted] was assigned to the AMR wipe down team. He noticed water was dripping out of P7. Upon receiving word that P7 was deenergized, he opened the cover and proceeded to wipedown the panel interior. He was unable to reach the back of the panel with the rubber glove on. He removed the glove and proceeded to wipe down the back of the panel with a kimwipe. He sustained an electrical shock and was unable to break contact with the electrical

source. He started yelling for help. [redacted] got a wetted rubber glove (nothing else was immediately available) and pulled him from the panel by his belt. In the process [redacted] could feel electrical current flowing up his arm. [encl (51), (25), (26), (28)]

Opinions

The causes of this mishap can be summarized into three categories. The [redacted]

1. T[redacted] had ample information or external indicators to determine that curre[redacted]uld not support either a personnel transfer or personnel topside once outside the breakwater. [fof (6), (7), (8), (20), (25), (32)]

2. Personnel topside [redacted] nd outfitted to support a personnel transfer in unprotected waters. [redacted]

3. Given the weather conditions and physical lay-out of the harbor, the decision to keep the pilot aboard through the breakwater was unnecessary for a safe departure from the harbor. (The decision to keep a tug with OLYMPIA began a domino effect which directly led to the mishap. Keeping the tug necessitated keeping the pilot. Keeping the pilot required personnel topside. Personnel topside given the weather conditions inexorably led to men in the water.) [fof (16), (17), (27)]

4. No operational necessity would have prevented a delay in the ship's scheduled departure. [fof (19)]

[redacted]

5. [redacted] [fof (5), (6), (7), (8), (16)]

6. Contrary to [redacted] statement, he provided little if any assistance to the ship's bridge watch team. Specifically, he provided no information regarding weather conditions. [fof (25)]

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE LOSS OVERBOARD OF SEVEN CREWMEMBERS OF THE USS OLYMPIA (SSN 717), AND THE SUBSEQUENT RECOVERY OF THESE MEN ON 4 NOVEMBER 1999 WHILE GETTING UNDERWAY FROM BERTH 30, PORT RASHID, DUBAI, UAE

7. [redacted] failed to schedule a piloting brief for the underway outbound from Dubai. It just never dawned on them to do one even though they were in port for 7 days. Contributing to this was the familiarity they perceived to have with this port. From their perspective Port Rashid is an easy port to get in and out of. However, OLYMPIA had only piloted in and out of Dubai once before and approximately six weeks had elapsed since then. [fof (2), (9), (10), (16)]

8. All equipment required by the Maneuvering Bill was not appropriately staged, specifically the Man Overboard bag. Additionally, the ship's long ladder, if broken out, could have provided an additional option to the bridge team when addressing the mishap. [fof (10), (11)]

9. Improper rigging of the safety harnesses significantly contributed to the injuries sustained by [redacted] and very nearly led to their drowning. [fof (07), (08), (20), (30)]

10. Employment of heavy weather equipment, specifically a bathtub rig attached to the forward escape trunk, would have minimized water damage to equipment, and enabled the ship to keep the lower hatch to the Forward Escape Trunk open. [fof (32)]

11. Ship failed to actively seek the most current weather report. (Specifically, the most recent METOC message was not onboard.) [fof (3)]

12. The broadcast control authority (COMSUBPAC) screened the most recent weather message (031212Z) and prevented USS Olympia from receiving it. This message would have warned the ship of building seas. [fof (4)]

Weather:

13. An unusual northwest wind (in excess of 25 knots) created difficult sea conditions that were not expected. [fof (3), (5)]

Minor opinions and observations:

14. No one in authority looked at the watchbill arrangement concerning critical positions: specifically the [redacted]. In this case, the [redacted] for the maneuvering watch was the Engineer who [redacted] with the Reactor and Engineroom startup. As a consequence, he went to bed at 2300 the night before and got up at 0400 to supervise the engineroom startup. In the middle of this complex evolution, he had to disengage himself and refocus his attention to getting the ship underway. In the meantime, his designated Junior Officer of the Deck, the Supply Officer is also busy in closing out port service accounts. Although the Supply Officer managed to discuss the underway routine with [redacted] he failed to

stand his watch so that he could tend to port service accounts and last minute Supply Department business. Interestingly enough, the Supply Officer was in the same predicament the last time they got underway from Dubai. It is apparent that the [redacted] did not learn from this. [fof (12), (13), (14), (15), (16), (18), (21)]

15. The ship requires increased attention to certain administrative functions. The ship's pre-underway administration was far from complete. The navigation department pre-underway checklist was not completed, nor was it reviewed by the division LPO, the ANAV or the Navigator. Additionally, the maneuvering watch watchbill was not properly manned. [fof (11)]

16. The injuries sustained by [redacted] were sustained in the line of duty not due to their own misconduct. [fof (66), (67), (68), (78), (80), (83)]

Recommendations

1. I recommend that [redacted] be awarded the Navy Commendation Medal for his potentially lifesaving action in pulling [redacted] off of P-7 and preventing further shock.

2. I recommend that [redacted] be awarded the Navy Commendation Medal for his efforts to rescue [redacted]

3. I recommend that [redacted] be awarded the Navy Commendation Medal for his efforts to assist [redacted]

4. I recommend that [redacted] and the [redacted] be recognized with Navy Commendation Medals for their rapid, professional response to the medical emergencies.

5. I recommend that, with the assistance of U.S. Naval Forces, Central Command, [redacted] and his crew be properly recognized for recovering four crewmembers of the USS Olympia (SSN 717) from the water.

6. I recommend that [redacted] receive a non-punitive letter of caution for failing to inquire into the winds or sea state outside of the breakwater. Furthermore, given the information and weather indicators he did observe, [redacted] demonstrated poor judgement in keeping the tug with USS Olympia (SSN 717) and attempting a personnel transfer outside of the breakwater. Additionally, [redacted] failed to ensure his ship was properly briefed for this underway and ready for all contingencies.

Subj: COMMAND INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE LOSS OVERBOARD OF SEVEN CREWMEMBERS OF THE USS OLYMPIA (SSN 717), AND THE SUBSEQUENT RECOVERY OF THESE MEN ON 4 NOVEMBER 1999 WHILE GETTING UNDERWAY FROM BERTH 30, PORT RASHID, DUBAI, UAE

[redacted]

[redacted]

[redacted]

[redacted]

11. I recommend that an independent assesment be made of the ship's training effectiveness targeted towards preparations for entering and departing ports, topside safety with respect to underways, conduct of pre-underways and the effectiveness of the ship's pre-underway checklist.

12. I recommend that an administrative review training within the Navigations/Operations department be conducted.

13. I recommend that COMHELHEL I discuss with port authorities in Dubai the necessity to have pilots inform the ships of prevailing weather conditions outside the protected harbor.

14. The broadcast control authority should take steps to ensure that the most recent weather messages are delivered to ships.

[redacted]

Investigating Officer

Required Reading (Class [illegible])

00X - [redacted]
From
Sent: [illegible] 8:27 AM
To: CWO - Communications Watch Officer; 00X - CAPT(SEL) Glen A. Nederhauser; 00X2 - FTCS A [illegible] L. Kerney; N7000 - CDR Joe Watkins; N701 - LCDR Scott A. Maple; #NHMS@HQ.CSP.NAVY.SMIL.MIL; [illegible]; RamseyDC@hq.csp.navy.smil.mil; CDWOCSP@wisdtuk@hq.csp.navy.smil.mil; CCOMCSP@hq.csp.navy.smil.mil; CWO - Communications Watch Officer; CCWOCSP@hq.csp.navy.smil.mil; MDCCSP@hq.csp.navy.smil.mil; MurphyTJ@hq.csp.navy.smil.mil; [illegible]; BarcomR@hq.csp.navy.smil.mil; [illegible]; HaleAM@hq.csp.navy.smil.mil; [illegible]; [illegible]; [illegible]; [illegible]; MacDougalJA@hq.csp.navy.smil.mil; [illegible]; STTCSP@hq.csp.navy.smil.mil; N701 - LCDR Scott A. Maple; N00X1 - Lt Neal H. [illegible]; MontaqDP@hq.csp.navy.smil.mil; [illegible]; CucciwJD@hq.csp.navy.smil.mil; [illegible]; [illegible]; [illegible]; GuaddoLC@hq.csp.navy.smil.mil; [illegible]; RogersMA@hq.csp.navy.smil.mil; DunoulaWT@hq.csp.navy.smil.mil; [illegible]; [illegible]; MatousDM@hq.csp.navy.smil.mil; HesterHL@hq.csp.navy.smil.mil; ParkerTR@hq.csp.navy.smil.mil; HamilJJ@hq.csp.navy.smil.mil; GraerRC@hq.csp.navy.smil.mil; HainiRL@hq.csp.navy.smil.mil; RoycerRT@hq.csp.navy.smil.mil; HoranRJ@hq.csp.navy.smil.mil; WeinhsWL@hq.csp.navy.smil.mil; CarusDJ@hq.csp.navy.smil.mil; EsselbRR@hq.csp.navy.smil.mil; [illegible]; FeltovJG@hq.csp.navy.smil.mil; HartingMR@hq.csp.navy.smil.mil; [illegible]
Subject: DRAFT MAN OVERBOARD LESSONS LEARNED:240997Z NOV:UNCLAS

-------- U N C L A S S I F I E D --------

RATUZYUW RHHMMCC2246 3280954-UUUU--RHHMDBA
ZNR UUUUU ZLT RUAYIAA7742 3285307
R 240997Z NOV 99 ZYB PSN 380941H02
FM COMSUBGRU SEVEN
TO RHHMDBA/COMSUBPAC PEARL HARBOR HI
INFO RUAYIAC/CTG SEVEN FOUR PT TWO//TCO//
BT
UNCLAS //N04790//
MSGID/GENADMIN/CSG//
SUBJ/DRAFT MAN OVERBOARD LESSONS LEARNED//
RMKS/1. THE FOLLOWING PROPOSED LESSONS LEARNED MESSAGE IS PROVIDED FOR COMSUBPAC REVIEW AND FORWARDING TO ALL SUBFAS. [illegible]

R XXXXXXZ NOV 99

FM COMSUBPAC PEARL HARBOR HI
TO SUBFAS
INFO COMSUBLANT NORFOLK VA
BT
UNCLAS //N04790//
MSGID/GENADMIN/COMSUBPAC/NOV//

ENCL (30)

SUBJ/MAN OVERBOARD LESSONS LEARNED//
RMKS/1. RECENTLY SEVEN CREWMEMBERS WERE WASHED OVERBOARD AND ANOTHER WAS ELECTRICALLY SHOCKED AS A RESULT OF HEAVY SEAS DURING AN UNDERWAY. THIS INCIDENT INDICATES A SERIOUS DEFICIENCY IN OPERATIONAL RISK MANAGEMENT BY OUR SUPERVISORS.

2. *THE FOLLOWING SUMMARIZES THE INCIDENT:*

A. **SHIP WAS UNDERWAY ON THE SURFACE DURING THE MANEUVERING WATCH** PROCEEDING OUT OF A PROTECTED HARBOR INTO UNSHELTERED COASTAL WATERS. PRIOR TO UNDERWAY, SHIP OBSERVED HIGH WINDS, CHOPPY WAVES UP TO THREE FEET INSIDE THE BREAKWATER, AND PERIODIC SPRAY COMING OVER THE BREAKWATER.

B. **WHEN EXITING THE BREAKWATER WITH THE SMALL BOAT TRANSFER PARTY** TOPSIDE, THE SHIP TOOK NUMEROUS WAVES OVER THE DECK AND INTO OPENED FORWARD ESCAPE TRUNK AND A SIGNIFICANT AMOUNT OF WATER WAS TAKEN ONBOARD. THE FORWARD ESCAPE TRUNK LOWER HATCH WAS SHUT TO PREVENT FURTHER FLOODING. THE FORWARD ESCAPE TRUNK THEN QUICKLY FILLED WITH WATER PREVENTING ITS REOPENING. TWELVE PERSONNEL WERE TRAPPED TOPSIDE.

C. **ALL PERSONNEL REMAINING ON DECK ATTEMPTED TO INFLATE THEIR LIFE** VEST. ONE LIFE VEST DID NOT INFLATE. TWO OF THE THREE PERSONNEL IN HARNESSES ATTACHED THEMSELVES TO THE DECK AND THE OTHER ATTACHED HIMSELF TO A CREWMEMBER WHO WAS ATTACHED TO THE DECK AS HE DID NOT HAVE A DECK CRAWLER.

D. **AS THE SHIP MANEUVERED TO RETURN TO PORT, SEVERAL LARGE WAVES** WASHED OVER THE DECK SWEEPING THE SEVEN PERSONNEL OVERBOARD INCLUDING THE THREE PERSONNEL IN HARNESSES. THE PERSONNEL IN HARNESSES WERE STILL ATTACHED TO THE SAFETY TRACK. THE INDIVIDUAL WHO WAS ATTACHED BY HIMSELF WAS ABLE TO CLIMB BACK ON DECK AFTER SEVERAL ATTEMPTS. HE THEN ATTEMPTED TO RECOVER THE TWO INDIVIDUALS WHO WERE HARNESSED TOGETHER BUT WAS UNABLE TO DO SO DUE TO THEIR WEIGHT. FINALLY, WITH AID OF SEVERAL CREWMEMBERS AND THE SEAS WASHING OVER THE DECK, BOTH PERSONNEL WERE RECOVERED.

E. **AFTER THE SHIP ENTERED THE BREAKWATER, THE FWD ESCAPE TRUNK WAS** DRAINED AND THE PERSONNEL TOPSIDE WERE RECOVERED. THE TWO PERSONNEL TETHERED TO THE SHIP TOGETHER SUSTAINED INJURIES REQUIRING HOSPITALIZATION. ONE PETTY OFFICER REQUIRED HOSPITALIZATION DUE TO MULTIPLE DEEP LACERATIONS AND ABRASIONS TO BOTH ARMS AND HANDS. THE OTHER WAS HOSPITALIZED FOR THREE DAYS FOR OBSERVATION RELATING TO SEAWATER INGESTION. THE FOUR PERSONNEL WASHED CLEAR OF THE SHIP WERE PICKED UP BY THE PILOT BOAT AND RECEIVED MINOR ABRASIONS.

F. **MULTIPLE PIECES OF EQUIPMENT IN THE AUXILIARY MACHINERY ROOM** UNDER THE HATCH WERE WETTED. DURING WIPE DOWN, AN EM2 NOTED WATER DRIPPING OUT OF AN ELECTRICAL POWER PANEL AND DIRECTED ITS FEEDER BREAKER BE OPENED. ONCE BREAKER WAS REPORTED OPENED, HE COMMENCED WIPE DOWN. IN AN ATTEMPT TO GAIN BETTER ACCESS TO THE BACK OF THE PANEL,

HE REDUCED [illegible] SAFETY CLUTCH [illegible] HAND AND COULD NOT RELEASE HIMSELF FROM THE PANEL. ANOTHER SAILOR IN THE [illegible] HEARD HIS CRY FOR HELP AND PICKED UP [illegible] GLOVE AND PULLED HIM OUT OF THE PANEL. THE PMS WAS TRANSFERRED TO THE HOSPITAL AND TREATED FOR THIRD DEGREE BURNS AND ELECTRICAL SHOCK. THE AMR WAS DEWATERED AND ALL OTHER ELECTRICAL EQUIPMENT WAS WIPED DOWN. THE SHIP RETURNED TO PORT.

3. *LESSONS LEARNED:*

A. ALTHOUGH AWARE OF HEIGHTENED WEATHER CONDITIONS INSIDE THE HARBOR, NO ONE IN THE SHIPS SENIOR LEADERSHIP QUESTIONED THE WEATHERS IMPACT ON SEA CONDITIONS OUTSIDE THE BREAKWATER. NO NAVIGATION PERSONNEL HAD OBTAINED THE LATEST WEATHER REPORT FOR THE AREA. COMMANDING OFFICER, NAVIGATOR, AND OOD DID NOT CONSULT THE PILOT CONCERNING WEATHER CONDITIONS OUTSIDE THE BREAKWATER. CONTRIBUTING TO THIS WAS THE FACT THAT A PILOTING BRIEF WAS NOT CONDUCTED PRIOR TO DEPARTURE, ALTHOUGH THE SHIP HAD BEEN IN PORT FOR SEVEN DAYS.

B. THE DECISION TO KEEP THE PILOT ONBOARD THROUGH THE BREAKWATER WAS UNNECESSARY FOR A SAFE DEPARTURE FROM THE HARBOR. PHYSICAL LAY OUT OF THE HARBOR WOULD HAVE ALLOWED CONDUCTING THE PILOT TRANSFER PRIOR TO THE BREAKWATER. THIS DECISION TO KEEP THE PILOT BEGAN A DOMINO EFFECT THAT DIRECTLY LED TO THE MISHAP. HAD AN ADEQUATE OPERATIONAL RISK ASSESSMENT BEEN DONE, THE MISHAP COULD HAVE BEEN AVOIDED.

C. THERE WAS NO OPERATIONAL NECESSITY THAT WOULD HAVE PREVENTED A DELAY IN THE SHIPS SCHEDULED DEPARTURE. AGAIN AN INADEQUATE OPERATIONAL RISK ASSESSMENT LED TO THE CHAIN OF EVENTS CAUSING THIS MISHAP.

D. THE MAN OVERBOARD BAG WAS NOT APPROPRIATELY STAGED AS REQUIRED BY THE MANEUVERING BILL. ADDITIONALLY THE SHIPS LONG LADDER TO THE SAIL IF BROKEN OUT COULD HAVE PROVIDED AN ALTERNATE MEANS OF ESCAPE FOR THE PERSONNEL TRAPPED TOPSIDE. A LACK OF PROCEDURAL COMPLIANCE AND THE FAILURE OF SUPERVISORY PERSONNEL TO CHECK THESE ITEMS ALLOWED THESE MISTAKES TO OCCUR.

E. PERSONNEL TOPSIDE WERE NOT PROPERLY OUTFITTED TO SUPPORT A PERSONNEL TRANSFER IN UNPROTECTED WATERS. IMPROPER RIGGING OF SAFETY HARNESSES SIGNIFICANTLY CONTRIBUTED TO THE INJURIES SUSTAINED BY THE THREE PERSONNEL WASHED OVERBOARD. INADEQUATE TRAINING AND THE FAILURE OF THE SENIOR SUPERVISORS TO CHECK THE CONDITION OF THE PERSONNEL TOPSIDE DIRECTLY LED TO THESE INJURIES.

F. NO SUPERVISORY PERSONNEL REVIEWED THE WATCH BILL ARRANGEMENT CONCERNING CRITICAL POSITIONS. IN THIS CASE THE OOD FOR THE MANEUVERING WATCH WAS THE ENGINEER WHO WAS PREOCCUPIED WITH THE REACTOR AND ENGINEROOM STARTUP. AS A RESULT, HE HAD TO DISENGAGE HIMSELF FROM THIS EVOLUTION AND REFOCUS HIS ATTENTION TO GETTING THE SHIP UNDERWAY. THE JOOD (THE SUPPLY OFFICER) WAS BUSY CLOSING OUT PORT SERVICE ACCOUNTS

AND FAILED TO REPORT TO THE BRIDGE. A REVIEW BY THE SENIOR LEADERSHIP SHOULD HAVE PREVENTED THIS FROM OCCURRING.

G. PETTY OFFICER REMOVED HIS SAFETY GLOVE AND ENTERED A DERANGED

ELECTRICAL PANEL WITH NEITHER PROPER ELECTRICAL SAFETY PRECAUTIONS NOR PERMISSION.

4. THIS CASUALTY CAUSED MINOR DAMAGE TO EQUIPMENT AND SERIOUS INJURY

TO PERSONNEL. THIS INCIDENT WAS AVOIDABLE.
.BT
..UNQUOTE..//
BT
#2246
NNNN
N471 (ACT)
N7 N61 CCWO COW MDC N621A N45 N452A N454 N462 N46 N66 N312
N00X N701A N711 N712 N74 N741 N742 N7411 N7412 N714 N715
N751 N752 N753 N754 N701 N3126 N64 N64A N64B N60 N63 N611
N633 N61B N61C N61D N61E N65 CWO N61
!!! /D6/8/11/5/N047*/35135/
!!! /D6/10/26/15/LESSONS/31900/
!!! /D6/11/49/8/MESSAGE*/33410/

From: [redacted]
To: Commander, Submarine Group EIGHT

Subj: PERSONAL OBSERVATIONS WRT PLYMOUTH HARBOR AND BREAKWATER

Encl: (1) PowerPoint slides

1. On 8 January 2007, [redacted] transited the prescribed Plymouth harbor outbound track in a Queen's Harbor Master pilot boat. Weather conditions were similar to, though less severe, than those that existed on 29 December 2006: visibility was approximately 6000 yards in light rain; wind was 25-30 knots from the southwest. Tide was on ebb, about halfway towards low tide. The following observations were noted.

a. In the middle and slightly on the harbor side of the breakwater, there is a tall fort structure that would protrude well above the water even at high tide when the breakwater itself would be mostly submerged.

b. Waves and spray could easily be seen over the top of the breakwater and against the west breakwater light.

c. On the harbor's north shore, waves could be seen breaking on the rocks beyond the breakwater's lee, but waves were not breaking on the shore protected by the breakwater.

d. While on the 250 leg and looking ahead, it was not apparent visually that large swells existed beyond the breakwater. The pilot boat coxswain concurred, noting that the pilot boats usually needed to go past the breakwater's west end to determine actual swell magnitude.

e. Waves inside the harbor were 3-5 feet. Immediately behind the breakwater waves were 1-2 feet.

f. Approximately 100 yards from the breakwater's west end (Plymouth Breakwater Light bearing 190°), it was possible to see the large swells (8-10 feet high) beyond the breakwater's lee.

g. At the point where the pilot left USS MINN-ST. PAUL's bridge near the "C" mooring buoy, the Plymouth

Breakwater Light appeared close enough that continuing on the 250 track at 8 knots would quickly take a vessel well beyond the breakwater's end.

h. Conditions in the swell beyond the end of the breakwater were such that recovery of personnel attached to a submarine would be impossible.

i. Enclosure (1) shows several views of Plymouth Sound and Plymouth breakwater.

/5/

[redacted]

ENCL (31)

PLYMOUTH HARBOR OVERVIEW AT LOW TIDE – SHIP AT MOORING BOUY "E"

PLYMOUTH HARBOR OVERVIEW WITH OUTBOUND WARSHIP – BREAKWATER AT HIGH TIDE

WARSHIP NEAR LOCATION OF INCIDENT

APPEARANCE OF PLYMOUTH BREAKWATER LIGHT FROM MOORING BUOY "C"

WAVES ON NORTH HARBOR SHORE AT LOCATION OF BREAKWATER'S LEE

SEA CONDITIONS JUST INSIDE BREAKWATER'S LEE

SEA CONDITIONS JUST BEYOND BREAKWATER'S LEE

[redacted]

From: [redacted]
Sent: Wednesday, January 10, 2007 10:19 PM
To: [redacted]
Cc: [redacted]
Subject: RE: MSP INVESTIGATION DATA

[redacted]

Below is additional information requested:

29DEC06 Plymouth Harbor UK

Tides:

LOW: 0628-3.59ft

HIGH: 1231-14.31ft

LOW: 1857-3.51ft

SLAP: No offset from Zulu

Sunrise- 0743
Sunset- 1547
Moonrise-1150
Moonset- 0149

Illumination- 70%

[redacted]

-----Original Message-----
From: [redacted]
Sent: Wednesday, January 10, 2007 4:03 PM
To: [redacted]
Cc: [redacted]
Subject: RE: MSP INVESTIGATION DATA (UNCLASSIFIED)

[redacted]

The attached files (letter and referenced enclosures relating to the MSP incident) are forwarded for your use in your investigation.
r/

[redacted]

Caveats: NONE

ENCLOSURE (32)

DEPARTMENT OF THE NAVY
NAVAL MARITIME FORECAST ACTIVITY
9141 THIRD AVENUE
NORFOLK, VIRGINIA 23511-2394

3140
Ser 00/3/S001
10 Jan 07

From: Officer in Charge, Naval Maritime Forecast Activity, Norfolk

To: [redacted]

Subj: WEATHER RELATED DAMAGE ICO USS MINNEAPOLIS ST PAUL

Encl: (1) Timeline of events
(2) WEAXs sent to USS MINNEAPOLIS ST PAUL (u)
(3) Bouy data
(4) QuickScat data
(5) Plymouth observation data

1. As per your request, the enclosed information is provided.

2. If you have any additional questions, my point of contact is [redacted].

/s/
[redacted]

[redacted]

ENCLOSURE (33)

TIMELINE OF EVENTS

280636Z Chat between NMFA OTSR and NEPOCC. OTSR advises that MSP will see gales with 21-25 ft seas 29/12Z - 30/12Z west of the channel. NEPOCC states that CTF69 is aware of the forecasted conditions.

280653Z WEAX VT:281200Z. Outlook period indicates gales and seas 8-10 ft rapidly building beyond the breakwater to 12-16.

281958Z QuickScat indicates winds 180@20KT in the channel vicinity Plymouth.

290328Z WEAX VT:291200Z. Indicates gales and 14-18ft seas building 21-25.

290750Z EGHD(Plymouth airport approx 12 miles inland) Winds: 190@20G30KT, Vis: 4 miles in rain.

290800Z EGDB (Plymouth Mount Batten, port entrance) Winds: 190@32KT, Vis: 3 miles in rain.

290800Z Channel Lightship bouy 62103 (in center of channel south of Plymouth) Winds: 180@33KT, Seas 8.9ft.

290950Z EGHD Winds:200@20G32KT, Vis 1.25 miles in rain and fog.

291000Z EGDB Winds: 200@32KT, Vis 1.7 miles in rain.

291000Z 62103 Winds: 180@35KT, Seas 11.5ft.

291130Z MSP scheduled departure time from Plymouth per SUBNOTE 181423Z.

291150Z EGHD Winds: 20@18G28KT, Vis .5 miles in rain and fog.

291200Z EGDB Winds: 200@31KT, Vis 1.6 miles in rain.

291200Z 62103 Winds: 180@26KT, Seas 11.5ft.

291226Z MSP incident occurs.

291341Z Chat between NMFA CDO and NOAD Naples provides initial report of the incident.

291415Z MSP SITREP reports shipboard mishap. CDR Sims informs

NMFA CDO of possible casualties.

291513Z QuickScat indicates winds 200@35-40KT in the channel vicinity Plymouth.

291631Z CTF69 SITREP is follow up on MSP mishap, reports 2 fatalities.

291830Z C6F Staff Oceanographer email (CNE-C6F Staff O Oceanographer/METOC Officer), email states that CTF69 was briefed on the heavy weather and advised to get underway the next day instead.

Data from bouys 62103, 62305 and 62304 29 Dec 2006

ENCLOSURE (34)

SECTION G - Mission Planning Practical Exercises (U)

1. (U) There are five practical exercises. If operations of opportunity permit, actual performance of these exercises is preferred since the experience will be richer. In every case however, a simulated situation is allowed. Where applicable, your plan should include chart preparation, ship's tracks, navigation plans, watch-bills, timelines, force protection plans, decision points, and tripwires to conduct the evolution. Brief these exercises/plans to the Commanding Officer and wardroom. Lessons learned from incidents and problems experienced by the submarine force conducting the missions should be included. Suggested incidents are noted. Two of these briefs, chosen by the qualifying officer, will be presented to Squadron Commander or Post-Command Deputy Commander.

a. (U) Anchoring. Prepare to anchor your ship in a deployment anchorage designated by the Commanding Officer. When preparing for and briefing this event, the lessons learned from USS JEFFERSON CITY dragging anchor in Thailand should be included.

_____

Commanding Officer/ Date
Squadron Commander

b.

_____

Commanding Officer/ Date
Squadron Commander

c.

(5) Phase V: After execution, a set of External Deliverables is developed. These include all messages and reports to the operational commander. A self assessment is used to improve internal planning and standing tactical plans. It might also result in a BP/LL deliverable to the force.

d. This model can be used for a relatively short-term mission (e.g. a HUMEVAC), a longer event (e.g. a choke point transit), or an extended event (e.g. an ISR mission, although for an extended mission, the plan should be updated to reflect BP/LL learned during the mission).

e. The intent of this model is NOT to develop a checklist to be executed by rote. On the contrary, the planning process, combined with proper training and briefing, is intended to improve situational awareness by leveraging experience and stimulating thought during the planning phases. Used in this way, the plan then enables true forceful backup by trained operators and fluid decision-making by officers who are acutely aware of their priorities, tasking, adversary and environment.

f. Enclosure (2) is a planning template. As stated above, every evolution will not require the fully developed outline. Scale the plan to the evolution, including those elements that are appropriate. For complex evolutions, the template provided might be filled out completely to help ensure the right questions are being explored. Use the template with the following techniques to prepare your plan:

(1) Phase I: External Tasking

(a) Commander's Intent. Review the mission and situation. Study the tasking. Break it down into primary and secondary tasking; specified and implied tasks. Make sure you understand the *intent* of the tasking. Consider the available intelligence and Rules of Engagement associated with the tasking. Understand what deliverables will be required at the end of the mission.

WITHHELD IAW
5 USC 552(b)(1)

WITHHELD IAW
5 USC 552(b)(1)

Chapter 9

THE SENIOR OFFICER PRESENT

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0901. The Senior Officer Present.

Unless some other officer has been so designated by competent authority, the "senior officer present" is the senior line officer of the Navy on active duty, eligible for command at sea, who is present and in command of any part of the Department of the Navy in the locality or within an area prescribed by competent authority, except where personnel of both the Navy and the Marine Corps are present on shore and the officer of the Marine Corps who is in command is senior to the senior line officer of the Navy. In such cases, the officer of the Marine Corps shall be the senior officer present on shore.

0902. Eligibility for Command at Sea.

All officers of the line of the Navy, including Naval Reserve, on active duty, except those designated for the performance of engineering, aeronautical engineering or special duties, and except those limited duty officers who are not authorized to perform all deck duties afloat, are eligible for command at sea.

0903. Authority and Responsibility.

At all times and places not excluded in these regulations, or in orders from competent authority, the senior officer present shall assume command and direct the movements and efforts of all persons in the Department of the Navy present when, in his or her judgment, the exercise of authority for the purpose of cooperation or otherwise is necessary. The senior officer present shall exercise this authority in a manner consistent with the operational

ENCLOSURE (39)

The ship is getting underway, approaching restricted waters, operating in restricted waters, or operating in open ocean.

2.3 PROCEDURES

2.3.1 PROCEDURES FOR NAVIGATING IN RESTRICTED WATERS

a. The Navigator shall prepare a voyage plan for safe and prudent passage, including piloting. In preparing this plan, the Navigator shall ensure that:

(1) The information obtained for preparing a navigation plan will be the most current information available.

(2) All charts to be used, including digital charts, are corrected in accordance with **Reference 6** and all charts are compared to ensure that hazards to navigation are properly annotated. Use of the paper and electronic chart correction information from the NGA website (www.nga.mil) to support this effort is encouraged.

(3) Piloting charts are selected based upon the largest scale charts available with consideration given for navigation aid availability, plotting surface size, and parallel motion protractor (PMP) mobility.

(4) The ship's proposed track is laid down on all charts used for navigation in restricted waters, including VMS, other electronic (commercial) plotters, the bridge, the navigation plot, and any training plots. It is acceptable to use Electronic Chart Display units on the bridge and in Sonar, however paper charts shall be used if the electronic display is inoperable or when digital charts are not available. The information required by the Piloting Preparations Checkoff and/or the Planned Operations/Navigation Checkoff lists of Reference 1 must be documented for each leg of the track on all charts and to the extent possible, any electronic navigation systems.

(5) GPS waypoints should be entered into the WRN-6 and all Commercial GPS units and the planned track should be entered into the VMS and any other commercial electronic charting systems installed. Waypoint entries must be verified entered correctly prior to navigation using these electronic systems.

(6) Upon shifting to a new GPS waypoint, the Navigator or Navigation Supervisor shall personally verify this new waypoint is correctly displayed. The purpose of this in situ check of every waypoint, is to mitigate the risk of fixing ship's position using GPS waypoints. Submarine groundings and near-groundings have occurred due to improper entry and/or use of GPS waypoints when used as a fix source (i.e. bearing and range to a predetermined waypoint). Commanding Officers must ensure measures are in place to eliminate the possibility of improper waypoint entry into any navigation system if those waypoints will be used to determine ship's position.

b. The Navigator and OOD shall brief all members of the navigation piloting party, before sailing or entering restricted waters. This briefing will conform to the following guidelines:

(1) The briefing will normally include a review of the navigation plan including a review of all tracks and charts to be used while in restricted waters with emphasis on navigational hazards, navigational aids anticipated to be used, tides and

currents, predicted weather conditions, contingency plans, GPS datum, expected traffic flow, expected depth of water and associated red, yellow and minimum expected soundings, the nomenclature to be used by all members of the party when referring to navigational aids, day/night characteristics of all navigation landmarks intended for use, assignment of personnel to party stations, and a review of duties. The OOD should discuss his plan for turns, mooring and line handling, use of the SPM (when to lower, train, and secure, as a minimum). He should be familiar with and discuss use of navaids (including headmarks, sternmarks, danger bearings and turn bearings), currents, proximity to shoal water and points of action (pilot pickup, blind bend signals, communication points, etc). Photos of navigation aids should be an integral part of the preparation of the bridge party.

(2) A piloting brief shall precede every piloting evolution before sailing or entering restricted waters. The contents of the brief and the required attendees may be modified according to the situation and experience level. For example, frequently visited ports may warrant an abbreviated briefing of the key elements described in paragraph 2.3.1.b.(1). Furthermore, a piloting brief preceding the submerged transit of a narrow strait in restricted waters may only involve applicable watchstanders of the affected watchsection(s).

(3) This briefing should not be combined into both an entering port and getting underway brief for a completely unfamiliar port (e.g., a liberty port on an overseas deployment). Instead, the underway brief should be conducted a short time prior to leaving port.

c. The Navigator shall verify that all navigation equipment is on board and operating properly and that the navigation pre-underway or entering port checklists are completed in accordance with **Reference 1**, navigation department checklists, and individual equipment operating procedures. The Navigator shall critically evaluate the impact of inoperative equipment and make recommendations to the Commanding Officer.

2.3.2 PROCEDURES FOR PILOTING

The duties and responsibilities for the watch stations discussed in this section are for the maneuvering watch piloting party; however, they apply to any situation that requires the navigation piloting party to be stationed.

The CO shall require the Navigator to develop a plan for safe and accurate piloting. This plan shall be reviewed by the XO and approved by the CO before getting his ship underway or approaching restricted waters. Any changes to the plan made after approval by the CO should undergo a similar review and approval process.

a. The Executive Officer shall:

(1) During the maneuvering watch, the XO should station himself to supervise in an area where he considers his presence necessary to ensure safe conduct of piloting and the maneuvering watch. He shall review and concur in all navigation plans and any changes to existing plans.

(2) When in the control room, the XO should periodically monitor the performance of the piloting party and watchstanders ensuring that the Navigator is properly able to carry out his duties and the ship is properly navigated. He should also periodically monitor the coordination of contact management between the Contact Coordinator (CC) and the Navigator. Ensure their method

12 Jan 07

From: JAGMAN Investigation Team
To: Commander, Submarine Group EIGHT

Subj: EXAMINATION OF CONSTABULARY EVIDENCE ICO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. On 8 January 2007, the JAGMAN investigation team examined evidence collected in the subject case by the Devon-Cornwall Constabulary at the Crown Hill Police Station in Plymouth, England.

2. Of note, no knives of any kind were found among the effects of Petty Officer Holtz and Senior Chief Higgins.

/S/

[redacted]

ENCL (41)

[redacted]

From: [redacted]
Sent:
To:
Subject: RE: MSP DEPARTURE WX (

[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, December 27, 2006 10:31 AM
To: [redacted]
Subject: RE: MSP DEPARTURE WX

Caveats: NONE

In the paragraph below I meant to say early 28th, vice late 28th. Also, if you didn't understand the chart, the Dive point seas are the seas at the dive point if thy departed at respective high tide time. (e.g. Depart high tide: 29/00Z; CSTL Seas at departure: 4-6 ft; Dive point seas 15 hours later: 18-20 ft (wnd S@35kt))

v/r,

[redacted]

From: [redacted]
Sent: Wednesday, December 27, 2006 10:05 AM
To: [redacted]

Importance: High

Caveats: NONE

~~encl. (5)~~

ENCLOSURE (42)

FAITHFUL

FAITHFUL

LONG ROOM VHF RECORDING (Not yet rec'd)

Enclosure (44)

Maintenance Effectiveness Review (MER) Analyzed 01/22/1999

DISTRIBUTION STATEMENT D:

Distribution authorized to DOD components and DOD contractors only; Critical Technology; January 2006. Other requests for this document shall be referred to Naval Sea Systems Command (SEA 04RM). Destroy by any method that will prevent disclosure of contents or reconstruction of the document.

Date: January 2006		**MIP Series:**	6231	**Periodicity:**	R-1

Location: Equipment Guide List Recommended

Ship System:

System:

SubSystem:

Equipment: Safety Harness (Parachute-Type)

Rates	Man-Hours	Rates	Man-Hours	Rates	Man-Hours
BM/TM/EM/ET	0.1				
Total Man-Hours:	0.1	**Elapsed Time:**	0.1		

MAINTENANCE REQUIREMENT DESCRIPTION

1. Inspect Safety Harness, Safety Lanyard, Working Lanyard, and Attachments.
2. Prepare Safety Harness For Operation in Spark Sensitive Space.

SAFETY PRECAUTIONS

1. Forces afloat comply with NAVOSH Program Manual for Forces Afloat, OPNAVINST 5100.19 series.
2. Do not attempt repairs. Any securing system found to be defective or any securing system that has been subjected to impact loads, even though it may appear in good condition, should be immediately cut into several pieces and discarded. Do not attempt to salvage component parts.
3. Do not wear safety harness with exposed metal in a spark sensitive space.

TOOLS, PARTS, MATERIALS, TEST EQUIPMENT

MATERIALS

1. [01624] Tape, insulation, electrical, MIL-I-24391
2. [03934] Shrink sleeving, MIL-I-23053/5

NOTE: Numbers in brackets can be referenced to Standard PMS Materials Identification Guide (SPMIG) for identification.

PROCEDURE

NOTE 1 : Accomplish this maintenance requirement when any of the following periodicities or situations occur.

a. Prior to each use.

b. After each use when used for vertical ascent-descent firefighting (Surface Ships only) .

1. Inspect Safety Harness, Safety Lanyard, Working Lanyard, and Attachments.

NOTE 2 : Omit inspection of working lanyard if it is not required to accomplish this maintenance task.

NOTE 3 : Definition of safety lanyard, working lanyard, and proper usage is as follows:

a. Safety lanyard - a 1/2" diameter adjustable nylon line, (or nylon webbing) with a Double-Locking Snap Hook at each end, with attached shock absorber that must be attached to D-ring on back section of safety harness. Safety lanyard shall be used at all times.

b. Working lanyard - a 1/2" diameter nylon line, with a Double-Locking Snap Hook at each end, that is attached to waist belt D-ring. Working lanyard is used in addition to safety lanyard to support user in desired working position where no platform/deck exists.

NOTE 4 : Item 1.a.(4) applies only to harnesses which are fitted with sliding D-rings. When such a harness is to be used in conjunction with a climber safety rail, one D-ring should be adjusted (slipped) to the front so as to provide a centered connection point for attachment of the climber safety sleeve snap hook.

WARNING: Do not attempt repairs. Any securing system found to be defective or any securing system that has been subjected to impact loads, even though it may appear in good condition, should be immediately cut into several pieces and discarded. Do not attempt to salvage component parts.

a. Inspect safety harness and attached components for proper operation and worn or missing parts.
   (1) Nylon webbing and stitching for frayed edges, broken strands, cut, burned, or pulled threads/stitches, and damage from heat, chemicals or excessive paint in fibers or brittleness in harness webbing, safety, and working lanyard.
   (2) Inspect D-rings and adjustment buckles for distortion, cracks, and sharp or rough edges.
   (3) Single-pass waist belt buckle for damage
   (4) Waist belt synthetic D-ring pads for damage
   (5) Nylon safety lanyard with attached Double-Locking snap hooks, thimble, and shock absorber for damaged, worn, or missing parts

NOTE 5 : Snap hook keeper and locking latch should work freely with minimum side play and close securely under spring tension to the lock closed position when pressure on the locking latched is removed.

b. Inspect safety and working lanyards.
   (1) Inspect entire circumference and length for abrasion damage indicated by fuzzy, worn, broken, or cut fibers. Inspect for noticeable change in original width/diameter, indicating a weakened area, and damage from heat, chemicals, or excessive paint in fibers or brittleness in lanyard webbing.
   (2) Inspect thimbles for distortion and sharp edges; ensure thimbles are right in eye of splice, if applicable.
   (3) Inspect splices. Splices should be tight with no loose strands; ends should be securely held to prevent unraveling.
   (4) Inspect keeper and spring for distortion and obstruction to prevent binding or improper closing.
   (5) Inspect lanyard webbing/stitching near shock absorber for deterioration or excessive wear.

NOTE 6 : Steps 1.c., 2.a., and 2.b. apply only to before-use inspections.

c. Adjust safety harness on user to ensure snug fit at shoulders, waist, and thighs.

NOTE 7 : Omit step 2. if harness is not used in a spark sensitive space.

2. Prepare Safety Harness For Operation in Spark Sensitive Space.

WARNING: Do not wear safety harness with exposed metal in a spark sensitive space.

a. Wrap all exposed metal on the safety harness with shrink wrap or electrical tape.
b. Wrap all exposed metal on the nylon lanyard with electrical tape or shrink wrap.

DISTRIBUTION STATEMENT D:

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Date: January 2006		**MIP Series:**	5832	**Periodicity:**	R-4

Location:

Ship System:	Auxiliary Systems 500
System:	Mechanical Handling Systems 580
SubSystem:	Lifesaving Equipment (other than boats) 5832
Equipment:	Life Preserver Inherently Buoyant 5832XY

Rates	Man-Hours	Rates	Man-Hours	Rates	Man-Hours
BM3	0.1				
Total Man-Hours:	0.1	**Elapsed Time:**	0.1		

MAINTENANCE REQUIREMENT DESCRIPTION

1. Inspect Life Preserver.

SAFETY PRECAUTIONS

1. Forces afloat comply with NAVOSH Program Manual for Forces Afloat, OPNAVINST 5100.19 series.

TOOLS, PARTS, MATERIALS, TEST EQUIPMENT

None

PROCEDURE

NOTE 1 : Accomplish this maintenance requirement when any of the following periodicities or situations occur.

a. Prior to each days use.

NOTE 2 : This MRC is applicable to fibrous glass or foamed plastic-filled life preservers utilized for boat crews, maneuvering watch, underway replenishment, etc.

NOTE 3 : Work Center Supervisor review MRC; omit step(s) not applicable.

Preliminary

a. Ensure inspection area is clear of snags and sharp edges.

1. Inspect Life Preserver.

NOTE 4 : **Statement of Relevance** - This task ensures cover is undamaged and preserver is properly equipped.

a. Inspect life preserver cover for tears, mildew, missing or worn tapes, webbing and hardware.

NOTE 5 : Work type life preservers, worn ashore and in protected waters, are not required to be equipped with the following accessories: whistle, and DML or PML.

b. Ensure flashlight type distress marker light (DML) or chemical personnel marker light (PML) is attached to life preserver.

c. Ensure whistle is attached to life preserver with lanyard.

d.

Test flashlight type distress marker light (DML), if applicable.

(1) Turn DML on; bulb should illuminate brightly.

(2) Replace battery/bulb or repair/replace DML if required.

(3) Repeat step 1.d.(1), if applicable.

(4) Turn DML off.

e. If Man Overboard Indicator (MOBI) is installed, ensure manual switch faces opening on side of pouch and antenna is attached to underside of collar with lanyard clip (see Figure 1).

Figure 1 Inherently Buoyant Life Preserver with MOBI Backfit

DISTRIBUTION STATEMENT D:

Distribution authorized to DOD components and DOD contractors only; Critical Technology; October 2006. Other requests for this document shall be referred to Naval Sea Systems Command (SEA 04RM). Destroy by any method that will prevent disclosure of contents or reconstruction of the document.

Date: October 2006 **MIP Series:** 6231 **Periodicity:** R-1

Location: Equipment Guide List Recommended

Ship System:

System:

SubSystem:

Equipment: Safety Harness (Parachute and Cross-over Type)

Rates	Man-Hours	Rates	Man-Hours	Rates	Man-Hours
BM/TM/EM/ET	0.1				
Total Man-Hours:	0.1	**Elapsed Time:**	0.1		

MAINTENANCE REQUIREMENT DESCRIPTION

1. Inspect Safety Harness, Safety Lanyard, Working Lanyard, and Attachments.
2. Prepare Safety Harness For Operation in Spark Sensitive Space.

SAFETY PRECAUTIONS

1. Forces afloat comply with NAVOSH Program Manual for Forces Afloat, OPNAVINST 5100.19 series.
2. Do not attempt repairs. Any securing system found to be defective or any securing system that has been subjected to impact loads, even though it may appear in good condition, should be immediately cut into several pieces and discarded. Do not attempt to salvage component parts.
3. Do not wear safety harness with exposed metal in a spark sensitive space.

TOOLS, PARTS, MATERIALS, TEST EQUIPMENT

MATERIALS

1. [01624] Tape, insulation, electrical, MIL-I-24391
2. [03934] Shrink sleeving, MIL-I-23053/5

NOTE: Numbers in brackets can be referenced to Standard PMS Materials Identification Guide (SPMIG) for identification.

PROCEDURE

NOTE 1 : Accomplish this maintenance requirement when any of the following periodicities or situations occur.

a. Prior to each use.
b. After each use when used for vertical ascent-descent firefighting (Surface Ships only) .

1. Inspect Safety Harness, Safety Lanyard, Working Lanyard, and Attachments.

NOTE 2 : Omit inspection of working lanyard if it is not required to accomplish this maintenance task.

NOTE 3 : Definition of safety lanyard, working lanyard, and proper usage is as follows:

a. Safety lanyard - a 1/2" diameter adjustable nylon line, (or nylon webbing) with a Double-Locking Snap Hook at each end, with attached shock absorber that must be attached to D-ring on back section of safety harness. Safety lanyard shall be used at all times.
b. Working lanyard - a 1/2" diameter nylon line, with a Double-Locking Snap Hook at each end, that is attached to waist belt D-ring. Working lanyard is used in addition to safety lanyard to support user in desired working position where no platform/deck exists.

NOTE 4 : Item 1.a.(4) applies only to harnesses which are fitted with sliding D-rings. When such a harness is to be used in conjunction with a climber safety rail, one D-ring should be adjusted (slipped) to the front so as to provide a centered connection point for attachment of the climber safety sleeve snap hook.

WARNING: Do not attempt repairs. Any securing system found to be defective or any securing system that has been subjected to impact loads, even though it may appear in good condition, should be immediately cut into several pieces and discarded. Do not attempt to salvage component parts.

a. Inspect safety harness and attached components for proper operation and worn or missing parts.
   (1) Nylon webbing and stitching for frayed edges, broken strands, cut, burned, or pulled threads/stitches, and damage from heat, chemicals or excessive paint in fibers or brittleness in harness webbing, safety, and working lanyard.
   (2) Inspect D-rings and adjustment buckles for distortion, cracks, and sharp or rough edges.
   (3) Single-pass waist belt buckle for damage
   (4) Waist belt synthetic D-ring pads for damage
   (5) Nylon safety lanyard with attached Double-Locking snap hooks, thimble, and shock absorber for damaged, worn, or missing parts

NOTE 5 : Snap hook keeper and locking latch should work freely with minimum side play and close securely under spring tension to the lock closed position when pressure on the locking latched is removed.

b. Inspect safety and working lanyards.
   (1) Inspect entire circumference and length for abrasion damage indicated by fuzzy, worn, broken, or cut fibers. Inspect for noticeable change in original width/diameter, indicating a weakened area, and damage from heat, chemicals, or excessive paint in fibers or brittleness in lanyard webbing.
   (2) Inspect thimbles for distortion and sharp edges; ensure thimbles are right in eye of splice, if applicable.
   (3) Inspect splices. Splices should be tight with no loose strands; ends should be securely held to prevent unraveling.
   (4) Inspect keeper and spring for distortion and obstruction to prevent binding or improper closing.
   (5) Inspect lanyard webbing/stitching near shock absorber for deterioration or excessive wear.

NOTE 6 : Steps 1.c., 2.a., and 2.b. apply only to before-use inspections.

c. Adjust safety harness on user to ensure snug fit at shoulders, waist, and thighs.

NOTE 7 : Omit step 2. if harness is not used in a spark sensitive space.

2. Prepare Safety Harness For Operation in Spark Sensitive Space.

WARNING: Do not wear safety harness with exposed metal in a spark sensitive space

a. Wrap all exposed metal on the safety harness with shrink wrap or electrical tape.
b. Wrap all exposed metal on the nylon lanyard with electrical tape or shrink wrap.

Maintenance Effectiveness Review (MER) Analyzed 12/16/2005

DISTRIBUTION STATEMENT D:

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Date: September 2006 **MIP Series:** 5832 **Periodicity:** R-1

Location:

Ship System:	Auxiliary Systems 500
System:	Mechanical Handling Systems 580
SubSystem:	Lifesaving Equipment 5832
Equipment:	Auto-Inflatable Life Preserver MK1, Commercial Models 5832XY

Rates	Man-Hours	Rates	Man-Hours	Rates	Man-Hours
SN/AN/FN	0.1				
Total Man-Hours:	0.1	**Elapsed Time:**	0.1		

MAINTENANCE REQUIREMENT DESCRIPTION

1. Inspect MK-1 Life Preserver.

SAFETY PRECAUTIONS

1. Forces afloat comply with NAVOSH Program Manual for Forces Afloat, OPNAVINST 5100.19 series.
2. Any components or safety items that are missing or fail to function properly must be replaced prior to use or stowage.
3. Secumatic or S-TRON model auto-inflater assemblies do not require seat seal O-rings. Installing an O-ring in S-TRON or Secumatic auto-inflator may prevent proper actuation.
4. Only shear-type electrical copper wire shall be used to secure inflation assembly actuation lever.

TOOLS, PARTS, MATERIALS, TEST EQUIPMENT

TEST EQUIPMENT

1. [00289] Clip, paper Clip, paper

NOTE: Numbers in brackets can be referenced to Standard PMS Materials Identification Guide (SPMIG) for identification.

PROCEDURE

NOTE 1 : Accomplish this maintenance requirement when any of the following periodicities or situations occur.
a. Prior to each use.

NOTE 2 : Any unserviceable component or safety item that fails to function properly must be replaced. Deliver life preserver to Work Center Supervisor for replacement of components, safety items, or life preserver as applicable. Refer to MRC U-6 for information on replacement parts and materials.

WARNING: Any components or safety items that are missing or fail to function properly must be replaced prior to use or stowage.

1. Inspect MK-I Life Preserver.

NOTE 3 : **Statement of Relevance** - This task identifies vest contains all components required for operation.

NOTE 4 : Refer to figures 1 through 3 for location of specific components.

a. Inspect cover for grease, tears, missing or broken snaps, zippers and proper placement/condition of reflective material. If tears or punctures are suspected of penetrating bladder, remove from service and accomplish MRC Q-1.
b. Verify that bladder is not twisted in cover and snaps on bladder are fastened to inside front of cover on right and left sides.
c. Ensure whistle, DML and sea dye marker are attached and in serviceable condition.

NOTE 5 : Firefly 3 Waterbug lights will replace SDU-5/E, SDU-39/N and Firefly 2 lights by attrition. Perform either step 1.d or step 1.e, as applicable.

d. Test Firefly 3 Waterbug light:
(1) Remove DML from pouch.
(2) Place conducting material (tool or bent paper clip) across two metal discs on front of DML to activate strobe light.
(3) Switch DML to OFF position to deactivate light; remove tool from metal discs.
(4) Switch DML to ON position to re-arm strobe; light should not activate.
(5) Place DML in pouch with strobe facing up.

e. Test Firefly 2, SDU-39/N, or SDU-5/E light:
(1) Remove DML from pouch.
(2) Switch DML to ON position; verify 3 bright flashes; set switch to OFF position.
(3) Place DML in pouch with strobe facing down.

NOTE 6 : COMNAVAIRFOR directed installation of chemical lights as a supplement to the DML on MK-1 life preservers. This is not a NAVSEA requirement. Ships subject to NAVAIR direction refer to COMNAVAIRFOR 191006Z FEB 03 for details.

f. Verify proper operation of whistle; restow in whistle pouch.
g. Ensure oral inflation tube cap is in place.
h. Ensure anti-sabotage compound on inflation block assembly and retainer nut has not been disturbed.
i. Remove CO2 cylinder and verify that cylinder has not been punctured (activated).

WARNING: Secumatic or S-TRON model auto-inflater assemblies do not require seat seal O-rings. Installing an O-ring in S-TRON or Secumatic auto-inflator may prevent proper actuation.

j. Ensure on CONAX model auto-inflator that seat seal O-ring is in place and is not damaged.

CAUTION: Care should be taken to ensure that inflation assembly threaded hole is clean of all foreign matter and that CO2 cylinder is not cross-threaded when screwed in place.

NOTE 7 : For life preservers with cylinder restraining straps, pass cylinder behind restraining strap prior to installing into inflation assembly.

k. Reinstall CO2 cylinder and screw in hand tight.

WARNING: Only shear-type electrical copper wire shall be used to secure inflation assembly actuation lever.

l. Inspect inflation assembly housing for cracks at base of cylinder attachment point.
m. Ensure inflation assembly actuation lever is secured by one strand of copper shear-wire.

NOTE 8 : Step 1.n applies only to SECUMATIC chemical pill type inflation assemblies.

n. Verify that GREEN indicators show at windows marked "B" and "C" on inflation assembly. If RED shows at either window, life preserver is not ready for service.
o. Ensure actuator lanyard pull button is in down position and not stored under flap.
p. If Man Overboard Indicator (MOBI) is installed, ensure manual switch faces opening on side of pouch and antenna is properly installed (see Figure 1 or 4, as applicable).
q. Don life preserver.

DISTRIBUTION STATEMENT D:

Distribution authorized to DOD components and DOD contractors only; Critical Technology; December 1997. Other requests for this document shall be referred to Naval Sea Systems Command (SEA 04RM). Destroy by any method that will prevent disclosure of contents or reconstruction of the document.

Date: December 1997 **MIP Series:** 5832 **Periodicity:** Q-2R

Location:

Ship System:

System:

SubSystem:

Equipment: Man-Overboard Bag Equipment

Rates	Man-Hours	Rates	Man-Hours	Rates	Man-Hours
TM2	0.5				
Total Man-Hours:	0.5	**Elapsed Time:**	0.5		

MAINTENANCE REQUIREMENT DESCRIPTION

1. Inspect and inventory man-overboard equipment.

SAFETY PRECAUTIONS

1. Forces afloat comply with NAVOSH Program Manual for Forces Afloat, OPNAVINST 5100.19 series.

TOOLS, PARTS, MATERIALS, TEST EQUIPMENT

MATERIALS

1. [01102] Rag, wiping
2. [01679] Battery, nonrechargeable
   Hazardous Material User's Guide (HMUG) Group 21 , Disposal Method 1

MISCELLANEOUS

1. Equipment check-off list (See NOTE 2)
2. Spare flashlight bulb

NOTE: Numbers in brackets can be referenced to Standard PMS Materials Identification Guide (SPMIG) for identification.

HAZARDOUS MATERIALS CONTROL STATEMENT(U)

The Hazardous Material Users Guide (HMUG), OPNAVINST 5100.28, provides additional control measures, precautions, personal protective equipment (PPE), and spill controls for the hazardous material(s) identified in the Tools, Parts, Materials, Test, Equipment block. Maintenance personnel shall determine if additional PPE is necessary to accomplish the MRC and take appropriate action to obtain and wear such PPE to ensure the safety of maintenance personnel. Report any deficiencies via PMS feedback report.

PROCEDURE

NOTE 1 : Accomplish quarterly and after each use of equipment.

1. Inspect and Inventory Man-Overboard Equipment.

a. Remove man-overboard bag from stowage and lay out bag's equipment.

NOTE 2 : The contents of man-overboard bag are left to discretion of commanding officer. Obtain list from ship's current instructions before accomplishing this MRC. Omit items not applicable to ship. List applicable items on equipment guide list.

b. Inventory man-overboard bag equipment.
c. Remove flashlight lens piece and batteries.
d. Inspect flashlight internal parts for moisture and corrosion. Remove any corrosion with rags. If casing is leaking moisture, replace entire flashlight.
e. Wipe lens clean, tighten bulb, and reassemble flashlight; test for proper operation.
f. Inspect remaining hardware for corrosion, distortion, chips, cracks, excessive wear, loose pins, and other signs of weakness. Ensure knife blades are sharp.
g. Inspect fiber lines for broken strands, weakened splices, loose whippings, distortion, excessive wear, and other signs of deterioration.

h. Ensure man-overboard bag, swimmer's harness and diver's knife sheath and belt are free of cuts, tears, broken stitching, and decay.
i. Restow equipment and return bag to stowage.

DISPOSAL METHODS FOR HAZARDOUS MATERIAL/WASTE IDENTIFIED IN THE TOOLS, PARTS, MATERIAL, AND TEST EQUIPMENT BLOCK

Method 1: If shipboard HAZMINCEN exists, turn in all spent HM and items contaminated with HM to the shipboard HAZMINCEN for collection, processing, and disposal. Containerize waste in original container or use standard container as listed in Appendix C23-A of OPNAVINST 5100.19D Navy Occupational Safety and Health (NAVOSH) Program Manual for Forces Afloat and the Naval Ships' Technical Manual (NSTM), S9086-TO-STM-010/CH-593, Pollution Control. Store in accordance with OPNAVINST 5100.19D, Appendix C23-C and D15-E. Mark, label, or tag the container with the specific contents and any information on the contaminants. This information must also be provided on the DD Form 1348-1A at the time of off-loading. Empty container guidance is available in the CNO Policy Guide for Shipboard Hazardous Material Container Disposal, OPNAV P-45-114-95. Contact the receiving shore activity (e.g., Fleet and Industrial Supply Center and Public Works Center) to determine the appropriate local off-loading requirements.

Figure 1 MK-1 Life Preserver Components

Figure 2 Automatic Inflation Assembly (Battery Type)

Figure 3 Automatic Inflation Assembly (Chemical Pill Type)

Figure 4 MK-1 Life Preserver with MOBI Backfit

Maintenance Effectiveness Review (MER) Analyzed 12/14/2001

DISTRIBUTION STATEMENT D:

Distribution authorized to DOD components and DOD contractors only; Critical Technology; December 2002. Other requests for this document shall be referred to Naval Sea Systems Command (SEA 04RM). Destroy by any method that will prevent disclosure of contents or reconstruction of the document.

Date: December 2002 **MIP Series:** 5832 **Periodicity:** R-2

Location:

Ship System:	Auxiliary Systems 500
System:	Mechanical Handling Systems 580
SubSystem:	Lifesaving Equipment (Other than boats) 5832
Equipment:	Auto-Inflatable Utility Life Preserver MARK 5 MOD 0

Rates	Man-Hours	Rates	Man-Hours	Rates	Man-Hours
SN	0.1				
Total Man-Hours:	0.1	**Elapsed Time:**	0.1		

MAINTENANCE REQUIREMENT DESCRIPTION

1. Inspect auto-inflatable utility life preserver.

SAFETY PRECAUTIONS

1. Auto-inflator assemblies manufactured by S-TRON and SECUMATIC do not require seat seal o-rings. Installing an o-ring in a S-TRON or SECUMATIC auto-inflator may prevent proper actuation.
2. Loss of buoyancy may result during activation if bladder stabilizing strap and cover are not securely tied together.
3. Inflation device lanyard must hang outside cover to provide rapid access in emergency situation.
4. Any component or safety item that is missing or fails to function properly must be replaced in accordance with MRCs Q-1, R-1, or the technical manual prior to use.

TOOLS, PARTS, MATERIALS, TEST EQUIPMENT

None

PROCEDURE

NOTE 1 : Accomplish prior to use.

1. Inspect auto-inflatable utility life preserver.

NOTE 2 : **Statement of Relevance** - This task ensures all components are present and operational.

a. Inspect fabric cover and pockets for tears, missing or broken grommets, and broken zippers or buckles.
b Ensure whistle is tied with nylon cord to grommet in wearer's right front pocket; verify proper operation of whistle.
c. Unfasten hook and pile fasteners on lower right side of life preserver to expose inflation assembly.
d. Ensure anti-sabotage compound on inflation block assembly and retainer nut has not been disturbed.
e. Verify actuation lever is in closed position (against inflator body) with one strand of shear wire installed.
f. Unscrew CO_2 cylinder and verify that it has not been punctured.

WARNING: Auto-inflator assemblies manufactured by S-TRON and SECUMATIC do not require seat seal o-rings. Installing an o-ring in a S-TRON or SECUMATIC auto-inflator may prevent proper actuation.

NOTE 3 : Be sure to insert cylinder through retaining loop before screwing into place.

g. Ensure CONAX model auto-inflator seat seal o-ring is in place.
h. Re-install CO_2 cylinder; hand tighten.

WARNING: Loss of buoyancy may result during activation if bladder stabilizing strap and cover are not securely tied

together.

i. Ensure stabilizing straps are securely attached to cover.

NOTE 4 : Step 1.j. applies only to SECUMATIC chemical pill type inflation assemblies.

j. Verify that green indicator shows at windows marked "B" and "C" on inflation assembly. If red shows at either window, life preserver is not ready for service.
k. Fasten hook and pile fasteners aroung sides until bladder is completely enclosed.

WARNING: Inflation device lanyard must hang outside cover to provide rapid access in emergency situation.

l. Ensure auto-inflation device lanyard and knob extend outside hook and pile fasteners on cover.

WARNING: Any component or safety item that is missing or fails to function properly must be replaced in accordance with MRCs Q-1, R-1, or the technical manual prior to use.

13 Week Report

Quarter 91 : Week 13
(12/25/2006 - 12/31/2006)

[illegible]	COMPONENT NAME	MRC	TAG OUT #	MAINTENANCE RESPONSIBILITY	SIGNATURE	DATE
58[illegible]/[illegible]-16	Life Saving Equipment	R-4		[redacted]	/S/	12/29/06
5832/014-76	Life Saving Equipment	R-3#		[redacted]	/S/	12/28/06
5832/014-76	Life Saving Equipment	R-2		[redacted]	/S/	12/28/06
5832/014-76	Life Saving Equipment	R-1		[redacted]	/S/	12/28/06
5832/014-76	Life Saving Equipment	M-1R		[redacted]	/S/	12/28/06
6231/001-16	Safety Harness	R-1		[redacted]	/S/	12/29/06

ENCL(46)

Div Officer: [redacted] Date: 12/31/06

Workcenter: WK01

W/C Supervisor: [redacted] Date: 12/31/06

04 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 9 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since August, 2006. My job aboard MSP is [redacted]

2. At the time of the incident, I was the Primary Plotter.

3. The pilot transfer was planned for just before the breakwater. My best guess as to the ship's expected speed was about 5 knots. There was nothing discussed during the brief as to "Go/No-Go" or tripwires.

4. The incident happened right at the edge of the breakwater. Things were going as planned at the time. I plotted where the man went overboard. There were men overboard port and starboard side. There was really no plan ahead of that. We were close to the breakwater and had to turn away from it as soon as possible. I'd estimate the distance to be about 500 yards.

5. The bridge didn't really explain what they were trying to accomplish with their maneuver. Nav made course recommendations because of our proximity to the shore.

6. I was at the piloting brief. The most significant hazard to our track was a merchant ship anchored in the area. There was mention of the shoals and additionally, discussion about the weather.

7. We have information on tactical diameter about the ship in binders that are easily accessible.

ENCLOSURE (47)

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 709) ON 29 DECEMBER 2006

8. I don't recall when the pilot came down from the bridge the first time.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 4th day of January 2007, at USS MINNEAPOLIS-ST. PAUL (SSN 708).

/s/

[redacted]

Recollection of Significant Maneuvering Watch Events on 29 Dec 2006

This is the statement of LT Patrick W. Bosserman, stationed as Control Room Supervisor during the Maneuvering Watch on 29 December 2006 onboard USS Minneapolis-Saint Paul.

I attended the Piloting brief on 28 December 2006, which discussed all courses, expected tides, expected soundings, all turns, small boat transfer location, force protection requirements, and communications requirements.

During the brief, it was discussed that said large waves and foul weather would be expected out at sea. HN pilot agreed to the transfer location at the brief.

Weather reports indicated foul weather out at sea.

For my watch, in addition to attending the piloting brief, I prepared by looking again at the Navigation Plot prior to stationing myself, obtaining a course card and Navigation Rules of the Road book.

The Maneuvering Watch was stationed in the Bridge, Control, and Maneuvering. I stationed as Control Room Supervisor. After this, the full Maneuvering Watch was stationed. I ensured the pre-underway checks were completed and the rig for dive was in progress.

When underway, I ensure the Helmsman follows all orders by the Officer of the Deck (OOD).

Prior to all planned turns, I briefed the helmsman on the approximate time until the turn, direction of the turn, next course, and approximate time on next course.

I am not sure of the order of all of the following events due to many things happening simultaneously. Due to my position as CRS, I received many reports, some erratic due to the spontaneity of the events.

The purpose for sending men topside was to conduct small boat transfer of HN pilot, who came down from the bridge, wished us farewell in the control room, and headed to forward compartment middle level for the small boat transfer.

The Chief of the Boat (COB) coordinated with the OOD the draining and opening of the Forward Escape Trunk (FET) lower hatch and upper hatch.

The COB requested from the Officer of the Deck (OOD) permission to send personnel topside to transfer the pilot.

The OOD ordered the COB to send personnel topside to conduct the small boat transfer.

The pilot was transferred off at some point, I am not sure when with respect to men overboard due to the following confusion. I don't believe a report was made to Control that the pilot had been transferred until much later.

Several "man overboard" announcements were made. In a short amount of time, it was realized that several men had went overboard close to the same time.

Actions were taken to recover men overboard.

The Perivis (off #2 Scope) showed the diver overboard. Soon after people were saying they saw him being recovered.

Casualty Procedures for man overboard were broken out to ensure applicable actions were completed. At one time, the shaft was ordered stopped by the OOD.

At some time the PXO assumed #2 Scope and exclaimed that he could see a person topside, hanging by his harness and lanyard over the side of the boat. The sea states were

rough at this time. Large amounts of water was came down the Forward Escape Trunk, the only access to topside.

Contact Coordinator asked if anyone had exposure times. Deck Log indicated man overboard times, but due to the heavy seas and large amounts of water coming down the Forward Escape Trunk, nobody could immediately be sent topside to assist anyone topside. At some time it was reported by the scope operator (I do not recall who it was at this time) that one person, who looked like the COB, was free of the boat and was picked up by the small boat. The order was given to cut the other man loose from his harness to have the small boat pick him up. It was done. It was reported by the scope operator that the person was picked up.

We received the AMR high bilge level alarm at the BCP due to the large amounts of water.

I ordered, with the XO's concurrence, to use the main drain system to dewater the AMR bilge due to the auxiliary drain pump being electrically grounded from all the seawater.

/s/

ENCL (48)

04 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for a total of 16 years with a break in service between 1993-1998 and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since November 2005. My job aboard MSP is [redacted]

2. At the time of the incident, I was the Control Room Supervisor (CRS). On MSP, the main role of CRS is to provide backup to the helm because the eyes and ears are on the bridge of the ship. I ensure the pre-underway checks are completed and ensure rig for dive is in progress. With regard to casualties, I ensure all applicable procedures are followed, and I make reports to the bridge. During the maneuvering watch, I am usually forced to remain in the vicinity of the ship's control panel.

With regard to the piloting brief - At all piloting briefs, the CRS is required to be there, bridge to bridge operator, XO, CO, pilot of host nation invited to attend and did attend. All officers and piloting party are required to be there. COB always attends the piloting brief. When we go underway, the COB is usually the last man down the hatch from topside. COB usually coordinates the draining of the hatch with the OOD with a Motorola or the 7-MC.

Piloting Brief: goes through every chart, every turn and things to look for. Expected sounding shifts, force protection, tides and traffic in and out. In Plymouth, at low tide, you cannot go in or out. Expected weather and comms channels were discussed. Pilot transfer discussed and pilot agreed with proposed transfer. Pilot discussed coming off of proposed track, but this was far inland, nowhere near the transfer point. I don't remember exactly where the transfer point was supposed to be.

At the piloting brief, the ANAV discussed that the weather was going to be bad - 12-24 foot waves (I think this was out at sea, vice in the harbor/inland area). I remember the ANAV discussed tides, winds and waves. We did not discuss "triggers" or "go/no go" criteria for the piloting transfer.

When we got underway, it was cold, windy and rainy. In the control room, where I was, it didn't feel like the weather was

ENCLOSURE (49)

worsening. When we were approaching the transfer point, I don't recall anyone saying the weather conditions were worsening. I don't recall whether there was a bridge-to-bridge call to inquire about conditions further out towards the transfer point.

When we received a report of "man overboard," there were several reports of MO in a short period of time. Procedures called for putting men topside, but there was a great deal of water coming down the hatch. Best judgments were up on the bridge, as they were able to see exactly what was going on. The scope operator trained the scope on the man overboard. I remember the shaft being stopped for at least one of the MO calls, but I don't believe the shaft was stopped for all of the MO calls. The communication channels were a bit shaky - and sometimes the calls came over 7MC and other times over the 1MC. I recall the PXO, on the scope, saying something about seeing a man still attached to a harness. I recall the ENG, acting as OOD, saying that he wanted to go back into calmer waters. Within minutes of an MO call, we heard reports of small boats picking up the men in the water.

I think the boat did everything it could to pick the men up once they were overboard. I remember certain host national Naval personnel questioning whether it would be advisable to leave when we did. I don't remember who these people were as it was never stated in an official capacity. But the host nation pilot agreed to get underway with us and take us out in the conditions as they were. I think a reliable quick disconnect from a safety harness may help to prevent similar incidents in the future. If a man is still attached to his harness, I believe it would take at least one or two men to pull him back topside.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 709) ON 29 DECEMBER 2006

Sworn to and subscribed before me this 04th day of January 2007, at USS MINNEAPOLIS-ST. PAUL (SSN 708).

/s/

[redacted]

ENCL (49)

01/01/07

This is the statement of [redacted]. On 29 December 2006 at approximately 1330 the ship was getting the pilot off in a open ocean transfer. The COB, [redacted] and STS2 Holtz went topside. They were dressed; out in a harness with a lanyard and a turn around, they were all wearing kapoks. The COB ordered the Swimmer [redacted] to stay below and if they were needed they would be called up. He told me to hand up the Jacobs ladder and the boat hook when they were topside.

The Hatch was ordered to be drained and opened and the Small Boat handling party went topside. The COB called down for the ladder and Boat hook to come topside. Approximately 5 minutes later Man overboard was called then the Diver and the tender followed by [redacted] all went topside to assist. [redacted] were washed over the side immediately Degler made it back to the hatch. At this point water was pouring down the hatch. [redacted] were in the hatch waiting to rig it for dive. [redacted] was below the hatch waiting to pump the hatch shut if necessary. The [redacted] came down the hatch then [redacted] were washed down the hatch. The order was given to shut the hatch due to the inrush of water coming into the boat. [redacted] tried to shut the hatch 3 times but the Jacobs ladder kept getting stuck. [redacted] freed the ladder and we shut the hatch. Then [redacted] came down.

The Order was then given to open the hatch and sent [redacted] topside and to gather the ladder. So we suited up [redacted] to assist the pilot off the ship. The hatch was drained and opened and the three went topside water was still coming in the boat [redacted] got [redacted] off came back down. Then the hatch was shut.

The Hatch was ordered open one more time to go and cut [redacted] free from the boat the hatch was opened and [redacted] went topside to free STS2 Holtz. Holtz was cut free and [redacted] came back down. The hatch was then shut and dogged.

/s/

[redacted] 1/4/07

ENCL (52)

06 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

This statement supplements the two I provided to the investigation team on 4 January 2007.

From the ANAV and the Navigator, I knew that we were to expect rough weather on the way to the dive point. I thought that we would encounter this weather well out to sea. As the Control Room Supervisor, I wouldn't know what point on the chart would trigger concern for men going topside. At the piloting brief, I was mainly focused on my responsibilities as Control Room Supervisor and Force Protection.

The pilot transfer, as discussed at the piloting brief, seemed routine. The ANAV, Navigator, OOD, CO and host nation pilot were all confident about the planned transfer.

I "own" Deck Division as Weapons Officer. But personnel transfer evolutions topside are between the COB/handling party and the bridge, where the CO is usually located. MSP's Control Room Party is able to hear all communications between them.

Had I known the seas were going to be bad beyond the breakwater, I would have been concerned. I don't know if I have seen the 28 December 2006 DTG WEAX message routed to my Outlook Inbox at 0551 on 29 December 2006. But because it is my routine practice to review message traffic, it is likely that I saw this message.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 06th day of January 2007, at Naval Station Rota.

/s/

[redacted]

ENCL (50)

SUSPECT'S RIGHTS ACKNOWLEDGEMENT/STATEMENT (See JAGMAN 0170)

FULL NAME (ACCUSED/SUSPECT)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ACTIVITY/UNIT: MSP (SSN 708)			DATE OF BIRTH
NAME (INTERVIEWER)	**SSN**	**RATE/RANK**	**SERVICE (BRANCH)**
[redacted]		[redacted]	USN
ORGANIZATION		**BILLET**	
[redacted]		[redacted]	
LOCATION OF INTERVIEW		**TIME**	**DATE**
NAVSTA ROTA		1600	8 JAN 07

RIGHTS

I certify and acknowledge by my signature and initials set forth below that, before the interviewer requested a statement from me, he warned me that:

(1) I am suspected of having committed the following offense(s): NEGLIGENT DERELICTION OF DUTY /S/

(2) I have the right to remain silent; - /S/

(3) Any statement I do make may be used as evidence against me in trial by court-martial, - - - - - /S/

(4) I have the right to consult with lawyer counsel prior to any questioning. This lawyer counsel may be a civilian lawyer retained by me at my own expense, a military lawyer appointed to act as my counsel without cost to me, or both; and - /S/

(5) I have the right to have such retained civilian lawyer and/or appointed military lawyer present during this interview. - /S/

WAIVER OF RIGHTS

I further certify and acknowledge that I have read the above statement of my rights and fully understand them, and that, - /S/

(1) I expressly desire to waive my right to remain silent; - /S/

(2) I expressly desire to make a statement; - /S/

(3) I expressly do not desire to consult with either a civilian lawyer retained by me or a military lawyer appointed as my counsel without cost to me prior to any questioning; - - - - - - - - - /S/

(4) I expressly do not desire to have such lawyer present with me during this interview; and - - - - /S/

ENCL (51)

(5) This acknowledgment and waiver of rights is made freely and voluntarily by, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.- - - -

04 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 18 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) for six and a half months. My job aboard MSP [redacted] This statement supplements the one I provided to the investigation team on 4 January 2007.

2. At the time of the incident, I was Man in Charge in the Crew's Mess for the Small Boat Handling Team. After the Small Boat team went topside, they asked for the Jacob's ladder to transfer the pilot off. The Jacob's ladder was passed up. The men topside had trouble closing the hatch after the ladder was passed up. It was less than five minutes after the men went topside that I heard the first man overboard call. [redacted] was adamant about getting off of the ship. He said that he had to get off in order to guide the tugs. After the men were washed overboard and we were coming about, [redacted] were sent up to transfer [redacted] off. [redacted] was transferred, and [redacted] came back down. At this point, I was ordered to open the hatch and send [redacted] up to cut Holtz loose.

I have only been onboard for a little more than six months, but I have not seen any formal training on ORM since I have been onboard.

I think we should have transferred [redacted] inside of the breakwater, because we, everybody, knew that the seas were rough. In order to prevent future incidents of this nature, I believe we should get rid of the lanyards entirely.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/ [redacted] 1/4/07

ENCLOSURE (53)

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

Sworn to and subscribed before me this 04th day of January 2007, at USS MINNEAPOLIS-ST. PAUL (SSN 708).

/s/

C. W. OLCOTT
LT, JAGC, USN

ENCL (53)

This is the statement of [redacted] and I herby swear to the truthfulness and accuracy of this statement.

On December 29th, 2006 I [redacted] was on the small boat handling party as the dive tender. As COB, [redacted] and STS2 Holtz went topside to [redacted] over the pilot boat [redacted] and I stayed below decks by the hatch in case they called man overboard. When man overboard starboard side was called over the 1MC [redacted] and myself proceeded topside to get the personnel that had fallen over the side out of the water. As [redacted] and I got topside seen the COB, [redacted] and STS2 Holtz on the starboard side still attached to the submarine. [redacted] attempted to pull COB, [redacted] and STS2 Holtz out of the water as the first of many waves coming over the submarine had swepted [redacted] over the side as well. At that point [redacted] was pulling himself back on the submarine I grabbed his hand and helped him get back topside. As soon as [redacted] set back up to continue pulling the COB, [redacted] and STS2 Holtz out of the water the second set of waves swepted [redacted] again over the side. As the waves cleared for a split second I seen [redacted] by the rudder in the water and the COB, [redacted] and STS2 Holtz were laying on top of the submarine by the aft escape hatch. As I called for the COB, [redacted], and STS2 Holtz by their names the only one I got a response from was [redacted] looked at me and proceeded to crawl towards were I was at in the forward escape trunk. When [redacted] got close enough I grabbed him and proceeded down the hatch were [redacted] told [redacted] nd myself to get below. We both went below and that's were they guys below grab us and took us to the wardroom to get checked by [redacted] That is all that I recollect of the incident that happened on December 29th, 2006.

/S/

[redacted]

04JAN06

ENCL (54)

COMPLIANCE WITH SECTION 0221 OF THE JAG MANUAL

I, [redacted] have been advised that:

-questions have arisen concerning whether or not my injury/ disease, sustained or discovered on 29DEC06 was incurred in the line of duty or as a result of my own misconduct;

-in the event such injury/disease is determined to have been incurred not in the line of duty or as a result of my own misconduct, I will be required to serve for an additional period beyond my present enlistment to make up for the duty time lost;

-lost duty time will not count as creditable service for pay entitlement purposes;

-I may be required to forfeit some pay (where absence from duty in excess of one day immediately follows intemperate use of liquor or habit-forming drugs);

-if I am permanently disabled and that disability is determined to have been the result of misconduct or was incurred not in the line of duty, I may be barred from receiving disability pay or allowances, as well as veterans' benefits;

-I may not be required to give a statement relating to the origin, incidence, or aggravation of any disease/injury that I may have.

I do/do not desire to submit a statement

04 JAN 07 /S/

Date Signature

[redacted]

Witness Signature

[redacted]

Witness Name/Rate/Grade/Unit/Telephone Number

[redacted] statement pertaining to the man overboard on 12/29/06:

Normally I would be a topside swimmer, but I had just returned from a first half deployment augmentation. I was getting re-proficient Engine Room Forward [redacted] Man Overboard was called via 1MC & I left [redacted] I noticed water up to the sight glass in the RC tunnel door, so waited until a left roll to open the door. I entered crews mess and immediately requested to go topside, but due to the water coming down the hatch the order had gone out to shut the forward escape truck upper hatch. Water continued to enter the boat and the order came out to shut the forward escape truck lower hatch (latter to find out that the Jacob's Ladder was stuck in the upper hatch , but did not see this myself). I made an attempt to shut the lower hatch, but due to the inrush of water ran out of air before succeeding. I was about to attempt again when the upper hatch shut. I reentered the crews mess and learned that someone was left topside, the order then went out to open the forward escape truck upper hatch and for me to go topside to cut the man loose. I went topside, while tethered by someone in the forward escape trunk, and saw [redacted] suspended on the port side in the water with a British Rib boat attempting unhook him. I cut the deck crawler line and he was picked up by the boat. I reentered the crews mess the upper hatch was shut. The pilot entered crews mess from the control ladder and requested to go up. The upper hatch was again reopened and I escorted the pilot off of the boat.

/s/ 12/5/07

5 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 6 years, 2 months, and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since [redacted] 2002. My job aboard MSP is [redacted]. This statement supplements the written statement I provided the investigation team from 4 Jan 07.

2. At the time of the incident, I was working Engineroom Forward (Under Instruction) and because I am a diver, I responded to the man overboard.

3. I was called up three times; the first time I was not called up topside. They were closing the upper hatch. I went topside twice, once to cut Petty Officer Holtz free and then for the Pilot transfer.

4. Between the first and second times I made it topside, about 7 minutes, the weather was significantly different.

5. Petty Officer Holtz was face up, feet to the aft, wearing a life vest, and there wasn't enough room on his line for the RHIB boat to be able to get close enough to free him. I cut him free with my diver's knife and no problems doing so.

6. When I saw Petty Officer Holtz, he was unconscious and had either vomit or foam at the mouth, and a bump on his head that was bleeding but not very bad. I wasn't close enough to him to tell if he was breathing, but I thought since he was bleeding he was going to be OK. He wasn't bleeding profusely but blood was still coming out of his head.

ENCLOSURE (57)

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 5th day of January 2007, at Naval Station Rota, Spain.

/s/

[redacted]

ENCL (57)

From: [redacted] USS Minneapolis-St. Paul.
To: Mishap Investigation Board

Subj: Statement of recollection of events on 29 Dec. 06

During the course of events surrounding the tragic mishap on 29 December, I was assigned the duties of [redacted] manning the number one periscope with the primary duty of safely piloting the ship through restricted waters. I also assumed the secondary duty of contact management, assisting the Executive Officer, Contact Coordinator and number two periscope operator to this end. I have over 19 years experience in submarine navigation, piloting and contact management, including two full tours and one partial tour as Assistant Navigator. Additionally, I have over 32 years experience in the handling and navigation of ships and craft of various sizes and I am current in my International Maritime Organization certifications in the use of ECDIS, ARPA, Radar Observer and Marine Weather Observer. Preparations for this event included a thorough personal review of weather forecasts (both NLMOC and local agency) for the English Channel and the Western Approaches, and a thorough piloting brief, conducted at 1400 on 28 December, 2006 onboard USS Minneapolis-St. Paul. The piloting brief was prepared by the Navigator, Engineer and I, and covered transit timeline, tug and pilot arrangements (to include debarkation point and topside line handler plan), tidal and weather forecasts (briefed by me), track plan (briefed by the Engineer) and small-boat handling procedures (briefed by the COB). The QHM Pilot was in attendance and provided guidance on the location and methods for pilot debarkation and cautioned us of a container ship moored to a buoy in the vicinity of the breakwater.

Note: Times, and time-periods given are approximate. All times are GMT.

At about 0800 on the morning of 29 Dec., I consulted the most recent NLMOC weather forecast for the English Channel, which warned of deteriorating weather conditions. At about 0900, I monitored a VHF radio "Securitě" call from Brixham (UK) Coast Guard, warning of "Gale Force 8" winds increasing to "Severe Gale 9" later in the day. At about 1015, I contacted QHM Longroom Port Control on VHF radio, who advised of 2 nautical mile visibility and 25-knot winds in the vicinity of the Plymouth Breakwater. Shortly before going to the bridge (about 1055), the Commanding Officer asked me if "I was comfortable getting the ship underway (with the forecast weather conditions)", to which I responded in the affirmative. Conditions at the time of underway were conducive to a safe transit and would easily support sending personnel topside in complete safety. The underway from the pier and outbound transit through The Narrows and Smeaton Pass were uneventful with no indications of worsening weather conditions. At approximately 1215Z, I heard the OOD and COB coordinating over the 7MC to drain the FET lower hatch and send personnel topside for the Pilot transfer. At about 1220, the OOD gave the order to send personnel topside. During this timeframe, my attention was focused on maneuvering the ship around a large merchant vessel tied to Mooring Buoy "C", whose stern was encroaching into the main channel from the south, and avoiding the breakwater to the south, and I did not make an observation of the aft deck with regard to sea-state.

Shortly after hearing the order to send personnel topside, I observed the pilot boat "Opal" take station on the port quarter in preparation for coming alongside. After observing the pilot boat, I returned my attention to visually fixing the ship's position and keeping the Navigator appraised of proximity to hazards. After about five minutes, I heard the "Man Overboard" call and immediately trained the periscope on where I believed the man would emerge from visual baffles. Looking aft, I was surprised to see that sea conditions had rapidly deteriorated, with seas breaking well forward of the AET. I saw no personnel in the water and assumed that they had been recovered by virtue of their safety harnesses. My attention again returned to keeping the Navigator abreast of the ship's proximity to hazards. Shortly thereafter, I heard several more calls of "Man Overboard" and again, immediately trained the periscope aft. After about one minute, I could not see anyone in the water, so I trained the scope optics to maximum depression (covers the area about mid-way between the FET and AET) where I observed Petty Officer Holtz hanging over the starboard side, attached to the ship by his safety harness. At this time, I learned that the COB was also overboard in the vicinity of the FET, also attached by his safety harness. I divided my attention about equally between fixing ship's position and observing the men in the water. Almost immediately, the rescue swimmer [redacted] and [redacted] went topside in an attempt to free the COB and Holtz. Shortly after going topside (less than 1 minute), Petersen was washed overboard, unrestrained, and I observed as he was quickly recovered by the pilot boat, signaling that he was OK. Almost immediately afterward, the rescue swimmer [redacted] was washed overboard on the starboard side, unrestrained, and I observed him clasp his hands over his head, signaling that he was OK. He was recovered by the "Opal" and was able to assist in getting himself aboard. Once again, my attention returned to keeping the ship clear of hazards and navigationally safe. At this time, as I recall, our intentions were to clear the breakwater, turn around and return to the harbor to again attempt rescue, and the pilot was summoned to the bridge. During this time, our maneuvers in close proximity to the breakwater demanded my constant attention and I was unable to observe the men in the water for several minutes. Shortly after returning to the harbor (about 5 minutes?), I observed the COB drifting aft and concluded to myself that his safety line must have broken free. He was floating face-up, though was not moving. MOD Police RHIB recovered him within 1 minute and I remained focused on him for several seconds, looking for signs of movement. After seeing him clear of the water, I again fixed ship's position visually and made my reports to the Navigator. My attention was again equally divided between navigating the ship visually, and observing Holtz, who was still trapped on the starboard side with no signs of consciousness. Several minutes (10 minutes?) later, I observed him drift aft, though at the time it was unclear to me if he was cut free or simply had broken free. I later learned that a second rescue swimmer had gone on deck and cut him free. Again, MOD Police RHIB quickly recovered him and immediately transferred him to the larger MOD Police escort vessel. Shortly thereafter, we received word via VHF radio that CPR was being performed on Holtz, though we received no word on the condition of the COB. Several minutes of communications ensued between MOD Police, Longroom Port Control, and the ship and we were able to sort out identities and conditions of personnel. After identities were confirmed and all personnel were accounted for, the ship proceeded to sea.

4 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 23 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) for approximately 41 months. My job aboard MSP is that of [redacted]. This statement supplements the written statement I have provided to the investigation team on 4 January 2007.

2. At the time of the mishap, I was the assistant navigator. Looking at the VMS printout confirms my statement that the first man overboard call was made inside the breakwater.

3. There were several of us who conducted various portions of the piloting brief the day prior to getting underway. Most of the information at the brief is put out by the OOD. I briefed the weather, tides and currents. The COB briefed small boat handling issues. The pilot was present at the brief and pointed out significant issues throughout the brief. With regard to my portion, I briefed that we would be getting underway about 45 minutes to an hour before high tide. We expected to have a falling tide by the time we reached the breakwater. I received conflicting weather information from METOC. One report received over message traffic calling for small craft warning conditions and a second graphic forecast off the METOC website indicating much more severe conditions. The local British Coast Guard forecast called for gale to severe gale conditions, with 20-25 foot seas in the English Channel Proper, well beyond the breakwater and surrounding headlands. I deferred to the local forecast and briefed this at the piloting brief.

ENCLOSURE (59)

4. We planned on maneuvering north of track past the buoy-moored container ship and transferring the pilot off after that point but before the west end of the breakwater. I don't recall whether the speed of the transfer was briefed. We usually do transfers at 3-6 knots, but will defer to what the pilot boat wants. The current was half a knot or less, as expected.

5. As we approached the transfer point, I was comfortable with how the pilot was steering the ship and staying on track. It was very soon after the small boat handling team was sent topside that we heard the first call of man overboard. There were many reports of man overboard, but I don't recall what was said about what side the men were on. The COB broke free on the port side, and when I saw him, he appeared to be unconscious.

6. On man overboard drills, we stop the shaft and turn toward the man overboard. After the rescue swimmer and tender went overboard, I didn't see any alternative other than going outside the breakwater to turn around. The tugs "Careful" and "Hopeful" were in the vicinity at the time of the incident. The conditions seemed to worsen very quickly as we moved toward the breakwater, though it did not seem as if the smaller escort boats were having any trouble.

7. I believe the last ORM training we had was just before leaving the shipyards in April or May of 2006. We do not typically use an ORM checklist for pilot transfers. We do use a piloting preparation checklist for chart preparations.

8. I believe this incident was caused by a failure to immediately assess the rapidly deteriorating conditions with regard to topside safety. Recommendations: get rid of locking

hooks on topside safety harness - a snap shackle would work significantly better and would allow for a quick release if in extremis. Hook knives with sewn-in pouches should be included with issued parachute-type harnesses.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/ Etc/SS

Sworn to and subscribed before me this 4th day of January 2007, at Naval Station Rota, Spain.

/S/

[redacted]

ENCL (59)

06 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

This statement supplements the two I provided to the investigation team on 4 January 2007.

At the piloting brief, I briefed the weather MSP was likely to expect in the English Channel on the way to the dive point. We expected to see the heavy seas beyond the headlands. I had no indication that we would run into the heavy seas anywhere in the harbor.

I have seen the 28 December DTG WEAX message distributed to my Outlook inbox at 0551 on 29 December 2006. It is my standard practice to check my message traffic immediately prior to getting underway. Accordingly, I would have seen this message. On the morning of the underway, I called port control and monitored the weather through Brixham Coast Guard. These weather reports were consistent with the weather reports I had briefed at the piloting brief the day prior for offshore conditions.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 06th day of January 2007, at Naval Station Rota.

/s/

[redacted]

ENCLOSURE (60)

SUSPECT'S RIGHTS ACKNOWLEDGEMENT/STATEMENT (See JAGMAN 0170)

FULL NAME (ACCUSED/SUSPECT)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ACTIVITY/UNIT			DATE OF BIRTH
MSP (SSN 708)			23 AUG 65
NAME (INTERVIEWER)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	[redacted]
ORGANIZATION		BILLET	
[redacted]		[redacted]	
LOCATION OF INTERVIEW		TIME	DATE
NAVSTA ROTA			6 JAN 0667

RIGHTS

I certify and acknowledge by my signature and initials set forth below that, before the interviewer requested a statement from me, he warned me that:

(1) I am suspected of having committed the following offense(s): NEGLIGENT DERELICTION OF DUTY [/S/]

(2) I have the right to remain silent; - [/S/]

(3) Any statement I do make may be used as evidence against me in trial by court-martial, - - - - - [/S/]

(4) I have the right to consult with lawyer counsel prior to any questioning. This lawyer counsel may be a civilian lawyer retained by me at my own expense, a military lawyer appointed to act as my counsel without cost to me, or both; and - [/S/]

(5) I have the right to have such retained civilian lawyer and/or appointed military lawyer present during this interview. - [/S/]

WAIVER OF RIGHTS

I further certify and acknowledge that I have read the above statement of my rights and fully understand them, and that, - [/S/]

(1) I expressly desire to waive my right to remain silent; - [/S/]

(2) I expressly desire to make a statement; - [/S/]

(3) I expressly do not desire to consult with either a civilian lawyer retained by me or a military lawyer appointed as my counsel without cost to me prior to any questioning; - - - - - - - - - - [/S/]

(4) I expressly do not desire to have such lawyer present with me during this interview; and - - - - [/S/]

ENCLOSURE (6.1)

(5) This acknowledgment and waiver of rights is made freely and voluntarily by, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.- - - -

The following is the statement of [redacted]. I was the [redacted] for the small boat handling party. I am not sure of the exact time of the sequence of events to follow. I was stationed in crews mess just prior to sending men topside to transfer the pilot. I did not have on a harness on as I would not be going topside. As men went topside (COB, [redacted] Holtz) I followed them up and stationed myself in the forward escape trunk (FET) with [redacted] to rig the hatch for dive and minimize the amount of time the hatch stayed open once personnel came down. The hatch was open approximately 4 minutes before the pilot went topside. Approximately 15 seconds after the pilot went topside a huge wave hit the boat and came down the FET. Approximatly 15 seconds after this the pilot came down with a bloody lip and said "they have gone overboard". I sent him down to recover. 20 seconds later the diver [redacted] and his tender [redacted] came up and went out the hatch. 30 seconds later [redacted] came up and went out. 10 seconds after [redacted] left the hatch I [redacted] came down and said "I couldn't hold him" (refering to the diver). On his way down [redacted] harness became caught on the upper hatch. I climbed up and freed him allowing him to get out of the escape trunk. [redacted] again got caught up at the entrance to the FET, about this time [redacted] came down the hatch. [redacted] was hanging on to the latter with all his might trying to prevent himself from crushing [redacted] Eventually [redacted] freed himself and was able to climb down. As [redacted] made his way down the hatch I realized he was still hooked in topside. I attempted to free him realizing this was impossible I told [redacted] to cut his line. After this I sent [redacted] down. At this point I heard that there was patrol boat topside recovering the men that had fallen overboard. I believed all men had fallen overboard and where no longer attached to the boat. The water was to loud to confirm this. My concern now was to prevent the ship from sinking. I knew we had taken on a severe amount of water and became afraid that we were in risk of loosing the ship. As I looked up at the upper hatch I noticed the jacobs latter was fouling the hatch not allowing it to shut. I climbed up the latter and pushed it out. The next wave forced the jacobs latter back into the hatch. I climbed back up and pushed it out. This cycle happened about 4 times. The fourth time the latter stayed outside the hatch. The men in athwart ships were pumping the hatch shut. It did not appear that the hatch was going to shut. At this point I began making preparations to shut the Lower Hatch. After clearing the hose from the lower hatch I realized that the upper hatch had gone shut. At this point I thought all men went over board and recovered. I went down to crews mess and went to get changed. Once changed I went back out to crews mess. This is when I realized that [redacted] was going topside to release Holtz from the ship. Once the hatch opened it appeared the waves had ceased. [redacted] went topside and freed Holtz. While topside I did not see any further water enter the ship.

/s/

[redacted]

ENCLOSURE (62)

05 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

I have been in the Navy for eight years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) for one year. My job aboard MSP is [redacted]. This statement supplements the one I provided to the investigation team on 5 January 2007.

At the time of the incident, I was the Officer of the Deck (OOD) for the Maneuvering Watch. When the ship arrived in Plymouth on 22 December, I was also the OOD for the Maneuvering Watch.

When we arrived on 22 December, we had planned to arrive early in the morning, about 0700, and had manned the maneuvering watch in order to pull in to the harbor. Conditions were windy and cold, although not particularly rough. As we approached the harbor, it became very foggy. We heard from Port Ops in Plymouth that the visibility was limited to an extent where we would not be able to pull in. We returned to the southeast and spent the day in a holding box, hoping that we would be able to pull on the next tidal cycle that evening. Over the course of the day, the visibility improved in the harbor area, and we were able to pull in the evening. While it was windy and cold, the conditions were better than when we pulled out of Plymouth a week later. I do not recall the direction of the wind. We transferred the pilot on to the boat, outside of the breakwater, on the 350 leg. I believe we did the transfer at 7-8 knots, something I believe I would have discussed with the pilot boat, but do not specifically recall. The BSP went slower than we wanted it to go, because I was unaware beforehand that the pilot boat wanted the Jacob's ladder positioned on the port side, where he came aboard. The seas were approximately 2-3 feet of chop. We were running north with the seas at the time. The deck was dry, although water was lapping up at the aft escape hatch.

I have been Maneuvering Watch OOD for most of the time I have been aboard MSP. As a Junior Officer, I had significant experience as Junior Officer of the Deck and OOD for the last eight months I was onboard [redacted]. I feel that I am more experienced than most guys as Maneuvering

(1.5)

Watch OOD. I am familiar with the concept of fetch, and how the wind affects the wave state.

At the piloting brief on 28 December 20006, we discussed the fact the weather was not likely to be good. I remember the ANAV read the weather message MSP had received. We had heard from CTF-69 that the expected weather for the transit out was likely to be rough. I expected winds from the south at 20-25 knots. We did use the wave and wind data forecasts that we had, but we did not use the charts to consider where the weather was likely to worsen or otherwise affect our transit out. This was our usual SOP at piloting briefs. At the brief, we discussed that if the weather seemed rough, we would conduct the BSP on the 250 leg of the transit out of the harbor. Otherwise, we would conduct the BSP outside of the breakwater. I don't recall whether we set a speed at which the BSP was to be conducted. We were expecting high seas on the way to the dive point. Accordingly, we planned to clear and de-rig the bridge as soon as possible.

On the way out, we decided we would conduct the BSP on the 250 leg after we turned around Drakes Island on the 169 leg. On the 169 leg, I could see that the seas looked choppy along the 250 leg. I feel that the breakwater had almost no effect on the wind because it was almost entirely submerged at high tide. I do feel that the breakwater provided protection against a rolling sea. I did not, however, see a sea state change on the 250 leg. I could see the wind was blowing the tops of waves both inside and beyond the harbor and based on sea conditions in the harbor, I did not feel comfortable attempting to transfer the pilot outside of the harbor. The sea state appeared to be consistent for the entire length of the 250 leg. On the 250 leg, we were encountering approximately 2-3 foot chop and strong winds. The 169 leg is the leg immediately before the 250 leg. We were likely going 8 or 9 knots on the 169 leg. I told the COB over the 7MC that we would be doing the transfer on the 250 leg. The 250 leg is approximately 1800 yards. On the 250 leg, we were maintaining approximately 8 knots. I believed that we would have approximately 4-5 minutes to conduct the transfer at the speed we were going before we would have to turn off of the 250 leg. I was using the west breakwater light as my visual cue to gauge the next turn. There was a vessel moored at "Charlie" buoy. I don't recall specifically where the vessel was in the

track, but I believe the tide had pushed it to the north-east of the "Charlie" buoy. Once we were clear of the vessel's stern, we "pressed go" to execute the BSP and the pilot left the bridge to depart the ship from the forward escape hatch. I wanted the BSP done, the pilot boat away from us, and my men going back below decks before we turned off of the 250 leg. If it was not done before that point, I was planning to loiter and talk to Harbor Patrol about our options at that point. I don't recall whether the pilot boat followed us out or was waiting for the transfer close to the transfer point. I don't recall the pilot boat providing any data on the conditions of the sea towards the transfer point.

During the beginning of the execution of the transfer, I could see that things were going slower than expected. I recall slowing MSP to allow us more time to execute the transfer prior to the turn. The pilot boat was alongside and in position to close the gap and effect the transfer at this time. On the 250 leg, I remember the pilot talked to the pilot boat. I also saw the CO talking to the pilot boat, but I remember the CO saying to me that he was not sure if the pilot boat could hear him. The CO was trying multiple channels to contact the pilot bridge. There are three bridge-to-bridge radios on the bridge - I normally keep one, the CO another and the third is usually hanging inside the cockpit. We could see the pilot boat captain about 10-15 yards off of our beam, but we could not make contact with him. Because we could not reach him over the radio, we also tried to wave him in with our arms. I am not sure why the pilot boat did not close the distance. I thought the pilot boat was probably waiting to see the Jacob's ladder go in to position and the guys on the deck indicate they were ready. I don't recall if, prior to the first men being washed overboard, the pilot boat approached MSP. Usually, I or the CO will make contact with the pilot boat. I believe that, as OOD, I need to be able to do everything on the bridge. The CO will sometimes provide assistance when I am busy.

We saw the transfer as an open ocean transfer. Accordingly, I wanted the guys on the SBHT to use harnesses and lanyards. I wanted to minimize the men topside. I know this sort of transfer is covered in the SORM. I know that the SORM discusses having men in harnesses and lanyard, the conditions of the waves, minimizing personnel on the deck. In my career, I have

seen this sort of transfer done, read the SORM, had Combat Search and Rescue training, and been in on many other briefings for BSPs and other piloting evolutions. I have received training on incidents similar to the one we had on 29 December, specifically an incident involving the [redacted] and another boat in the Pacific AOR.

After the first men were swept overboard, we ordered an all-stop. Once it was clear that the men were still attached to us, we focused on providing enough of a lee to get men topside to recover the men or allow an escort boat to approach and assist. After the men went overboard, we quickly went into a crisis situation - the atmosphere was initially confused with quite a bit of yelling. It quickly became clear that that our attempt to stop the ship was not working as we continued to take significant water over the deck and were drifting to the north towards shoal water, so we turned to come back in to more protected water. We were trying to stay clear of shoal water. Although we wanted to turn left, we had to turn right, away from the men, in order to safely execute a turn-around. The CO, the Navigator and I discussed the need to turn to the right. We did not think we would be able turn to the left. I don't recall the Navigator not concurring with my decisions with regard to steering the ship.

During the turn on the north-bound leg, the seas seemed to calm. During the entire incident and its aftermath, our speeds were based on trying to turn as quickly as possible, trying to find a lee, and maximize the time before we approached shoal water. Our speeds varied through the turn and the approach to protected water. After we had turned around and were headed north, the COB broke free, drifted past and was quickly picked up by an escort boat. We continued to drive towards more protected water in order to put someone topside in order to recover Petty Officer Holtz. We reached more protected water near the moored ship and were able to get [redacted] topside to cut Petty Officer Holtz free. [redacted] removed Holtz's lanyard, returned below decks, and shut the hatch. The pilot also successfully got off MSP during this time.

Throughout the incident, I was trying to maneuver the ship as well as I could and keep the ship from grounding. I was relaying my actions to the CO and to the Navigator. I was

trying to balance what was best for the ship with what was best for the men on the main deck getting bashed around by the water. It was hard to tell whether the ship's speed was having an effect on the men in the water. During the incident, the outboard was out and used to help me turn the ship in the right direction, and initially, to attempt to create a lee. I don't know for sure, but I think it would take three minutes to use the outboard to pivot the ship in perfectly calm seas - obviously, this does not account for current conditions.

I think this incident was caused by unanticipated shift in weather, causing the deck to go from dry to under four or five feet of water almost immediately. I don't know whether the seas had picked up or whether there was some sort of shift in sea state on the 250 leg. I did not see this shift in sea state, however.

To prevent a similar incident in the future, I would recommend not using harnesses and lanyards when there are escort boats in the area that can render aid. The man overboard procedures need to be amended, as well, as those procedures are not of much use in a situation where men are attached by lanyards to the ship. Consideration should be given to the proximity of rescue vessels.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/ 1/4/07

Sworn to and subscribed before me this 05th day of January 2007, at Naval Station Rota.

/S/

[redacted]

SUSPECT'S RIGHTS ACKNOWLEDGEMENT/STATEMENT (See JAGMAN 0170)

FULL NAME (ACCUSED/SUSPECT)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ACTIVITY/UNIT			DATE OF BIRTH
Minneapolis - St. Paul (SSN 708)			6 MAR 76
NAME (INTERVIEWER)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]			USN
ORGANIZATION		BILLET	
[redacted]		[redacted]	
LOCATION OF INTERVIEW		TIME	DATE
NAVAL STATION ROTA		0830	5 JAN 07

RIGHTS

I certify and acknowledge by my signature and initials set forth below that, before the interviewer requested a statement from me, he warned me that:

(1) I am suspected of having committed the following offense(s): NEGLIGENT DERELICTION OF DUTY & NEGLIGENT HOMICIDE /S/

(2) I have the right to remain silent; - /S/

(3) Any statement I do make may be used as evidence against me in trial by court-martial, - - - - - /S/

(4) I have the right to consult with lawyer counsel prior to any questioning. This lawyer counsel may be a civilian lawyer retained by me at my own expense, a military lawyer appointed to act as my counsel without cost to me, or both; and - /S/

(5) I have the right to have such retained civilian lawyer and/or appointed military lawyer present during this interview. - /S/

WAIVER OF RIGHTS

I further certify and acknowledge that I have read the above statement of my rights and fully understand them, and that, - /S/

(1) I expressly desire to waive my right to remain silent; - /S/

(2) I expressly desire to make a statement; - /S/

(3) I expressly do not desire to consult with either a civilian lawyer retained by me or a military lawyer appointed as my counsel without cost to me prior to any questioning; - - - - - - - - - /S/

(4) I expressly do not desire to have such lawyer present with me during this interview; and - - - /S/

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(5) This acknowledgment and waiver of rights is made freely and voluntarily by, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.- - - -

4 January 2007

From: [redacted]
To: Commander, SUBMARINE SQUADRON TWO TWO

Subj: OFFICER OF THE DECK STATEMENT OF EVENTS THAT OCCURRED ON 29 DECEMBER 2006

On 29 December 2006, I was stationed as the maneuvering watch Officer of the Deck.

Our underway from Plymouth, England, was scheduled for late morning on Friday, 29 December 2006. We held our brief on the crew's mess the previous afternoon, the 28th. The Navigator and I ran the brief in our typical fashion. The Royal Pilot attended, and periodically got up in front with the Navigator and I to present different aspects of the route from his perspective. We specifically discussed the expected weather conditions, the ship moored in the anchorage south of our 250 leg, and the plan for the Pilot to disembark. If weather conditions were poor, the pilot transfer would take place two-legs early, on the 250 leg, once we were clear of the ship at the anchorage. The Chief of the Boat briefed that his team would wear harnesses, he would minimize the number of personnel topside, and he would minimize the time that they were topside.

As expected, the weather the next morning was rainy, windy, and cold. Visibility was fair. The Pilot arrived at the ship about two hours before the underway, and I spent several minutes with him in the Wardroom discussing the weather conditions. He was upbeat about getting underway, said visibility and the weather were acceptable, and that the ship moored in the harbor anchorage was, in fact, pushed north across our track. This probability had been discussed the previous day, and we talked again about driving right of track and his disembarking right after we were clear of the ship.

The underway, from my perspective on the bridge, was routine to the point that the small boat handling party was swept overboard. I want to discuss in detail the events beginning with the turn to the 169 leg. This leg offered me the first clear view of the harbor, which previous to this had been obscured by Drake's Island. The harbor was choppy and there was some wind. Although choppy, it did not appear overly rough to me, and looked no worse than

ENCLOSURE (64)

times we had previously conducted BSPs. I could see clearly beyond the western breakwater, and the sea state appeared to be consistent throughout the harbor. I made a 7MC announcement to the Chief of the Boat at the Forward Escape Trunk to tell him what the seas looked like, and to tell him to prepare for the transfer on the 250 leg that we had briefed the day before.

I turned to the 250 leg early to stay north of track, and basically drove between the ship in the anchorage and a yellow buoy that marks shoal water to the north. I recall suggesting to the pilot that I was comfortable with the transit from this point, and that he could disembark earlier. The pilot said that he wanted to remain on the bridge until we were clear the ship in the anchorage. The pilot went below once the anchored ship was just forward of the port beam. I made a 7MC announcement to tell the control room and COB that the pilot was laying below, and to tell the COB to standby to go topside.

Ahead of us, the seas looked the same as they had since we entered the harbor, and I believed the seas would support personnel topside all the way past the turn to 224. We were clear of the ship in the anchorage, and the west breakwater light was off the port bow. The pilot vessel was about 15 or 20 yards to starboard, matching our course and speed. I looked aft, around the port side of the sail. Seas were coming from the port side of the ship. Small waves were periodically rolling over the Aft Escape Trunk, but the Forward Escape Trunk was dry. I told the Captain that I intended to send personnel topside. The Captain was also looking aft, and concurred with me. I made a 7MC announcement to order the Chief of the Boat and his team topside to conduct the personnel transfer.

I saw the Forward Escape Trunk hatch open, personnel man topside, and clip into the deck-runner. My focus at this point was primarily ahead of the ship, but I glanced periodically aft to observe the activity on the main deck. I'd estimate that I spent about 80% of my time looking forward and 20% looking aft. Although I could see a majority of the main deck clearly, due to my physical location on the bridge with respect to the aft end of the sail, my view of the personnel topside was mostly obscured.

Our maneuvering watch manning has a total of 6 personnel on the bridge, and we also had [redacted]

[redacted] on the bridge with us. The JOOD was standing in the center of the bridge cockpit. I was to the port side of the cockpit sitting/squatting/standing on the top of the sail. The Captain was standing on the starboard side of the sail, just aft of the cockpit. The JA phone talker was squatting just aft of me, to best hear and repeat what I was saying. The other phone talker was squatting behind him, in the aft port side of the flying bridge. The lookout was on the aft starboard side of the flying bridge. [redacted] was next to the JA phone talker, behind the Nav ID mast. Both [redacted] and the Captain could hold onto the Nav ID mast for support. Both periscopes were raised, and the Bridge Display Unit (BDU) was rigged on the starboard side of the cockpit. Overall, it is crowded and is sometimes difficult to see around the personnel, Nav ID mast, periscopes, and BDU. The physical positioning that I described above is what seems to work the best for us, and allows both me the Captain the best views. By sitting or squatting on top of the sail, I am high enough to see over the BDU and I can usually see around the phone talkers behind me. I can hold onto the forward-port flying bridge stanchion and lean around to the left to look aft - this affords me the best view of the main deck. I can see over the windshield and down the port side of the sail for a good view of the water near us, which helps me gage our movement through the water. The Captain can see similar views on the starboard side of the ship, since he is effectively in the opposite position from me.

The small boat party was setting-up for the transfer on the starboard side, just forward of the Forward Escape Trunk. This gave the Captain the better view of the personnel, although I continued to have a clear view of the rest of the main deck.

Two or three minutes into the pilot transfer, I began to have a sense that something was not going as smoothly as expected. The pilot boat had not moved in yet, and I could hear the Captain yell down to the COB to expedite the transfer. I expected, from previous times we had done this, that the evolution to take no more than about four or five minutes, from the time the hatch was opened until all personnel were below and the hatch was shut again. I had a sense that the transfer was going to take a minute or two longer than I had expected. I wanted the pilot off the ship and the pilot boat cast off prior to the turn to the

224 leg - not because of the weather conditions, but because I just didn't want to turn with the pilot boat pushing-up along side during a turn.

My visual cue from the bridge was the West Breakwater light - when West Breakwater was abaft the beam to port, we were near the turn. At this point, West Breakwater was still forward of the beam, but I was still concerned with the distance remaining to conduct the transfer before the turn. I ordered a 1/3 bell to slow the ship, and asked the Navigator to report distance to the turn, and to report good water beyond the turn. The Navigator reported that we were about 500 yards to the turn, and I think he reported that there was about 800 yards of good water beyond the turn. I relayed this report to the Captain, and informed him that I had slowed to give us more time for the transfer.

Within a few seconds after the Navigator's report, the bow of the ship lurched into a wave and the wind seemed to pick-up. I could not see the WLR-9, and the wave came several feet up the front of the sail. To this point, the seas had looked the same as they had when we first turned into the harbor. I had not seen any increased sea state ahead of the ship, and I was very surprised when the bow lurched.

I heard someone yell "man overboard" behind me, and I ordered all stop and announced the man overboard over the 7MC. I looked aft, it was hard to see due to the above-described manning in the bridge, and someone said that everyone was harnessed and was still on board. That made me feel better, and I made another 7MC that everyone was still onboard and harnessed. I did not know until a minute or two later that [redacted] had both gone overboard at this point. The waves kept coming and I knew that things were not going well on the main deck. I ordered a backing bell, with the intent of stopping the ship north of the breakwater, and I figured the small boats would help. As we slowed the waves seemed to be just as bad, and we were getting pushed north, which was not good. Around this time, one of the three topside personnel crawled to the Forward Escape Trunk, and made it back into the hatch.

The Navigator reported on the 7MC that we were taking water via the Forward Escape Trunk. I know I made several

7MCs as well, and really I was just trying to keep the Navigator in the loop and I figured between the two of us we could keep us in good water while we sorted out things on the main deck. I don't remember everything I said or how clear I sounded. To compensate for the northerly set, I called-up a slow bell and pointed us southwest with the west breakwater light off the port bow. We ended up driving around the breakwater, leaving it to the east of us, still trying to find a good lee and bring the small boats in to help. That clearly wasn't working, and things were just getting worse outside the breakwater, so I turned through the seas to the north to go back into the sheltered breakwater. The Captain said for the pilot to come back to the bridge, and I made a 7MC to call him back up. I think he got back up around the time I was turning back to the east on the 070 leg. As we turned north and ran with the sea, things calmed down some, and it looked for a minute like we could support sending more personnel topside to help recover the guys. At some point on the short north leg before I turned east, the COB broke loose and went overboard. I announced this on the 7MC and ordered the shaft stopped. A small boat picked him up immediately, and I put a bell back on. I drove past the breakwater toward the ship at the anchorage, keeping it to the starboard bow. There was some talk of driving all the way back in, and I was prepared to do so, but I don't believe the tides would have supported. I overheard the Captain, [redacted] and [redacted] briefly discuss mooring along a buoy or anchoring, but that was a very short discussion and the Captain said the plan was to get the topside guys safely off, attempt to get the pilot off, and then head back out to sea. The pilot directed one of the tugs to station off our starboard bow to help keep us off the anchored ship, which seemed like a good idea to me, and I stopped the ship with a backing bell and used the outboard to help position keep and twist us to best support a lee.

The main deck was dry again. Petty Officer Holtz was still topside, on the port side of the main deck just aft of the Forward Escape Trunk. The pilot boat was nearby, but was too big to come along side to get him - it looked to me that they were concerned with crushing him inadvertently. Within a minute or two, a small boat was back alongside, and drove right up on the deck next to him, basically t-boning us and pushing his bow up against our port deck. One of the small boat personnel tried unsuccessfully to reach Petty Officer Holtz. I had made a

couple of 7MCs at this point for our diver to come topside to cut Petty Officer Holtz loose for the small boat. There was some delay below decks in getting [redacted] (the diver) ready. I remember asking the XO for a "no kidding" time estimate over the 7MC, and the answer was "about 20 seconds". It took another minute or two for him to come topside, and I remember the Navigator talking to me on the 7MC to give me an update on things prior to the hatch opening.

Around this time [redacted] went below again to try and get off. The main deck was dry, and we were positioned well with respect to the ship in the anchorage. The hatch opened, and [redacted] came onto the main deck to cut Petty Officer Holtz loose. The small boat picked him up right away. The pilot boat came along the other side (starboard side), where the Jacob's Ladder was staged, and [redacted] got off. [redacted] got the Jacobs ladder below, went below himself, and the hatch shut.

As the pilot was disembarking, I began working on my turn to the west. I had a quick discussion with the Navigator via the 7MC regarding closest shoal water and which way I should turn. The Navigator recommended turning to starboard, but we were already turning to port, the tug was to starboard and could help push us to port, so I told him I was turning port. The Navigator concurred, and I used the outboard to help speed the turn once the pilot boat was clear. After the FET hatch was shut, I ordered a 2/3 bell to help me turn. I pointed about 250, keeping the west breakwater to port, and set-up for the turn to 224. I made that turn, and the next to 170, and we continued out to sea.

This statement is accurate to the best of my knowledge and recollection.

[redacted]

06 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

This statement supplements the two statements I provided to the investigation team on 5 January 2007.

If I had seen something that better explained the phenomenon we experienced within the harbor or if the pilot had expressed concern about the conditions we were likely to see, I would have taken different actions.

I have seen the WEAX weather message received by MSP on 29 December 2006 and distributed to my Outlook Inbox at 0551. I know that I checked message traffic before reactor startup and again after reactor startup on the morning of the underway. I believe I saw this message before I went to the bridge to stand my OOD watch. I feel that this message was consistent with the weather briefed at the piloting brief the day before. This message caused us to minimize the bridge rigging, allowing us to bring the bridge personnel down as soon as possible after the maneuvering watch. I expected to pick up the projected heavy seas as we transited to the south and west. We expected to see them later in the time period, as we moved from the tail end of the maneuvering watch - perhaps around 1300 to 1330.

I take my responsibilities as Maneuvering Watch OOD very seriously. I regularly prepare maps of the area and study whatever sources I can prior to standing OOD.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/ 1/6/07

Sworn to and subscribed before me this 06th day of January 2007, at Naval Station Rota.

/S/

[redacted]

ENCLOSURE (66)

SUSPECT'S RIGHTS ACKNOWLEDGEMENT/STATEMENT (See JAGMAN 0170)

FULL NAME (ACCUSED/SUSPECT)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ACTIVITY/UNIT			DATE OF BIRTH
[redacted]			[redacted]
NAME (INTERVIEWER)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ORGANIZATION		BILLET	
[redacted]		[redacted]	
LOCATION OF INTERVIEW		TIME	DATE
NAVSTA ROTA		1120	5 JAN 07

RIGHTS

I certify and acknowledge by my signature and initials set forth below that, before the interviewer requested a statement from me, he warned me that:

(1) I am suspected of having committed the following offense(s): NEGLIGENT DERELICTION OF DUTY

(2) I have the right to remain silent; - - -

(5) This acknowledgment and waiver of rights is made freely and voluntarily by, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.- - - -

January 4, 2007

From: [redacted]
To: Commander, SUBMARINE SQUADRON TWO TWO

Subj: STATEMENT RELEVANT TO EVENTS THAT TRANSPIRED ON 29 DECEMBER 2006

1. I will provide data that is pertinent to my role on the ship as the Navigator, Operations Officer, and Senior Watch Officer. I suspect the board will find the actions following the order to send men topside were done from a reactive standpoint and with the safety of the submarine and crew the foremost consideration. In hindsight I second guess very little of what was done following the point that the first man went overboard.

2. I write the officer watchbill for the maneuvering watch. Like any other submarine, it is reviewed by the XO and signed by the CO. I did two deployments as a JO under two different CO's. My first CO, [redacted] had the Engineer drive into every foreign port during the deployment, including Plymouth. My second CO had a different officer drive for each port. As a result I had the opportunity to drive in or out of Souda Bay, La Maddalena, Bahrain, and conn the ship through the Suez Canal. Both philosophies have their advantages and I have insisted on having the best of both worlds. The Engineer is clearly our best ship driver. The next best would be the DCA. The first time we pulled into Rota the AENG was the OOD, but I had the Engineer on the bridge as an "OOD Advisor." It worked out well because he ended up taking the deck and conn once we were in the basin as it ended up being a limited assist landing in high winds. My goal, as I have discussed with the CO, is for him to never to be in a position where he feels compelled to take the Conn while he is on the bridge. The right personnel were in the right positions. The results would have been much worse with less experienced personnel on the bridge.

The DCA, my second best line officer I have, was assigned topside supervisor. He is normally my choice for contact coordinator, but contact density is very light during the Plymouth maneuvering watch and it would have been a waste of talent. I like to make the DCA the topside supervisor as he had a good working relationship with the COB, he is a

diver, and he is someone that can be called upon for help as he is free for most of the maneuvering watch.

3. My piloting preparations were adequate. Plymouth is a very difficult port to pilot in and out of relative to what we are used to. The charts were British Admiralty charts approved by NGA and they were corrected and prepared in accordance with the NODORM. We spent a good bit of the piloting brief talking about how we would mark the turns and increase/decrease the rudder through the turn if necessary. The Pilot attended the piloting brief the day before the underway and provided insight and recommendations.

An area that I can self assess after the fact that I fell short in preparing for was understanding the exact extent of shoal water. In order to negotiate the channel safely you need to be at a high tide. During the incident I felt my recommendations may have restricted the ship as we probably would have been safe to venture further into the marked shoal water on the chart. This would not have prevented the incident, but it may have helped in getting the ship back in protected water faster. To steer into charted shoal water would have been risky as we were approaching the steep downward gradient of the tide cycle. While we had 20 feet of water under the keel at the time of the incident, we could have been aground soon if we continued to operate in the same area.

4. As the Operations Officer I consider myself one of the Captain's closest advisors. If a recommendation to not get underway were to be given, it should have been given by myself or the Executive Officer. We knew, and briefed at the Piloting Brief, that the weather was going to be rough during the surface transit. The weather in the morning was a little foggy, but visibility was reported as two nautical miles at the breakwater by Longroom Port Control. The winds were about 25 knots, but I assessed it not to be a navigation hazard as the majority of piloting is in protected waters. I did not recommend to the CO during our discussions that we stay in port as I thought the conditions were safe to get underway. As a matter of fact, the conditions seemed typical for the UK in late December. I probably placed too much trust in the Pilot as we had recent history calling off our arrival on 22 December. We were supposed to moor in the morning, but port operations

called it off without hesitating due to poor visibility. I trusted their judgement.

We planned for foul weather as CTF 69 advised us the day prior that seas would be 18-20 feet ivo SOPAREA ONE. I did not expect the seas to get that bad until we were around the Scilly Islands. We planned on how we were going to mitigate the risk of rigging the bridge for dive and how we would reposition the radar mast if it stopped due to getting hit with a wave. I asked CTF69 to revise our SUBNOTE so we could dive earlier. As written our SOPAREA was not going to open until 2330Z that night.

The question of the Pilot transfer point came up in my discussions with the Pilot. I asked him what the earliest he felt comfortable getting off the boat was. He informed me that it was the Charlie Buoy. The Charlie Buoy is on the 070/250 leg North of the breakwater. This seemed acceptable as there was really only one turn after that to get out in to open water. The night we arrived we embarked the Pilot seaward of the 070 leg. I thought a Pilot transfer on that leg would be safe.

5. I have a respect for opening the forward escape hatch when we are underway. As a junior officer I had the opportunity to be the OOD during a MEDEVAC in the Gulf of Aden when we transferred a shipmate off to a CRRC. The CO smoked an entire cigar in ten minutes and he was visibly sweating the evolution. I felt we had done much more dangerous things to that point in the deployment and was surprised he was so concerned. We maneuvered to find a good course and he eventually ordered personnel topside. That night at Officer Training he put a rule into effect that the OOD would no longer ask permission to do something, he would just say what he intended to do and wait for concurrence. It was undoubtedly because he felt that he single handedly made the decision to open the hatch. I have told this story a number of times at officer training and have insisted that the OOD look at the aft deck and when he is satisfied it is safe he will inform the CO that he intends to send men topside. The CO will concur as he has already made his own assessment of the situation. That is not in a standing order, but it is how I train the junior officers. That is the way business was conducted on 29 December.

When we open the FET in open ocean I am always in Control and usually commandeer one of the periscopes. I believe the CC and the XO were on the periscopes at the time we were about to send men topside. I asked the XO to look at the aft deck and he said he was satisfied. I saw some of the Deck on the SUBIS screen and saw some foam occasionally making it across the AET. The FET is not visible from the periscope. We were piloting at the time so I remained focused on that.

6. I knew we had lost someone when the Engineer ordered all stop and a rudder. I heart sank and I figured the Pilot fell in the water or something. I focused my attention on the chart and reported nearest shoal water and hazards to navigation. The situation quickly became more dire as several more men were reported overboard. The Pilot boat was going to come alongside to help. The ANAV was on number one scope and he looked at me and said "these guys don't have a prayer." He was saying that regarding taking a boat alongside. I looked at the SUBIS monitor and saw the diver go past the rudder as he was swept overboard. The ship was taking very large rolls and I saw at least a third of the screw come out of the water when I glanced at SUBIS. I knew we had to get back into sheltered waters or the situation would only get worse and we would not be able to help the men trapped topside. I started briefing a plan to the OOD on the 27MC and we both gathered ourselves quickly and got the boat turned around and back toward the northern side of the breakwater.

7. My assessment from control was there was absolute confusion in the crew's mess. They would not acknowledge the OOD's orders over the 7MC like they usually do. I vectored the XO to Crew's Mess to take charge. He appeared in Control a few minutes later. I was directing several actions in the control room as most people seemed pretty shell shocked at what was going on. The situation as I saw it was that the FET needed to be shut (with guys topside) and the ship was 300 yards from the southern end of the breakwater and getting washed closer and closer. I feared we were dangerously close to losing the ship as the FET was open, neither the bridge or COW could effectively communicate with CM/athwartships, and we were getting pushed against the rocks when we were using jockeying bells and the outboard. I briefed the Control Room the priority was to get the ship back on the other side of the

breakwater. We did that and somewhere along the way the FET was shut.

8. The situation I described above was not good. The only thing we could do was not make it worse. Grounding the ship or sustained flooding through the FET was my biggest concern and I think we did well preventing that. As I stated above the lessons learned from a navigation/operations perspective is to never get yourself in a situation like this. I thought our planning and ORM was sound at the time, but based on two shipmates getting killed we should have taken a harder look.

/s/

05 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

I have been in the Navy for 11 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) for 18 months. My job aboard MSP is Navigator. This statement supplements the one I provided to the investigation team on 5 January 2007.

At the time of the incident, I was the ship's Navigator. I normally stand between the two plotters while I am navigating. In my position there, I am able to hear bridge-to-bridge radio traffic.

At the time of the incident, our navigational equipment was working effectively. During the incident, I had no doubt about the ship's position. Our VMS equipment helped to give me the best idea of the ship's position. We do not use a camera to record our ship's plotting chart. It is my general policy to record my concurrence in the Deck Log.

At the piloting brief, we discussed the transfer and expected weather during the transit out. With regard to the weather, we knew that bad weather was expected, but we thought that would affect us more on the transit to the dive point. We do not usually keep our weather messages in a "Current Ops" binder. We discussed navigational aids we would encounter along the transit out of the harbor. We do not use a checklist to cover required subjects at our piloting briefs - I used to use an outline in my notebook, but at this point, I have the required elements of a piloting brief memorized. We discussed getting the pilot off after the moored vessel at "Charlie" buoy, but the exact point was not discussed. The pilot indicated the "Charlie" buoy would be the earliest point at which he would be comfortable getting off of the ship. There was no point designated by which we would want all men back below decks after transferring the pilot off of MSP. At the brief, we told the Small Boat Handling Team (SBHT) to prepare for an open-ocean pilot transfer. There was no discussion at the piloting brief or any other time as to when it would no longer be safe to transfer the pilot off of MSP. The change in sea state we encountered when the men were washed overboard was entirely unexpected. Before they were washed

ENCLOSURE (69)

overboard, I had not considered there would be any difference in sea state after passing the breakwater. I did not give the breakwater any more significance than any other navigational aid.

On the way in to the harbor on 22 December 2006, we had transferred the pilot onboard outside of the breakwater. The sea state while we were loitering away from the harbor waiting for the next tidal cycle was approximately 2-4 feet.

I would expect a pilot transfer in conditions to those similar to the ones we encountered on the 250 leg to take about 3-6 minutes total. MSP had an effective process for transferring pilots on and off the ship. I know open-ocean transfers are addressed in the Man Overboard procedures and, to a lesser degree, in the Combat Search and Rescue procedures. I have had training as a Junior Officer in topside evolutions. I don't recall seeing open-ocean transfers addressed in the SORM. The MSP also had conducted man-overboard drills. No training I have received ever covered a man-overboard scenario wherein the man washed overboard was still attached to the ship.

We felt comfortable doing the transfer at about 5 or 6 knots - We started the 250 leg at about 8 or 9 knots and I recall the OOD calling for a slowing. I concurred with the slowing. On the 250 leg, my attention was focused on the ship's position with respect to track and avoiding the moored vessel. I was aware that we needed to get the pilot transfer going. Before the men were swept overboard, I was thinking we needed to get the transfer going, but more than anything else, I was relieved that we had made it through the tricky turns that preceded the pilot transfer. During this time, I do not remember hearing any bridge-to-bridge radio traffic asking the pilot boat to approach. Similarly, I do not remember hearing anything from the pilot boat about conditions further down the track.

After the men were swept overboard, I recall that we were being sent to the north-east (towards the breakwater). At first, we were trying to maintain very low speeds, but we continued to transit out of the breakwater area. Immediately after the men were swept over, I recall the OOD calling down to me that he was attempting to create a lee to recover the men. I do not recall making immediate recommendations to the bridge. During the

piloting evolution preceding the incident, my navigational team performed, overall, at a below average level. I do not recall hearing the XO make any recommendations to the bridge during the incident. I do not recall hearing the XO voice any non-concurrences with maneuvers. I concurred with all of the maneuvers the OOD was calling for during the incident and its aftermath. At some point after the men were washed overboard, I recommended we turn around and Outside of the breakwater, I believe we were encountering approximately ten-foot swells traveling in a north-easterly direction. I think we had a two/thirds bell on when we executed our turn to the right to bring the ship into more protected water. I did not want to go faster than two/thirds because things could have gotten considerably worse much faster. There was no consideration given to using the outboard to pivot the ship around to the left. I didn't feel as though there was any time to analyze. My concern at the time was less for the men topside than for the forward hatch being open. My number one priority was to get the ship out of the dangerous position we were in and get the forward escape hatch shut. The XO was in Control for a majority of the incident and its aftermath, although at one point he went to Crew's Mess to re-establish comms. While in Control, the XO was forward of the scopes, so I don't know what he was doing during the incident.

On 28 December 2006, all personnel had to check in by 1600, although supervisors and the SBHT needed to be back before then. After personnel checked in, liberty expired at 0700 on 29 December 2006.

Knowing what we know now, it is apparent we should have incorporated "go/no go" criteria to get the pilot off well before the breakwater. Because the transfer on the way in was not bad, and I had not had trouble in Plymouth in the past, I did not think the sea would be as bad as it was as early as it was. Looking back on the incident, I wish I had known at the time how far I could have gone into the shoal waters without danger to the ship. At the time, I did not have a good sense of how much good water I actually had.

Sending men topside is always a judgment call. The two key decisions to this evolution was the decision to get underway or not and the decision to send men topside when we did. With

respect to the decision to get underway, my primary factor was visibility (which was reported to be about 2 nautical miles). The winds were strong, but not unexpected, and the pilot seemed comfortable getting us underway.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/ 1/5/07

Sworn to and subscribed before me this 5th day of January 2007, at Naval Station Rota, Spain.

/S/

[redacted]

06 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

This statement supplements the two I provided to the investigation team on 4 January 2007.

I would have been more concerned with the sea state at the end of the breakwater had it been briefed in sailing directions or Lessons Learned. It is my usual practice to review message traffic prior to getting underway.

I have seen the 28 December 2006 DTG WEAX message distributed to my Outlook inbox at 0551 on 29 December 2006. I believe I would have seen this message prior to getting underway on the morning of 29 December 2006, given my usual practice. This message is consistent with the weather we expected. However, given this message, I should have given more thought to the sea state beyond the breakwater. We knew that we could expect heavy seas on the way to the dive point.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 06th day of January 2007, at Naval Station Rota.

/s/

[redacted]

ENCLOSURE (70)

4 Jan 07

From: LTJg Kurt Hungerford, USN
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 3 years and my permanent duty station is USS GEORGIA (SSGN 729). I have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since 31 October 2006. This statement supplements the written statement I provided the investigation team from 4 Jan 07.

2. At the time of the incident, I was the Junior Officer of the Deck.

3. When we were ready to transfer the pilot belowdecks, I was in the cockpit. The OOD was up on the sail.

4. The weather didn't seem that bad during the transit down the river. It seemed to get considerably worse after we passed the anchored vessel. We were specifically warned at this point that we'd take water.

5. It was around the anchored ship that the incident happened. I believe the pilot had a radio on him but I'm not positive.

6. I don't recall any discussion modifying where the pilot would be transferred to his boat.

7. I've been on board the MSP since the beginning of November. Since I've been on board, there has been no formal ORM training.

8. I attended the pilot brief. There were no later modifications to the plans.

9. When the men were washed overboard initially, a backing bell was put on to slow the ship down. The OOD was talking about

ENCLOSURE (71)

getting a lee to make the recover of Petty Officer Holtz. No alarms were sounded. No flotation devices or dye markers were thrown as far as I know.

10. I have not heard of any other similar incidents to this.

11. When we had the pilot up and were making the transfer, it was a while before the first man went overboard. The Captain had asked why they hadn't come to pick up the pilot yet. I don't recall what was communicated via bridge-to-bridge radio.

12. There was a discussion at the pilot brief about the weather. The wave height was mentioned as was the tide, set and drift.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/

Sworn to and subscribed before me this 4th day of January 2007, at Naval Station Rota, Spain.

/S/
K. W. SIGURDSSON
LN1(SW), USN

COMPLIANCE WITH SECTION 0221 OF THE JAG MANUAL

I [redacted], have been advised that:

-questions have arisen concerning whether or not my injury/ disease, sustained or discovered on 29 DEC 06, was incurred in the line of duty or as a result of my own misconduct;

-in the event such injury/disease is determined to have been incurred not in the line of duty or as a result of my own misconduct, I will be required to serve for an additional period beyond my present enlistment to make up for the duty time lost;

-lost duty time will not count as creditable service for pay entitlement purposes;

-I may be required to forfeit some pay (where absence from duty in excess of one day immediately follows intemperate use of liquor or habit-forming drugs);

-if I am permanently disabled and that disability is determined to have been the result of misconduct or was incurred not in the line of duty, I may be barred from receiving disability pay or allowances, as well as veterans' benefits;

-I may not be required to give a statement relating to the origin, incidence, or aggravation of any disease/injury that I may have.

I ~~do~~ ~~do not~~ desire to submit a statement.

04 Jan 07
Date

/S/ FT1/SS
Signature

Witness Signature

[redacted]

Witness Name/Rate/Grade/Unit/Telephone Number

ENCLOSURE (72)

The following is the official statement of [redacted] regarding the events aboard USS Minneapolis St Paul during the maneuvering watch of 29Dec06 outbound from Plymouth, England.

During the maneuvering watch I was assigned duties as a line handler and as part of the small boat handling team. During the outbound transit the decision was made by the COB that due to the sea state we would send minimal personnel topside for transfer of the pilot off the submarine. Personnel assigned to go topside were the Senior Chief Higgins (COB), [redacted], STS2 Holtz (Deck LPO). [redacted] was the maneuvering watch diver and his assigned tender was [redacted] was assigned the position of phone talker/rig for dive in the upper portion of the escape trunk with [redacted] was directed to dress out as a standby below deck in the event additional assistance was required topside.

All personnel assigned to go topside were wearing harnesses with 1 dyna-brake, 1 extension, deck traveler, turnabout line, and kapok's. All personnel had assistance in ensure that their gear was donned correctly were double checked.

At approximately 1300 the order was given from the bridge to send personnel topside for the transfer. Looking at the SUBVIS display in crew's mess we could see that the seas were a little rough with occasional waves coming over topside. Shortly after personnel went topside the sea state increased and man overboard was announced over the 1MC. [redacted] immediately went topside to assist.

Not long after [redacted] went topside we began taking a large amount of water down the hatch. I went to the forward escape trunk to see if any assistance was required and say [redacted] attempting to hold the bathtub closed and to allow it to drain. The water coming through the hatch was such that it did not have time to drain and was filling the crews mess and athwartships with water. I was trying to help [redacted] keep the bathtub drained with [redacted] gave the order to secure power to the scrubbers and burners due to the large amount of water going into the machinery room. I secured power while [redacted] took over assisting [redacted]. At this point I was unaware of the condition of the topside party.

After securing power to the scrubbers and burners I started attempting to assist [redacted] and [redacted] with the bathtub again. [redacted] fell through the FET a short time later. He was caught up in his harness and couldn't get free. We cut him free with my knife and he was taken to the wardroom for our [redacted] for medical attention. Shortly after that [redacted] who was caught in the upper portion of the FET had to be cut free by personnel in the hatch and fell to the bottom of the ladder. He was also taken to the wardroom for medical attention.

At this point we were receiving reports that water had filled the bilges machinery room and was threatening to begin spilling through the rest of lower level. The order was given to shut and dog the upper hatch of the escape trunk. This was hindered by the fact that the jacob's ladder kept ketting washed back into the path of the hatch preventing us from coming fully shut with the hatch. During this [redacted] relieved [redacted] on the manual hand pump used to shut the

ENCLOSURE (73)

hatch. With assistance from the personnel in the escape hatch we managed to get the ladder clear and shut and dog the upper hatch. I went to the wardroom to see if any addition assistance was needed there when our IDC asked me about the status of STS2 Holtz. I had heard that several personnel had been washed over the side and had been retrieved by the pilot vessel. I went to verify the status of [redacted] and that was when I learned that the pilot vessel was keeping him above the water, but could not retrieve him because he was still attached to the submarine by his harness. We made for calm water and as soon as we were able to sent [redacted] another ship's diver, topside in a harness with a tender also in a harness to cut Holtz free. Shortly after that the pilot went topside and transferred off. After the pilot was transferred and the personnel with him below decks the hatch was shut and dogged. At one point the order was given to retrieve the Jacobs ladder but I am uncertain of when and how that was retrieved from topside

We were told on crew's mess that we could not go back into port due to the fact that the tide was going back out and could not make the transit back through the channel. The word passed over the 1MC was that our four shipmates that had been washed over the side had all been recovered by small boats and were being taken to a emergency room in England. With that the crew turned to the task of cleaning up all the water and assessing the damage to the ship.

/S/ [redacted]

4JAN06

05 Jan 07

I am [redacted]. My maneuvering watch on the morning of 29December 2006 was NIFTI operator. Upon hearing man overboard for the second time, I went to crews mess to assist in dressing personnel out in harnesses and found 3 to 4 inches of water on the decks and a constant pouring of water through the forward escape trunk. I assisted [redacted] with his harness. There was confusion as to who was actually topside. I knew that [redacted] were in the wardroom being attended to by the corpman. Everyone's concern was getting the people who were topside safely below decks but the water coming down the hatch made it impossible for anyone to go up. [redacted] one of the ships swimmers, tried to get up the ladder, but was not able to. At least 10 minutes went by, and an order from the 7mc and crews mess phone talker, that all men were clear topside, shut the forward escape trunk lower hatch. But again it was impossible to get up the ladder due to all the water [redacted] pumped the upper hatch shut. He was completely soaked in the water and showed obvious signs of fatigue and cold, so I helped him to the wardroom, where the corpman immediately attended to him. With buckets a number of us started dewatering crews mess. About 5 minutes passed and the XO came into crews mess and said that Holtz was still topside and gave the order to open the forward escape trunk and send someone to cut him free. [redacted] helped [redacted] get into a harness. At least another 5 minutes elapsed to get [redacted] dressed out. I opened the forward escape trunk lower hatch, and latched it. [redacted] verified the line up for opening the upper hatch and opened it. But it was dogged shut. I went up and opened it. There was a brief down pour of water and then the hatch was clear to pass. [redacted] came up with [redacted] right behind him as his tender. [redacted] went up and cut Holtz free, and we all went down. I went to change out of my wet clothes, and came back to crews mess to assist with the clean up efforts.

/S/
[redacted]

ENCLOSURE (74)

From: [redacted] USS Minneapolis-St-Paul.
TO: Mishap Investigation Board

Subj: Statement of recollection of events on 29 December 2006

During the course of events surrounding the tragic mishap on 29 December, I was assigned the duties of line three SUP. At approximately 1200Z the Small boat handling party was standing by in the crews to escort the pilot off the ship. Personnel consisted of COB, [redacted] STS2 Holtz, [redacted] and [redacted] (Standby as needed). COB briefed the Small boat handling party on small boat transfer. COB stated he wanted minimal amount of people topside for the transfer. At about 1230 the Order was given to open the fwd escape trunk upper hatch. And send the small boat handling party topside. All personnel were equipped with Kapoks and lanyards [redacted] was first on deck then COB and STS2 Holtz. The order was given to send up Boat hook, Jacobs ladder and life ring. The COB then ordered the pilot to lay topside. Soon after the boat took a roll. The ship then experienced a large intake of seawater through the fwd escape hatch. I went to control and ordered the COW to line up to pump the AMR bilge with drain pump. After the order was given to pump the AMR bilge with drain pump I proceeded back to the crews mess.during which time Man overboard was passed on the 1MC. Immediately Peterson went up the FWD escape trunk hatch followed by [redacted]. Water continued to come down the fwd escape trunk. After rescue party went topside man overboard was passed again on the 1MC. The pilot then came down fouled by [redacted] and [redacted] who was dangling by his lanyard. [redacted] was cut down by [redacted] I helped take [redacted] to the wardroom for medical treatment. I then helped suit up [redacted] in a harness and was tended below decks. He was sent topside to try to help STS2 Holtz, who was still attached to the boat by his lanyard. He also removed the Jacobs ladder that was fouling the fwd escape trunk hatch. The hatch was then shut and dewatering efforts were commenced. All personnel were then mustered on station.

/5/

EXCESS)
1/4/2007

ENCLOSURE (75)

04 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 709) ON 29 DECEMBER 2006

1. I have been in the Navy for three years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 709) since October 2005. My job aboard MSP is Anti-Terrorism Officer (ATO).

2. At the time of the collision, I was the Navigation Evaluator and bridge-to-bridge communicator. I am also the ship's ATO.

With regard to the piloting brief, I remember that it ws important for the pilot to be at the brief. We intended to do the transfer before leaving the protection of the breakwater but after we passed the vessel at anchor. I don't recall what speed the transfer was supposed to take place at. I don't recall any triggers or "go/no go" criteria for the pilot transfer being discussed at the piloting brief. I know that the weather was expected to be poor once we were out to sea, but I expected the weather would not overly affect us while we were still inside the breakwater.

On MSP, we don't have a hard and defined division of labor for who talks to whom over the comms channels - it is more situational.

I did not call the pilot boat to approach and I don't recall the bridge calling the pilot boat in. While in the control room, I understood the weather topside was windy, but I can't speak to the actual conditions. The pilot came down from the bridge prior to the transfer and said we would not want to be out in the weather. I don't recall comms being overly affected by wind noise. I don't recall anyone calling to the pilot boat at any time to inquire about weather conditions at the transfer point. With regard to the incident: I remember the first call of man overboard coming from the bridge and a second call of man overboard coming from the PXO who was manning the scope. Calls for MO followed in quick succession. We were also receiving calls of grounded equipment coming over the 1MC due to the water coming down the hatch. I made calls to surrounding boats enquiring about the status of the recovered men, trying to conduct a head count. I remember it took a long time to establish accountability for the COB - we finally got word that he had been recovered and was in an ambulance headed for the

hospital. While trying to establish the whereabouts of the entire crew and recover the men overboard, we had gone outside of the breakwater and then maneuvered back around inside the breakwater. After the calls for men overboard started to come in, I remember we stopped the shaft once. I don't recall any comms passed to escort boats informing them of our intentions with respect to the men overboard. We had no comms problems going out, but at one point we did have trouble reaching the police boats. We knew that men were attached while we were doing our turnaround.

I am not aware of previous lessons learned from similar events. I am not aware of specific ORM guidance prior to this evolution. I do recall receiving ORM training in the past. We do often use an ORM checklist, but I don't recall whether we used one for this evolution.

I don't know what we could have done differently or better to prevent this incident. One of the big problems in this case was the fact that Holtz and the COB remained attached to the ship - a quick release may have help to prevent similar incidents, particularly when there are escort boats in the area.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 04th day of January 2007, at USS MINNEAPOLIS-ST. PAUL (SSN 709).

/s/

[redacted]

ENCL (76)

Statement concerning the events of 29 December, 2006 onboard USS MINNEAPOLIS ST PAUL (SSN 708) [redacted]

I am the [redacted] assigned to those duties since July 06. Prior to that I was [redacted] in Groton, CT for 30 months. I embarked in Plymouth, England to ride to Rota, Spain. The purpose of my ride was to debrief the ship's last mission, brief and train them for the next mission, and to oversee connectivity improvements required for the next mission. [redacted] accompanied me.

I attended the piloting brief at 1400 on 28 December on the mess decks onboard the ship. Of note, the RN Devonport Harbor pilot was specifically invited by the ship to attend and was present at the piloting brief. The weather was discussed as deteriorating but expected to support the underway, and the tides dictated an 1130Z underway (the tidal swing and some shoals along the route require ingress/egress only at high tide). The pilot disembarkation was specifically discussed, and was planned to occur inside the breakwater in the vicinity of buoy (anchorage) Charlie. The piloting brief was pro forma and adequate – I had some minor comments for improvement for the Navigator which I discussed with him afterwards.

The day of underway, 29 December, I suited up and went to the bridge a little after the maneuvering watch was stationed. The weather was marginal, with winds gusting to about 35 kts, visibility about a mile, temperature in the 50s. The ship was moored bow in near Northwest Corner and I could see across the river but not much farther, about two miles. During the main engine warmup, the pilot reaffirmed the weather supported the underway. We were accompanied by the two tugs, two or three pilot type boats, and two FP type boats including one RHIB. After we moved away from the pier and began to spin around for the first southbound leg, I had to hold on to the NAV ID mast to stay upright and I estimate the wind gusts peaked at 50 kts during that soutbound leg, possibly funneled by the river banks. On this leg, I watched the COB and topside party rig cleats, get themselves down the FET and shut the hatch and it seemed quick, in one glance there were 3-4 people waiting to get down the hatch and the next time I looked back at the FET the hatch was coming shut. This played into my mental estimation of the time the ship would need to conduct the subsequent pilot transfer.

I have gotten underway and done BSPs in worse visibility and temperature conditions from Groton but have never felt wind like that on the bridge.

My interaction with the bridge team during the transit out to the pilot drop-off was minimal. The wind precluded easy communications, but I felt the actions conducted by the team were prudent and appropriate. The two long turns through the banks were conned, as briefed. As we progressed through the outbound track, the wind eased considerably at times, on several occasions almost slackening, but on two further southbound legs increased to the same intensity as before. Again, I'm not sure if this was due to funneling along the river or to a variable system that was passing through in waves. Our speed was never greater than 9 kts throughout.

Turning onto the 250 leg, which was the breakwater / pilot disembark leg, the pilot gave some last minute instructions and headed below. An RN ship was tied at 'Charlie' bouy; this was briefed at the piloting brief and again prior to underway. The ship had swung partly into the channel, which was also as briefed. As I was further aft on the top of the sail for most of the pilotage, I had been looking at the Fwd Escape Trunk (FET) fairly often, and I took a hard look as the pilot went below. The OOD had ordered a lower bell, 6 kts by log I think. No waves were coming near the DSRV ring and it looked acceptable to open the hatch, and I looked ahead down the track and didn't see anything alarming, in fact the water looked confused but fairly flat past the end of the breakwater. The CO and OOD independently made the same assessment and sent the small boat handling party (SBHP) topside. By this time we had slowed and the pilot pickup boat was directed to close. For some reason he was staying about 100 yds north of the ship. The COB plus 2x SBHP came topside, in full open ocean gear and harnesses, proceeded to clip their harnesses into the safety track, and began rigging the jacob's ladder. I am not sure of names so I'm leaving them out. My recollection of the bearing to the tip of the breakwater was about 340R as the SBHP was ordered topside, and our crab angle to remain on track with reduced turns was about 20 degrees left of base course.

At this point the jacob's ladder was mostly rigged. I looked ahead down the track and saw some chop about 500 yds down track, near the breakwater tip, and told the CO "it's not getting any better topside there, they better hurry up." He agreed and had the word passed below decks to expedite getting the pilot topside, and also directed the OOD to call the pilot boat in again. In the next minute or so I saw a ripple come near the Aft Escape Trunk and the CO appeared to notice the same thing, because he passed the word again to expedite getting the pilot boat alongside. The pilot boat was pointed to close but not closing, and about a minute later the CO ordered the SBHP below, as I think he saw something forward that I didn't. I was motioning to the pilot boat to come closer and they seemed frozen, station keeping 100 yds to the north. The wind was howling at this point, and I looked down at the FET in time to see a wave break about 4 feet over the hatch and wash the three clipped in SBHP over the side. The lookout and OOD immediately called "Man Overboard, Stbd Side." All three were tethered to the ship and getting washed against the hull. The CO was yelling to send more people topside to help the SBHP get below and we were both noticing water going down the hatch. One or two of the SBHP were washed topside and one of them made it to the hatch [redacted]. Then the swimmer made it topside up the hatch and went to assist the two remaining SBHP get below. When he was kneeling by the TA fairing pulling up on one of the lanyards he was washed over the side by a smaller wave. More 'Man Overboard' calls were made. A RHIB from the port, I believe on station for FP duties, promptly plucked him out of the water. The CO looked at me, said we needed to get the guys below, and I suggested that we take all way off. The CO directed the OOD to back down and take way off. I thought about continuing to back down but between the restricted waters and the set/drift I didn't think we'd be able to maintain control of the ship. In the next minute it became apparent that the waves were not due to our headway, with 4-5 ft waves continued to intermittently wash over the open FET and bashing the two guys on the tethers against the ship. One more guy, in a harness, came topside to help the two SBHP on tethers, but he was washed overboard

before he had a chance to hook in. He was washed astern, and also picked up by the RHIB.

The CO said we needed to turn the ship around and get back into protected water, I agreed, and the CO ordered the FET hatch shut. There was a problem getting the lower hatch shut and the FET team ended up shutting the upper hatch after a minute or two. The ship headed out past the tip of the breakwater to turn around. The CO focused the OOD (ENG) to 'drive the ship' and continued to call in the pilot boat to assist. The navigator was passing recommendations on turning around along with distance to shoal water, and had obviously been appraised or had figured out we were headed out past the breakwater to turn around. The CO via the OOD summoned the pilot back to the bridge to assist since he had not disembarked yet. The only significant exchange I had with the CO as we turned around was about sending personnel topside, he wanted to reopen the hatch send more people topside to help with the two remaining tethered SBHP, but I pointed out the water steadily breaking over the hatch and said that would make things worse. He agreed. The pilot wanted to know if we wanted a helicopter for assistance and I told him I didn't think one would be much use in this wind, and the CO later said the same thing to him.

Sometime during the turn around, one of the two SBHP tethers broke and he was washed down the side of the ship. The RHIB picked him up and transferred him to one of the chase/pilot boats also accompanying us. Throughout the turn the OOD / NAV continuously passed intentions and distance from shoal water. Once steady on the 070 leg, the RHIB attempted to get close enough to the remaining tethered SBHP to cut him loose but was unable. We proceeded back up the 070 track until around the 'Charlie' bouy and ship, and the waves and wind subsided completely. The CO ordered the OOD to slow and open the hatch and by the time most of the way was taken off the ship, the hatch was opened. A tethered swimmer was directed topside to cut the last SBHP loose, with the RHIB immediately beneath him. The RHIB crew plucked him from the water and they sped north. The pilot now disembarked via the jacob's ladder to the pilot boat. At this point all MOB personnel were recovered and the ship appeared to be in stable waters, and the CO made the decision to rig topside for dive, clearing the remaining tethers and jacobs ladder below decks. The CO hadn't formally decided that we were not returning to Plymouth but that was my assumption. The weather / visibility was getting worse, and I knew about the tidal restrictions. We used one of the accompanying tugs to assist in turning around, and proceeded outbound, after shutting the FET hatch. The seas picked up again near the breakwater mouth but seemed less than before. The ship loitered south of the breakwater and I came down from the bridge to assess the damage from the water, talked to the corpsman about injuries. When it was apparent that we had no life-threatening injuries onboard, I talked to the CO, came up in chat to CTF 69 to make a report, pass our status, and give intentions. CTF 69 was unclear if we wanted to return to port, and also if the pilot had gotten off. I confirmed we were heading out to sea and that the pilot had disembarked. We proceeded out in very rough seas to the dive point, which was about 14 hrs away.

/S/

[redacted]

Page 3

04 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 20.5 years. I am assigned to [redacted] and have been so since July 2006. Prior to that, I was the [redacted] for thirty months. This statement supplements the one I provided to the investigation team on 4 January 2007.

At the time of the incident, I was a rider -- I was there to brief and train the crew for their next mission and to oversee connectivity improvements required for the next mission.

At the piloting brief, I remember seeing the METOC weather message on the screen in a powerpoint brief. The forecast called for worsening conditions. We also heard from local nationals that the conditions were going to be bad and getting worse. Although the pilot was used to getting off outside the breakwater, because of forecast conditions, we decided to get him off inside of the breakwater. We discussed ORM procedures for poor sea conditions outside of the breakwater (such as getting the bridge broken down quickly and safely).

There was no formal tripwire or "go/no go" criteria for getting the pilot off, although as I mentioned, we made the call to get the pilot off prior to leaving the protection of the breakwater. While we were approaching the proposed transfer point, I did not see anything indicating it would be unsafe to transfer the pilot. I considered the efficiency of the ship in getting people up and down from topside upon getting underway, the number of people who were going topside, and the fact that there were no waves breaking over either hatch at the time we opened the forward hatch. The wind was howling at the proposed transfer point and I was holding on to the NavID mast to stay upright.

The tugs escorting us were both "pull" and "push" boats. The pilot and the tugs communicated very effectively. The pilot used his own radio to communicate with the tugs. After speaking with the pilot at the piloting brief, I feel that he demonstrated experience and familiarity with the conditions. I was comfortable going to sea with him.

ENCLOSURE (78)

The breakwater is awash, meaning that waves were occasionally breaking over the breakwater. The waves inside and outside of the breakwater were about the same. There was whitewater and confused seas inside the breakwater, as well as outside of the breakwater.

About the time we reached the anchored ship, the pilot left the bridge. The OOD told the pilot that he, the OOD, was ready for the pilot to get off of the ship. The OOD and the CO both had radios - I believe that both the OOD and the CO called to the pilot boat to approach and pick up the pilot. The small boat handling party went topside. At the time, I looked down the track and felt we could complete the evolution safely. However, I could also see that conditions were worsening - at this point, water was starting to gather around the aft escape hatch. Accordingly, I told the CO that things were not getting any better and the evolution needed to be expedited. I believe I remember the CO calling to the pilot boat a second time to approach and transfer the pilot. At the same time, I was waving the pilot boat in manually. I don't know whether the wind was not letting the boat approach, but regardless, the pilot boat did not close the distance between itself and MSP.

I think that the men were swept overboard because the wave height went from almost nothing to almost shoulder level almost immediately. At this point, the OOD was driving the boat, receiving guidance from the CO. The OOD continued to drive the boat throughout the incident and worked with the Navigator to stay away from shoal water and bring MSP back to safer water. As I remember, the CO noticed the worsening conditions and ordered the men below before the men were swept overboard. This was not a freak wave, but the beginning of much deeper troughs than I had seen. The wave seemed to come almost straight down the sail, although because the men were washed over the starboard side, it must have had a port-side component. This was still behind the breakwater. At one point after the men were washed over, a wave washed one of the men attached to the ship with his lanyard to the other side of the ship. As we turned around, the waves were smaller than the ones that had washed the men overboard, although the waves were still washing over the aft portion of the ship.

After the men were swept overboard, we first tried to take all way off of the ship, but that did not help the waves. I believe our only option then was to go forward out of the breakwater and turn around because it was not safe to back down and we could not send any other personnel topside to help the men washed overboard. We did not want to back down the track because of the danger of running into shoal water, as well as concerns about the merchant vessel moored to the "Charlie" buoy. Because the waves were so big where the men were washed over (perhaps four feet over the hatch), I don't believe we could have created a lee with the ship to recover the men. I don't believe we considered using the outboard to spin MSP around. As we turned around, we felt we needed to turn the ship around as fast as possible, but we were not going to execute the turn too fast because of the men attached to the ship. I don't believe we discussed what particular speed would be too fast to execute the turn. I don't think the escort boats could have approached MSP to cut the tethers of the attached men. In fact, even in more protected water, the escort boat did try to approach MSP, but they were not able to cut the attached men loose.

I am not aware of any equipment casualties that affected this incident, although the 7MC occasionally had a "squeal," likely from the rainy conditions on the bridge.

I feel that the crew's togetherness as a team is well above average. Groups were very effective at working as distinct teams to support each other and solve the problems that had emerged as a result of the crisis. The Engineer is a very effective OOD, in fact, one of the strongest I have ever seen. I believe the CO needs to do a better job of ensuring forward procedures are followed, but I don't think this contributed to this incident.

I feel that the events were caused by unanticipated weather conditions. At the two southbound legs, before the pilot transfer point, the wind was easily twice as strong as what it had been when we got underway. When we got underway, the wind was probably blowing 25-30 knots. I believe the pilot still felt that he could safely be transferred off of MSP. Nobody suggested MSP not get underway when we did, in fact, we heard that the weather would be even worse the next day. The people making the decision to get underway felt that we had seen worse;

while the conditions were not ideal, we assessed that we could do so safely. Neither the ship nor the pilot gave a great deal of consideration to the manner in which the wind would affect the wave height. The pilot was most concerned about the timing of the tides.

In general, I feel that the submarine force does not have a lot of experience driving in and out of ports, especially different ports. I feel that procedures need to be established that set up tripwires to have people back below decks as part of the chart preparation and ORM prior to getting underway.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/

CMA/USN

Sworn to and subscribed before me this 04th day of January 2007, at Naval Station Rota.

/S/

[redacted]

04 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 22 and 1/2 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since the end of October 2004. My job aboard MSP is LCPO in Electrical Division. This statement supplements the one I provided to the investigation team on 4 January 2004.

2. At the time of the incident, I was Chief in Charge of the Damage Control party. I was not involved with the attempt to recover the men who had been swept overboard. When I was in the auxiliary machinery room (AMR), the water was up to the deck plates in the aft end of the machinery room.

I recall quite a bit of ORM training onboard in the last year. I practice ORM on a daily basis in my division.

Damage from taking water down to the hatch extended to the diesel generator, both COH2 burners, #2 scrubber, the P7 power panel, the trim pump, the auxiliary drain pump controller, one of the transfer pump controllers, and lighting in deep bilge.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/ [redacted] 1/4/07

Sworn to and subscribed before me this 04th day of January 2007, at ~~USS MINNEAPOLIS-ST. PAUL (SSN 709)~~. KS
NAVAL STATION ROTA, SPAIN KS

/S/
[redacted]

ENCLOSURE (79)

5 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 5 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since September, 2002. My job aboard MSP is a Sonar Technician. This statement supplements the written statement I provided the investigation team from 4 Jan 07.

2. At the time of the incident, I was Petty Officer of the Deck.

3. When I was tending the line, I was up where I could see. I was told by [redacted] that if a wave took someone over, to let them go.

4. At that point, the seas were rough but there was no water coming over the deck.

5. When I was topside, the wind was coming from starboard to port as I was facing aft. I believe the waves were coming the same direction as the wind but by then the wind had died down.

6. I could see Petty Officer Holtz after he was cut free. He had a cut on his head and appeared to be unconscious. I didn't see any sign of life from him at all.

7. The RHIB boat was 30-40 feet out when I was topside.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

ENCLOSURE (82)

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

/s/

Sworn to and subscribed before me this 5th day of January 2007, at Naval Station Rota, Spain.

/s/

[redacted]

4 JAN 2007

I am [redacted] the Auxiliary Machinery Room Watch. On 29 Dec 2006 the day of the underway from Plymouth, England. The morning before the underway I heard word to expect 16 to 20 foot seas and to ensure our spaces were stowed for sea. When the COW called down to pump AMR deep bilge I noticed the upper hatch was drained and they were about to send personnel topside. I was on the port side of AMR and boat was taking some noticeable rolls when man overboard was called away. At that time is large amounts of salt water come pouring down into the AMR, followed by 2 other reports of man overboard. I was in the aft end of AMR giving reports to the JA phone talker on the quickly rising bilge level. At 3 ½ft to 4ft I recommend pumping the AMR deep bilge with the drain pump. Shortly after reaching 6 1/2ft the order was passed to me to open the bilge suction to AMR. At this time AMR was raining buckets of water and made operating the bilge suction very difficult withou[redacted]holding the hatch and blocking the water from me while I opened the bilge suction. The bilge suction was opened as the water rose to the bottom of the deck plate, then the drain pump was started and the bilge level started to drop then more water came down from above to fill the AMR 6-8 in above the lowest deck in AMR. Orders were passed to control to secure power to EOG, scrubbers and burners from [redacted] Then personnel ran down to AMR to grab A-DIV'S safety harness to send [redacted]opside to cut petty officer Holtz free from the boat. The word starting filtering down that the COB was unconscious topside and that Petty officer Holtz was still attached to the boat in the water unconscious. I heard word that both were given CPR on the pilot boat on the way back to the pier and that both were stable. It wasn't until the next day that we got the news of the passing of both of them. This statement is to the best of my knowledge of the events that unfolded on 29 Dec 2006.

R/

[redacted]

/S/ 1/4/07

ENCLOSURE (80)

5 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 3 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since January, 2006. My job aboard MSP is the Supply Officer.

2. At the time of the collision, I was the Contact Coordinator. As the contact coordinator, I look at AIS contacts and fire control solutions. I looked out the scope immediately after getting underway, and then again after we were beyond the breakwater - otherwise, the assistant scope operator, [redacted] [redacted] and [redacted] were on the scope.

3. At the piloting brief the day before the incident, I remember the pilot discussing the river and the transfer. I don't remember whether the transfer was supposed to be inside or outside of the breakwater. We usually do our transfer at four or five knots, but the speed was not specifically discussed at the piloting brief. At the piloting brief, we were more concerned with getting off the pier and down the river, as the river has many turns. At the brief, the weather was discussed: it was expected to be bad with high winds. We were going to get underway about an hour before high tide. We were expecting 18-24 foot seas, but not until we were outside the breakwater. The pilot was focused on the turns down the river; he did not discuss the transfer point. Sending a minimum number of people topside was discussed because of the expected weather. I don't

ENCLOSURE (81)

recall tripwires or "go/no-go" criteria for the transfer being discussed at the piloting brief.

4. With regard to the incident, I was below decks, but I was aware that the ship was rolling. I also knew waves were rolling over the aft of the ship, as I could see this on the SUBIS monitor. I don't recall any conversation about weather/wave condition down the track towards the transfer point. There was no contact made with the pilot boat to discuss the transfer or weather at the point of transfer.

5. Prior to the proposed transfer point, I know that the pilot came down from the bridge after we maneuvered around the ship anchored at the "Charlie" buoy. Because of the building tide, this ship had drifted into the channel. I don't recall communications coming over the radio between the bridge and the pilot boat, but this contact is usually initiated by the OOD.

6. On man overboard drill, we practice a "straight back" maneuver. When the call for MO went out on the day of the incident, I could not see anyone on the SUBIS monitor. I also remember after the first MO call went out, there was quickly a call that said he had been recovered. This was followed by a series of additional MO calls and calls that men had been recovered. At this point, we started maneuvering to come back inside the shelter of the breakwater. I know that there was some debate on whether we should turn to port or starboard in order to come around inside the breakwater - the OOD thought we should turn to port, and ANAV said we needed to turn to starboard. I

assume we did not do our practiced backing maneuver to recover the men overboard because escorts behind the ship and speed which the RHIB recovered the men. [redacted] mentioned seeing one man attached on the port side after we had maneuvered back inside the breakwater. He was able to see this from the #2 scope.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 5th day of January 2007, at Naval Station Rota, Spain.

/s/

[redacted]

SUSPECT'S RIGHTS ACKNOWLEDGEMENT/STATEMENT (See JAGMAN 0170)

FULL NAME (ACCUSED/SUSPECT)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ACTIVITY/UNIT			DATE OF BIRTH
MSP (SSN 708)			[redacted]
NAME (INTERVIEWER)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ORGANIZATION		BILLET	
CSS 22		[redacted]	
LOCATION OF INTERVIEW		TIME	DATE
NAVSTA ROTA		0925	5 JAN 07

RIGHTS

I certify and acknowledge by my signature and initials set forth below that, before the interviewer requested a statement from me, he warned me that:

(1) I am suspected of having committed the following offense(s): NEGLIGENT DERELICTION OF DUTY [redacted] /S/

(2) I have the right to remain silent; - /S/

(3) Any statement I do make may be used as evidence against me in trial by court-martial, - - - - - /S/

(4) I have the right to consult with lawyer counsel prior to any questioning. This lawyer counsel may be a civilian lawyer retained by me at my own expense, a military lawyer appointed to act as my counsel without cost to me, or both; and - /S/

(5) I have the right to have such retained civilian lawyer and/or appointed military lawyer present during this interview. - /S/

WAIVER OF RIGHTS

I further certify and acknowledge that I have read the above statement of my rights and fully understand them, and that, - /S/

(1) I expressly desire to waive my right to remain silent; - /S/

(2) I expressly desire to make a statement; - /S/

(3) I expressly do not desire to consult with either a civilian lawyer retained by me or a military lawyer appointed as my counsel without cost to me prior to any questioning; - - - - - - - - - - /S/

(4) I expressly do not desire to have such lawyer present with me during this interview; and - - - - /S/

ENCLOSURE (83)

(5) This acknowledgment and waiver of rights is made freely and voluntarily by, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me. /S/

SIGNATURE (ACCUSED/SUSPECT)	TIME	DATE
/S/	0926	1/6/07
SIGNATURE (INTERVIEWER)	TIME	DATE
/S/	0926	1/6/07
SIGNATURE (WITNESS)	TIME	DATE
/S/	0926	6 JAN 07

The statement which appears on this page (and the following ____ page(s), all of which are signed by me), is made freely and voluntarily by me, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.

SIGNATURE (ACCUSED/SUSPECT)

PLS SEE ATTACHED

[redacted]

- Provided 6 JAN 07

Statement about the events on 29 December 2006.

The ship was scheduled to moor in Plymouth England on the morning of 22 December. The ship is not allowed to transit into or out of the port without a pilot. The ENG was the OOD as he is the ship's best ship driver. As we manned the maneuvering watch for a 0645 local transit start we ran into a fog back that limited visibility to about 4K yards. The ship was [redacted] and we were discussing not proceeding in to Plymouth. The British Pilots organization, Long Room Port Control, told us that visibility inland was at about 200 yards and that the ship could not come in. This was the right decision. The ship set up a steaming box and loitered for 12 hours and commenced the inbound transit at about 1900 local. We embarked the pilot before we were on the first leg (350/170) of our maneuvering track well outside the harbor. The outboard was lowered prior to picking up the pilot. These events told me two things. The first thing was that the pilots would get on and off the ship well outside of the harbor, which was in agreement with the Sailing Directions. The second was that the Pilot organization was very willing to call off the transit/pilot transfer if the weather did not support. This gave me a good feeling that Long Room Port Control was very engaged and very interested in safety of the ship.

On Thursday the 28th of December [redacted] informed us that the seas would be rough/high on the way to the dive point. I tasked my leadership to discuss the issue of the heavy weather and to do the appropriate ORM to safely get the ship to the dive point. The team came up with a plan to derig the bridge as fast as possible once completing the maneuvering watch to allow shifting the watch below decks as soon as possible if required. We also worked with [redacted] to get water to allow us to dive earlier to allow the ship to submerge sooner in time to get below the rough seas. The ship had dealt with heavy seas several times in the past during surface transits and had rolled the lessons learned into this ORM. When off the coast of Brest France in October 2006 we had heavy seas on our four surface transits with the worst being the transits to and from Brest for the BSP to get the [redacted] off the ship.

Our piloting brief was held on 28 December in the afternoon. I requested that the pilot attend the brief and the Navigation team was told that the pilots do not attend the piloting briefs. I really wanted the local expertise to discuss our plans with us so I ordered my XO to personally engage the pilots and see if he could get them there or if I had to engage at a higher level. The XO called the pilots and they agreed to come to the brief.

At the piloting brief we discussed the transit with the navigation team and pilot. We discussed expected tides, currents, and weather. [redacted] attended the brief. We discussed expected rudder orders, SPM usage, a ship anchored at the C buoy, where and how we would debark the pilot. We discussed the possibility that the anchored ship may be blocking our track and that we would have to conn off track to the north to clear the ship. The pilot said that the pilot normally gets off the ship after the piloting is done on the 170 leg. We discussed that if the weather was bad he would debark on the 250 leg once we were safely past anchored ship. This transfer would be two legs early but we felt that we could safely navigate the ship out without the pilot on

board at this point. The ENG and the COB discussed getting the line handlers down from topside once away from the pier and then sending them back up shortly before the pilot transfer. The ENG discussed that the team may need to be limited to three people and in Open Ocean transfer gear vice using the full small boat handling party. We have used this method in the past very successfully – sending the First Lieutenant, the COB, and the Deck LPO up and staging the swimmer and tender in the trunk and the rest of the party staying below decks. This allows us to get the team up and down within about 3-5 minutes and minimize the number of personnel on deck to a small set of highly proficient people, reducing the number of personnel at risk. We had executed many BSPs in this manner, sometimes in seas that would occasionally put water over the FET. We learned that we could put a beach ball in the hatch to deflect the water from coming into the ship and quickly pop the beach ball to get below.

On the morning of the underway, 29 December, the weather was misty and overcast. Visibility reported to be at least two miles and winds at 25 knots. I was concerned with the weather and I asked my team for recommendations on getting the ship underway in these conditions and they all recommended getting underway. I discussed this personally with the NAV, ANAV, XO, PXO, COB, and the ENG. Each felt that it was safe to sail. I asked the ANAV to get updated reports from Long Room Port Control throughout the morning so we understood the conditions in the harbor. The ANAV did that and reported that the conditions were holding. The pilot was on the ship about two hours before the underway. Both the ENG and NAV discussed getting underway with the pilot and the pilot was very comfortable leaving the pier. I later discussed it with the pilot as well. The XO discussed the weather with the XO of our host ship, the HMS TRENCHANT, and the RN XO stated that this weather was not actually that bad and was typical of Plymouth. The RN XO stated that once away from the shore things could get rough but that would be well after we were done piloting. I took the recommendations of my team and made the decision to get underway. I discussed this with [redacted] to get his input as well. He agreed that we should get underway and stated that we both had gotten underway from Groton in weather worse than this. [redacted] also discussed that the weather was only going to get worse over the next few days and now was the time to go. Right prior to the underway I asked the pilot to confirm the conditions at the harbor and again got the report that visibility was still at least two miles and the winds were 20 - 25 knots.

The ship was ready to get underway before the sailing time of 1130. The pilot stated that we would wait until exactly 1130 to get the ship underway as we should leave on time. The ship got underway and twisted to head out. The weather supported the underway and we were able to use all visual NAV aides. The ship handled well as we used up to 30 degrees of rudder and the use of the SPM. Once we progressed to the first turn we were committed to going to sea as the tides in Plymouth will only support a one hour interval to get underway and get to sea and there was no place to turn the ship around until at the anchorages.

During the outbound transit the ENG did a good job of working closely with the pilot and driving the ship. The pilot and the ENG discussed the turns before we turned and then

executed the agreed upon plan. I would make recommendations to the ENG to assist him when I thought necessary. This is the way that I expect the OODs to drive the ship and me to stand back and provide oversight vice being the super OOD. Once steady on the 169 leg we could see the entire harbor and decided that the water supported the BSP on the 250 leg and waiting until the 170 leg would be too risky. The ENG ordered the COB to prepare for the pilot transfer using the open ocean type of transfer that we had discussed the day before and to drain the FET upper hatch. I expected the hatch to already be dry, as we were not taking any water across the deck.

As we approached the 250 leg we saw that the anchored ship had, as briefed the day prior, swung to the North and was indeed across the track. We conned the ship to the right to point half way between the ship and a buoy, which marked shoal water. The ENG discussed with the pilot that he was comfortable and asked him if he wanted to conduct the transfer now, as the ENG was comfortable with conning the ship out from here. The pilot stated that he wanted to stay on the bridge until we were past the stern of the anchored ship. The ENG discussed his intentions with me of sending the pilot below once the ship was abeam and conducting the transfer on the 250 leg. I looked ahead on the ships track and saw that the 250 leg would support the transfer all the way past the turn to the 224 leg if required and that we could safely conduct the transfer on the 224 leg if required but that the water was choppy on that leg and we ran the risk of taking some water down the FET if we had to conduct the transfer on the 224 leg. I then checked the after deck, which was dry at the FET, and there was occasional foam at the AET. Once the ship was abeam to port the pilot told us he was comfortable going below and leaving. The pilot radioed his small boat that we would be transferring him off soon and the pilot boat took station on the starboard side. The pilot went down and the pilot boat was on station on the starboard side. I saw the ENG look aft at the deck and noticed [redacted] looking as well. The ENG told me "Captain I intend to open the FET upper hatch and send personnel topside". I looked aft once more and concurred and ordered the ENG to send the COB topside and conduct the transfer. I looked aft and saw the hatch pop open. S[redacted] looked around and came topside, then called for the others to come topside. The COB and STS2 Holtz followed shortly. The deck remained dry through out this.

I saw the COB and his team take station and they seemed to be very comfortable topside and not have a sense of urgency. Based on history I have no doubt that the COB would have let me know if he was even slightly concerned. I asked the COB to expedite the transfer, as I am not comfortable with personnel topside and want to minimize the time they are up there. I looked ahead and saw that the water ahead was still good and that the light on the west end of the breakwater was at about 345 relative, just off the port bow. I then waved to the pilot boat to come alongside and attempted to contact him on the BTB. At this point the transfer was going slower than I liked and I then told the COB to again hurry up and the COB responded that they had the ladder rigged and were ready. [redacted] commented that the weather was not getting any better and that we needed to get the transfer done. The ENG then slowed the ship to AA1/2 to allow more time before the turn to conduct the transfer. None of us on the bridge were concerned with the weather but with getting the transfer done before the turn to 224 leg. All of my conversations with the COB were done with out a radio with me just talking/yelling to him from the top

of the sail. The delay was the pilot boat being very slow to work alongside. I looked ahead again as the ENG had the NAV report the distance to the turn and again was satisfied with the water in front of the ship. The breakwater light was still well forward of the beam. I looked aft again and saw the pilot try to come on deck but [redacted] ordered him into the trunk, a standard practice to minimize the number of personnel topside until he was absolutely needed. The team will have the pilot come up once the boat is ready as the pilot would not be in a harness and the team could not keep track of him and get the pilot boat to the right location. I heard the NAV report that there was 500 yards to the turn and that we had about 800 yds of good water past the turn in that direction. I saw the team on deck wave the pilot boat in and it approached closer. The pilot boat was riding smoothly in the water and was coming along side. Both [redacted] and me were motioning the boat over as well and I told the pilot boat to come along side again on the BTB. The team had been topside less than three minutes at this point.

The wind suddenly picked up and was howling. I looked forward and heard the ENG, I think, yell, "wave". Others on the bridge were yelling as well. I think I yelled for the team to go below as I turned aft but with the wind I do not think they heard me. I saw a large wave carry all three of the guys over the starboard side. The bridge team called away man overboard on the phones as the ENG did on the 7MC. The ENG ordered all stop and right full rudder initially. I told the ENG that the three men were tied to the ship and were not near the screw. The ENG reported that on the 7MC. At this time my memory is not as crisp as it was before this time in the sequence. I do remember thinking that I was happy the guys had harnesses on as they should be able to get back on the ship, or the two rib boats could pick them up if they used heir knives to cut free. I attempted to get the ribs to come up and assist on the BTB and heard the control party going out on the BTB as well. The wind was still very loud making communications very difficult. This was further compounded by the bridge party calling out various reports on the status of the men.

The winds and waves continued and the guys were getting bounced around pretty badly. We ordered back one third and then two thirds to try to get way off the ship and move backwards toward good water. The ship was drifting north toward shoal water at the time and the NAV kept us up to date on the ships position. We jockeyed bells and rudder and used the SPM to try to find a lee for the men. The FET hatch was still open as I wanted to keep it open as long as possible to allow the men to get below once they were back on deck. Immediately after the man overboard call the swimmer [redacted] went topside. His tender [redacted] stayed in the trunk. [redacted] also responded to the man overboard call and went topside in a kapok and with a harness he never attached to the deck. Both were washed overboard very quickly. I think [redacted] went down the port side and [redacted] went down the starboard side. The ENG ordered the shaft stopped again and the rudder to the right based on the call of [redacted] over the starboard side. Both [redacted] signaled they were ok and were rapidly picked up by the British small boats.

All three of the original men were washed up on the deck within a few minutes – maybe three to five at the most. The COB was flat and not moving on his back centerline

slightly aft of the FET. [redacted] was forward of him and went over to check the COB and then went into the hatch. Holtz was farther aft and was also on his back.

As this was happening the ship was moving to the west and we kept conning the ship to try to find a lee and stay out of shoal water. Throughout all of this the ENG, [redacted] and I were discussing ship maneuvers and options. At this point I ordered the hatch shut with the two men still topside and to maneuver the ship back further into the harbor. I saw that the drain pump was pumping overboard. The hatch did not go shut as fast as I would have liked. I also saw the Jacobs ladder float into that area as well. The hatch did eventually go shut and we continued to pump the AMR bilge. I received reports that water was up to the deck plates in the AMR.

I realized that the tide was going to drop rapidly but I was confident that we could get the ship up to the anchorages, get the men off the deck, the pilot off, and the ship back down track before we were in danger of going aground. I assumed some risk as we may end up operating in water that was marked as shoal on the chart but I was confident that we had water under the ship to support.

I had ordered the pilot back to the bridge. I am not sure of the time but it seemed around the 5-minute point. We were to the west of the breakwater and we told the NAV we were returning to anchorages. The pilot told us he had called for a rescue copter and told us that the ribs would not come along side to assist, as they would get damaged.

We used the outboard and a large rudder to turn to the right to head back towards the anchorages. As we were turning to the right the COB, who was on the starboard side broke free and was recovered quickly by the small boat. We continued the turn and approached the anchored ship on a 070 base course. As we approached the anchored ship the pilot put a tug on the starboard bow to help push us away from the anchored ship if required.

The pilot confirmed our belief that we could not go back to the Naval Base but he offered to us that we could tie up to one of the anchorage buoys that were there. I did not consider this a viable option since the ship had never conducted a buoy tie up, ever, and I had lost my topside specialists. I told him we would spin the ship and head back out to sea. At some point the winds died down and the seas calmed as well. The pilot agreed with our plan to stop the ship and turn to the left away from the breakwater using the outboard and one of the tugs on the starboard bow.

The pilot asked if he should try to get off now and we agreed. I ordered the XO to send a diver topside to cut Holtz's tether off. [redacted] was finally sent topside to cut Holtz, who was on the port side, free. A rib boat had tried to recover Holtz prior to this as we were starting to twist but could not get him off the ship. [redacted] cut Holtz free, retrieved the other lanyards and Jacobs ladder, helped the pilot off and went below. All of this was done west of the C anchorage in about the same area we were when we attempted the original transfer.

We headed toward sea at this point. We made the next two turns and immediately started to derig the bridge and send personnel below.

Once I was off the bridge I was informed that we were [redacted] and that they wanted a OPREP-3 NAVY BLUE vice a unit sitrep due to press interest. [redacted] informed them of our intentions not to go back into port, the fact that we could not get back in port right now. We discussed that the next tide cycle would be at midnight and that did not make any sense to go in then and we knew the weather was just going to get worse over the next three days. I also talked to our Corpsman; [redacted] told me that [redacted] was hurt but that is was not a life threatening injury. Since there was no personnel with life threatening injuries, and the tide cycle resulting in the next chance of going in at midnight, and the seas predicted to get worse over the next several days we decided to go to Rota as scheduled and have the crewmembers join us there. [redacted] while we loitered waiting for concurrence. Once we obtained the concurrence we proceeded down track.

06 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

I have been in the Navy for 23 ½ years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) for 26 months. My job aboard MSP is [redacted]. This statement supplements the one I provided to the investigation team on 6 January 2007.

Throughout the incident on 29 December 2006, I was on the bridge of MSP.

With regard to going in and out of ports, during my first tour, I was on an SSN out of Charleston - I had an average amount of ship-driving experience. My second tour was spent on a ship that was in the shipyard for the majority of my tour. My XO tour, I was XO of an SSBN. I have been on the bridge for every port evolution on MSP. I have been through the Submarine Command Course, as well, where some surface ship-driving is practiced. [redacted] I have been in and out of Norfolk, Groton, Kings Bay, Mayport, Brest, Rota, and Plymouth. MSP also conducted a pilot transfer off of Norway, although we did not go into port there.

I am familiar with an incident similar to the one that occurred on MSP, onboard USS OLYMPIA, although I don't believe that was in a formal training context where the Lessons Learned were discussed.

I have received training with respect to open ocean man-overboard drills. I know that the Small Boat Handling Party has trained on man-overboard drills. I also know that MSP has conducted Crew's Mess training on man-overboard drills since I have been CO. I have never received training on what to do when the man washed overboard is still attached to the ship in rough water. At the Submarine Command Course, we discussed when to open the hatch in open ocean transfers, vice what to do if someone went over still attached to a lanyard after the hatch was open. I have read the SORM article addressing life preservers and small boat practice procedures several times.

ENCLOSURE (85)

On the way into Plymouth on 22 December, we picked up the pilot well outside the breakwater. The sea conditions that day were calm. We conducted the transfer at approximately 7-9 knots, and I was not aware of any water going down the hatch at all.

On 28 December 2006, we received a message indicating we could expect heavy seas late the next day. We expected the conditions to continue to deteriorate over the next 48 hours. I believe the Navigator [redacted] learned that we could expect rough seas on the way to the dive point. We expected the seas to get very rough after we were away from the coast and headed out - past the Penlee navigational aid. We knew that before we passed Penlee, we had some sort of protection from the headland. As a basis for thinking the weather would worsen after Penlee, I relied on Lessons Learned from other submarines going in and out of Plymouth, as well as the sailing directions and information from the pilots. Those sources did not indicate anything suggesting bad conditions prior to leaving the protection of Penlee.

We did the piloting brief for the outbound transit the afternoon before we got underway. We typically do the piloting brief the day before we get underway - we do this so that we have time to modify the plan of our evolution if required, but close enough where the information is still fresh in people's minds at the time of the evolution. We do not have a formalized checklist for "go/no go" on the day of the underway, although I talk to every member of the team to make sure they still recommend getting the ship underway.

I require a standardized group of people to attend every pilot brief - including the piloting party, ship's control party, Control Room supervisor, Engineering Officer of the Watch, bridge personnel, and all of MSP's officers. I believe all of these personnel were at the brief on 28 December 2006. I was concerned enough with the transit out to request the pilot to attend the brief. Although he initially said he would not come and we had to push to get him there, he did attend the brief. We specifically asked the pilot if it would be safe to conduct the transfer before the 170 leg - he said that it would be.

At the brief, we identified the following hazards for the outbound transit: ship-driving through the complicated channel

down the river, the anchored vessel likely to have drifted into our track, and the pilot transfer. We discussed transferring the pilot outside the breakwater, although if the seas were bad, we would conduct the transfer on the 250 and 224 legs of the transit. I understood the pilot transfer would take place at approximately 6 knots, but I don't recall whether this was specifically discussed at the piloting brief. It ordinarily takes MSP 3-5 minutes to execute a pilot transfer, although we have never used a stopwatch to time the evolution. Our goal was to have the evolution completed before we turned off of the 250 leg. We did not have a set "drop dead" point, wherein the transfer could no longer be attempted or completed. The pilot was okay with our plan. I saw the ship-driving through the many turns as the primary hazard on the outbound transit. I did not anticipate trouble with the pilot transfer.

I do not recall the specific source of the weather that was briefed for the next day. The ANAV briefed the weather, using a large chart. He will typically use the WeatherFax and other websites to provide our weather forecasts. I left the brief expecting the seas to be coming from the southwest. We expected seas to build on our way out - the Navigator and [redacted] both discussed this. Nobody expected the seas to be overly rough until we were beyond the last headland. I also know that the XO had talked to another Royal Navy XO who said the weather on the day we left was typical for the area and that we should be able to get out safely.

Had I known there were going to be significant seas 500 yards prior to the turn off of the 250 leg, I would not have allowed anyone to be topside past that point. In hindsight, there are several different options we could have used to get the pilot off earlier in the transit - but we simply did not know there would be significant/rolling seas on the 250 leg. Had I known surface ships were not allowed to get underway in these conditions, I never would have allowed the pilot transfer to be conducted where it was, or even get underway at all. However, every source we consulted said that we would be okay getting underway.

After we left the pier, there were a few points in the river where we encountered howling winds that caused me some concern (these winds may have been caused by the funneling effect of the

steep river banks) - however, those winds moderated and we did not encounter the howling winds again until we were much further along in the transit, towards the end of the 250 leg.

When the Engineer is OOD, I usually let him drive as he sees fit, and I will let him know [redacted]. Usually the OOD will be the primary operator of the bridge-to-bridge radio. If OOD has his hands full, I may make any necessary calls. Occasionally, Control will make bridge-to-bridge calls. On 29 December 2006, the pilot had his own radio. I saw him call the pilot boat when we were ready to make the transfer. I then saw the pilot boat move into position on the starboard side of the ship.

With regard to the piloting evolution and getting underway, I make sure the ship is ready, our support (pilot, tugs, etc.) are ready, and finally, I make sure the visibility and weather conditions are adequate. I was concerned on the morning of 29 December about the weather, so I double-checked with my team to make sure they were ready to go.

As we moved down the track, I could see that it was a little choppy inside the breakwater. There were no large waves breaking over the breakwater, but it was awash. It did look rougher well out to sea, but our track inside the harbor appeared consistent, all the way to land on the 250 leg.

When I concurred with the decision to open the hatch to conduct the pilot transfer, I was satisfied that the aft deck was dry and the sea state did not look as though it was going to change in the near future. I was also made more comfortable by the fact that [redacted] was on the bridge with me - [redacted], had been a navigator, and [redacted] experienced sailor. It looked as though we could maintain a straight line on the 250 leg and not encounter any significant differences in sea state. I believed we could conduct the evolution safely without putting water down the hatch or losing anyone overboard. At the time, it did not appear that the breakwater was providing any significant protection. At the time the COB and the Small Boat Handling Party (SBHP) went topside, the winds were not bad - I was able to talk to the COB on the deck without a radio. The SBHP appeared comfortable with

the evolution. I did think they were not going as fast as they could so I directed the COB to hurry up.

The pilot boat did not close the gap after the SBHP was ready to conduct the transfer. I was calling the pilot boat on the bridge-to-bridge radio, as well as physically waving to the boat to come in. [redacted] and the COB were also waving the pilot boat over. Had the pilot boat come alongside promptly, however, I believe we would still have had men topside when we encountered the wave that swept the men overboard.

The winds did pick up as we moved down the 250 leg, which caused me some concern. At the time or just before the men were swept overboard, MSP may have lurched. I believe someone yelled, "wave." I believe I yelled, "get below!" I don't believe the men topside heard me or, if they had, that they would have been able to react in time to get below. At the time, I thought the wind had blown a large wave. In hindsight, I believe the wave was in fact a swell that came off of our port bow. When the men were swept overboard, the end of the breakwater was still well forward of the port beam, meaning that we had not yet passed the end of the breakwater. We still had 500 yards to the turn.

After the three men were swept overboard (the COB and Petty Officers [redacted] and Holtz), they stayed in the water. The diver and [redacted] were swept overboard after they went topside to assist. [redacted] was wearing a Kapok life preserver and harness, although he never hooked his harness to the rail. The COB, and Petty Officers Holtz and [redacted] were all washed back onto the deck. The COB did not appear to be moving at this point. Petty Officer Holtz was moving but stayed on his back. [redacted] was able to move, he checked on the COB, and crawled back to the forward escape hatch. There, I now know that [redacted] was able to cut [redacted] lanyard once he was in the hatch. The men may have slid slightly aft on the safety track. Petty Officer Holtz was the farthest man aft.

Immediately after the men went overboard, we intended to significantly slow the boat and make a lee to allow the men to be recovered. I was also cognizant of the sea state, and our proximity to the various navigational aids in the area. Our set and drift at the time was to the northeast, although I do not

recall how quickly we were being pushed. At the time, I was concerned about the ship moving too far to the north, because I knew we would quickly encounter shoal water in that direction. We were not having success creating a lee. I considered backing to the northeast, although I did not believe I had sufficient backing control to make this move. Our initial actions did not create the lee we were trying to. The stern of the ship was not moving in the direction I wanted it to with the outboard running. We have practiced surface backing on MSP many times, and I knew from previous experience that once the stern breaks loose, goes the wrong way, I would not be able to get the stern to move in the direction I wanted to go without moving forward again. We were using the outboard to try and control the boat, in addition to main propulsion and the rudder. It became apparent that we were not going to be able to recover the men without assistance and that they would not be able to regain the deck themselves. I was concerned about running the ship aground so we decided that we needed to turn the ship around. At this point, my priorities shifted from saving the men to saving the ship. We made the decision to shut the hatch. At about this time, I also ordered the pilot to be sent back to the bridge. I was calling the surrounding boats on the bridge-to-bridge to render aid - but they did not close the gap.

After the men were washed overboard, the OOD and I were both driving the ship. He was largely controlling the ship, but I would override some of his decisions throughout the incident. [redacted] the OOD and I were in agreement throughout the incident.

I am confident in my ability to drive the ship, but at this point, I was frustrated. I thought the men attached to the ship were very badly injured, and that the COB may have already died at this point.

Once we decided to turn around moving forward, the OOD considered turning left to turn around faster. I recognized that a left turn would potentially hazard the ship by running into the breakwater. We quickly realized on the bridge that a left turn was not an option. Accordingly, we turned to the right. The Navigator concurred. We had the COB still on the starboard side and Petty Officer Holtz on the port side so there was no preferred lee. We discussed how fast the turn should be

executed. In order to control the ship, we used sufficient speed to cause the ship to "bite." I could see the COB and Petty Officer Holtz were in bad shape at this time and I realized the men would not be able to regain the deck unassisted, so a faster bell would get us to calmer water and help quicker. As we executed the turn, I could see the COB and Petty Officer Holtz being dragged by the ship, although their heads were above water. At some point in the turn, the COB's lanyard broke and he drifted away from the ship.

After we turned around, we came back into calmer water. We stopped the ship with a backing bell. One of the British escort RHIBs approached the boat to try and get Petty Officer Holtz - they were unable to pick him out of the water while he was still attached to the ship. I ordered the XO to send the diver topside to cut Petty Officer Holtz loose. I knew that this would be quickest way to get him the medical attention I knew he would need. The pilot asked if we needed a rescue helicopter, and I knew that this wouldn't hurt, so I said yes.

I knew that because of the tides, we would not be able to return to the pier at this point. The pilot asked if I wanted to moor on one of the buoys - I said no, as this was a completely unfamiliar move. We then used the outboard and one tug to turn back around. At this point, the pilot asked if I would be comfortable with him getting off of the ship - I said yes. He was transferred off of the ship at this point. At the time he was transferred off, the ship was to the west of the moored merchant vessel at "Charlie" buoy. We then transited out of the harbor and out to sea.

I believe that our navigational equipment was functioning properly through the incident.

I believe this incident was caused by two principal factors: the men died because they were harnessed to the submarine and because something happened to the sea state that we did not recognize or anticipate. We did not expect the swell where we encountered it, so we did not plan for it. Every one of the principal decision makers [redacted] missed it - and every one of us was looking for changes down the track. Had I known British surface ships were not allowed to leave, or that seas were expected to build inside the

breakwater, we would not have attempted the pilot transfer where we did and may not have gotten underway at all. We made our decisions based on the information we had before we got underway.

Before we got underway, I saw the 28 December 2006 DTG WEAX message calling for a 24-hour forecast for combined seas 0-1 building southwest, 8-10 in exposed waters late in the period. The seas would build further the next day. The message did not indicate that we would encounter those seas near the breakwater at the time we got underway. We had nothing onboard indicating we could expect the heavy seas we encountered inside the breakwater. As we approached the breakwater and they tracked with the WEAX message indicating seas building in exposed waters well past the breakwater. We repeatedly called port control and asked for updates with regard to the conditions - but they did not indicate any heavy seas where we encountered them. There was no discussion in any messages or from Longroom port control of rolling seas. If I had known we would have encountered the swell we did, I never would have allowed men to go topside when they did.

I think that if the men had a quick release of some sort, they would have been able to disengage from the ship and would have been quickly picked up by the escort boats. I also think the man overboard procedures need to address the situation wherein a man is still lanyarded to the submarine. The submarine force should consider training officers on sea states similar to the one we encountered - where the sea did not build, it simply changed abruptly. Consolidated lessons learned for separate ports would also be helpful.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

Sworn to and subscribed before me this 06th day of January 2007, at Naval Station Rota.

/s/

[redacted]

10 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

This statement supplements the two I provided to the investigation team on 6 January 2007.

I was not aware that the topside personnel were wearing double lanyards at the time of the personnel transport. I found out following my last interview with [redacted]

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 10th day of January 2007, at Naval Station Rota.

/s/

[redacted]

ENCLOSURE (86)

Statement of [redacted] regarding the events of 29 December 2006 on board USS MINNEAPOLIS SAINT PAUL (SSN 708)

I arrived in Plymouth, UK on 21 December 2006 in order to meet the ship and report aboard [redacted] E[redacted]. When the ship arrived on 22 December 2006, I embarked with the pilot via a small boat and the forward escape trunk hatch outside of the Plymouth breakwater, and seas were fairly calm.

Prior to getting underway from Plymouth, I had read and overheard discussions of the weather reports calling for on the order of 14 to 24 foot seas. I attended the outbound piloting brief on 28 December 2006 in the Crew's Mess. I recall discussion that we would need to disembark the pilot before going outside the breakwater, but I do not recall the exact location where we intended to disembark the pilot. Plymouth is a very challenging port due to multiple turns in rapid succession, and the ship relies heavily on the pilot's guidance and recommendations to navigate the channel. The pilot expressed concern that there was a merchant at anchor near our track on the last leg before turning to exit the breakwater. The pilot stated with the winds from the south that the merchant would swing to the north and would be close to our track, so we would need to conn the ship around the merchant.

On the day of the underway, 29 December 2006, it was raining and the wind was blowing around 15 knots from the south. I donned a foul-weather jacket and an auto-inflatable life vest, and proceeded topside with the Chief of the Boat (COB), ETCS(SS) Thomas Higgins. I followed the COB around topside to observe what he did and how he interacted with the orders from the bridge. The ship cast off all lines and backed away from the pier, and all personnel laid below. I proceeded to the Control Room to supervise the ship's control party, contact management, and the piloting party.

After turning to the westerly course (the last leg inside the breakwater before turning south to leave the harbor), I remember comments in control about the heavy sea state outside the breakwater. Looking off our port beam on the periscope, I could see outside the breakwater were significant white-caps and waves. Looking forward though, the seas inside the harbor in front of the ship appeared calm. Around this time, I saw the COB standing in the forward end of control wearing his life vest and safety harness, ready to proceed topside.

When the bridge ordered the small boat handling party topside via the forward escape trunk, I was manning the #2 periscope. The ship was still inside the protected waters of the breakwater. I looked at the aft deck through the periscope and saw very light sheets of water washing over the deck aft of the aft escape trunk. The deck appeared to be dry forward of the aft escape trunk, but the field of view is limited and I could not see anything on deck forward of the aft escape trunk. From my past experience on two 688-class SSNs, that was not unusual to have a minimal amount of water over the aft escape trunk while the forward escape trunk was dry. I thought it was safe to disembark the pilot.

Shortly after the order for the small boat handling party to proceed topside via the forward escape trunk, I was very surprised to hear "Man Overboard Starboard Side" on the 1MC and immediately began watching for the man overboard. From the #2 scope it is not possible to see the forward escape trunk, so I did not see the hatch open, the personnel go topside, or the men get washed overboard. Subsequently a report came from the bridge that the men overboard were still attached to the ship via lanyards, and the bridge ordered personnel topside to recover the men overboard.

No sooner did the rescue swimmer go topside then he was washed overboard on the port side. I kept #2 Scope trained on the rescue swimmer in the water on the port side of the ship. After the swimmer was clear of the rudder and screw, I observed one of the Plymouth pilot vessels come in and pick up the rescue swimmer from the water.

The sequence of events after this is somewhat confused in my head. I stayed on #2 periscope continuously. I focused most of my attention on the aft deck to watch for men overboard and recovery efforts, with periodic 360 degree sweeps to check the ship's position with regard to hazards to navigation.

I remember seeing two personnel dangling from their safety lanyards on the starboard side of the ship. I knew one was the COB because of his green jacket (the jacket that the CO, XO, and COB wear). Both personnel were swinging in and out of my field of view on the periscope, but I saw no movement from either of them as waves were battering them along the side of the ship, and they spent a significant amount of time underwater in between waves pushing them up along the side of the hull.

As all this was happening, the ship continued to proceed down track past the breakwater and past the ship's

intended turn point to the south. There was a lot of communication between the bridge and the Navigator about the distance to shoal water and which direction the ship could turn to get back inside the protection of the breakwater, and the breakwater was less than 1,000 yards off our port quarter. For navigation safety, the ship had to turn to the south heading out of the harbor where there would be enough maneuvering room for the ship to turn around and go back inside the protection of the breakwater.

While on the southern leg passing the breakwater abeam to port, I observed one of the men on the starboard side break free. I announced "man overboard, starboard side" three times in control, but no control room watchstanders took any action because no report came from the bridge. The bridge watchstanders apparently did not observe the man break free. Without any action from the ship, the man did clear the rudder and screw. Only the top of his head was sticking out of the water, and I could see no signs of movement from the man. I observed a rigid-bottom inflatable boat drive up to the man and start to pull him out of the water, and a Plymouth Pilot boat close that position to render assistance.

I do remember on one occasion the bridge ordered maneuvering to "all stop, stop the shaft," but I am uncertain where that fell into the sequence of events.

In the final stages of the sequence of events, the ship reversed course and headed back into the protection of the breakwater. As we headed back into the harbor, I could see one man who was being alternately washed up onto the main deck and then washed into the water on the port and starboard sides of the ship alternately.

The bridge reported the ship's intention was to get inside the breakwater and send personnel topside with a knife to cut the man loose so one of the rescue boats could retrieve him from the water. I observed the small boat come in and retrieve the man.

After the last man overboard was recovered and the pilot had disembarked, the ship reversed course and proceeded out to sea. The tidal variations in Plymouth demand that a 688-class submarine only enter or leave port at high tide, and it was not prudent for the ship to return to port. The next high tide would not be until about 12 hours later, so it would be in darkness and weather was supposed to get worse over the next few days.

As the ship proceeded outbound, I focused on keeping the ship's control, contact management, and piloting parties focused on safe navigation of the ship. The XO and

Bridge-to-Bridge radio operator in the aft starboard side of control were in communications with the Plymouth rescue vessels to confirm the identity and determine the condition of each of our men overboard. I was surprised when they said there were four men overboard, because I only remembered seeing three. The Plymouth rescue boats confirmed they had four of our personnel and were taking them to the hospital.

/s/

05 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 12 and a half years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since 22 December 2006. Previously, I was a student at the Navy Submarine School since October 2006 attending the Submarine Command Course. I have extensive prior fast-attack experience throughout my career. At the time of the incident, my role aboard MSP was that of Prospective Executive Officer. This statement supplements the one I provided to the investigation team on 5 January 2007.

On 22 December, I was onboard the pilot vessel to go out to meet MSP. I met with the pilot boat at 0530, but soon learned that the visibility was diminished to the point that we could not escort the ship in. In the evening, the visibility was greatly improved and sea conditions were very calm. We transferred on to MSP outside of the breakwater. There were three Small Boat Handling Party (SBHP) on the deck waiting to help us on to the submarine. They used a boat-hook and Jacob's ladder to assist us across.

At the piloting brief on 28 December 2006, I recall that we were to expect very rough conditions at sea (on the order of 14-24 foot seas). I expected these conditions to start well outside the harbor. The pilot, who was at the brief, did not have any concerns about the forecast. At the piloting brief, we also discussed the transfer point to get the pilot off MSP. We planned to disembark the pilot after maneuvering past the merchant vessel moored at "Charlie" buoy. I know that we wanted to get the pilot off as early as possible to allow us time to de-rig the bridge in preparation for the expected heavy seas. I do not recall any discussion of the ship's speed for the pilot transfer. I imagined that the transfer would take place at our usual transfer speed, that is, 3-5 knots.

Liberty expired for all hands at 0730 on 29 December 2007. We had no issues with personnel reporting to work unfit for duty.

As we turned on to the 250 leg, I recall hearing people in Control talking about apparent heavy seas on the far side of the

ENCLOSURE (88)

breakwater. I could see heavy seas outside the breakwater, as well. I felt we could safely execute the pilot transfer where we were planning to. I think that, had the pilot transfer been planned for outside of the breakwater, I would have objected at that point and requested to return to more protected water. On the 250 leg, I don't remember the sea state appearing significantly different as we approached the far end of the breakwater.

When I saw the COB on the way through the Control, he was wearing a Kapok life-preserver and harness. According to the SORM and the anticipated weather, the SBHP was outfitted for an open-ocean topside evolution. Accordingly, they wore Kapoks, harness, one lanyard with a dyna-break, one extension, and a turn-around line (a lanyard with knots for grabbing).

I was in Control throughout the incident and its aftermath. After the man-overboard call, I don't recall where the XO was. He was on and off the periscope and monitoring communications between Control and the Crew's Mess. After we started to take on water, he went to Crew's Mess to evaluate the situation. I do not recall any orders or recommendations the XO gave to the bridge. I do recall hearing a bridge-to-bridge call to the pilot boat. I believe this call was made by the OOD, and asked the pilot boat to approach to make the transfer. I do not recall hearing the pilot boat acknowledge, but I do remember the pilot boat moving into position to effect the transfer shortly after the radio call.

At the time the men were washed overboard, I was looking out the #2 periscope. I do not recall seeing a wave wash down the hull of the ship.

With regard to the efforts to recover the men after they had been washed overboard, I recall an initial order for an all-stop, but this was quickly changed after it became apparent that the men were still attached to the ship with their lanyards. I recall an order sending the diver topside, I saw him washed overboard and recovered very quickly by one of the escort boats. I did not see [redacted] go over the opposite side of the ship. The atmosphere was chaotic, as we did not have a good idea of how many people had been knocked overboard. I could see the COB and Petty Officer Holtz being knocked against

the hull of the ship. Navigation safety required us to turn south out of the mouth of the harbor to turn back into the protected waters. I don't recall any discussion of other possible options in order to keep the ship safe and recover the men. The OOD and Navigator were concentrating on our maneuvering room and distance to shoal water. I am not sure whether backing down or spinning around would have been viable options under the circumstances. It did not occur to me that there was any other way to turn the ship around other than the maneuver we executed. I don't recall any discussion of the speed to be used during the turn around. I was concerned for navigational safety in the confused circumstances of our attempt to recover the men. I kept looking at the breakwater to make sure we were not coming too close. I don't think we could have done anything differently with regard to speed because of the size of the swells outside the breakwater. At one point after we came back inside the breakwater, Petty Officer Holtz was washed up onto the deck. He was still alive at this point as I could see him raise his hands to his head. However, another swell washed over the deck and washed him over the port side of the boat.

As we turned south, the COB broke free and floated down the hull. I could not see him moving at all. Once we were back in protected water, we sent someone topside to cut the last man free so that an escort boat could pick him up. Because of the tidal situation and worsening weather, it was not safe to return to the pier in Plymouth, so we transferred the pilot off of MSP and made our transit to the dive point without further incident.

I have had training at Submarine Command Course (SCC) about a similar incident involving men swept overboard in an open ocean environment. I took away from this training that open-ocean personnel transfers are dangerous. I am not familiar with the concept of "fetch" with respect to wind-driven waves. I have been involved with three open ocean transfers during SCC. I have never had any experience training for a man overboard drill wherein the man washed overboard is still attached to the ship.

With respect to ORM onboard MSP, I believe the principles of ORM are regularly applied, although checklists are not always used. The ship's planning for this evolution was in line with my

previous experience, and at the time, I believed it was adequate.

I believe this event was caused by a sudden unanticipated sea swell. I do not know why the sea state changed so rapidly, I would not have expected seas like the swells we encountered when the men were swept overboard until we were well down the track and beyond the Penlee navigational aid. The severity of the situation was compounded by concern for driving the ship around the anchored merchant vessel, causing us to have the pilot onboard for longer than necessary. I wonder whether we were overly-reliant on the pilot to get us out of the harbor. I think the pilot's apparent lack of concern with the weather and sea state may have affected MSP's analysis of the safety of the transfer point. I think that had the men swept overboard not been attached to the ship, they would have survived because of the proximity of rescue boats. I don't think we could have turned the ship around more expeditiously given the shoal waters in the area.
In order to prevent similar events in the future, I think the SORM should be amended to address the situation wherein small boats are nearby to render aid and whether it is still important to be lanyarded to the ship.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 05th day of January 2007, at Naval Station Rota.

/s/

[redacted]

06 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

This statement supplements the two I provided to the investigation team on 5 January 2007.

Since arriving onboard MSP, I regularly read the weather messages. I have seen the 28 December 2006 DTG WEAX message routed to my Outlook inbox at 0551, 29 December 2006. Given my regular practice, I probably read this message before we got underway on the morning of 29 December 2006. Given this message, I would think that the forecast rough seas would start to build outside of the breakwater, the farther we got out from land. I do not see anything in this message or in any of the information we had at the time that warned of sea swells coming out of the harbor. In my experience, where there is a unique feature of the local topography that contributes to significant sea swell, this is publicized to mariners. We had no similar information for Plymouth.

Even if we had the above-referenced message earlier, I don't think we would have executed our planned pilot transfer differently.

We would not have gotten underway had we known that the British surface ships were not allowed to get underway in the weather conditions on 29 December 2006.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before ~~me~~ this 06th ~~day~~ of January 2007, at Naval Station Rota.

/s/

[redacted]

ENCLOSURE (89)

COMPLIANCE WITH SECTION 0221 OF THE JAG MANUAL

I, [redacted], have been advised that:

-questions have arisen concerning whether or not my injury/ disease, sustained or discovered on 29DEC06, was incurred in the line of duty or as a result of my own misconduct;

-in the event such injury/disease is determined to have been incurred not in the line of duty or as a result of my own misconduct, I will be required to serve for an additional period beyond my present enlistment to make up for the duty time lost;

-lost duty time will not count as creditable service for pay entitlement purposes;

-I may be required to forfeit some pay (where absence from duty in excess of one day immediately follows intemperate use of liquor or habit-forming drugs);

-if I am permanently disabled and that disability is determined to have been the result of misconduct or was incurred not in the line of duty, I may be barred from receiving disability pay or allowances, as well as veterans' benefits;

-I may not be required to give a statement relating to the origin, incidence, or aggravation of any disease/injury that I may have.

I do/do not desire to submit a statement.

04 JAN 07
Date

/s/ [redacted] 1/4/07
Signature

/s/
Witness Signature

[redacted]
Witness Name/Rate/Grade/Unit/Telephone Number

ENCLOSURE (90)
PAGE 1 OF 1

This is the statement of [redacted] I was assigned as 1st LT on the small boat handling party. I did attend the piloting brief on 12/28/06 for exiting Plymouth I took away from this brief that the pilot would disembark near the breakwater exiting the river.
We came down from casting off lines and tugs shut the upper hatch left the drain lines open to monitor for water in the cavity, changed into harnesses (all harnesses had a shock lanyard, working lanyard and a turn around we all had knives mine was clipped to my pocket COB's to his harness and PO Holtz's to his belt I did not check the others) and kapoks and prepared to go topside with the boat hook and Jacobs ladder. The topside party would be myself, COB, Holtz, [redacted] as swimmer tender, [redacted] as swimmer, [redacted] would be phone talker remaining in the hatch [redacted] and another were assigned to dress out in case something happened.

The order came from the bridge "COB open the fwd hatch and send personnel topside" I undogged the hatch and said "hatch is undogged clear" COB opened the hatch and I went topside hooking into the safety track with a deck traveler I looked around to get my bearings and saw a bow wake fwd creating a flat spot aft of the sail to my stbd was the pilot boat approximately 100yds there were several ships farther out from the pilot boat.

I then hooked the COB into the safety track and helped him out of the hatch he went fwd near cleat 2 as I pulled the boat hook and handed it to the COB then the Jacobs ladder up the hatch brought it Fwd and secured it to cleat 2 and took the boat hook back from the COB. Holtz came up after the Jacobs ladder and hooked into the safety track. We were ready for the pilot boat to come. All looked clear and normal while waiting for the pilot boat we took some small waves over the deck maybe ankle high. After that we took a wave waist high or higher sweeping all three of us overboard, the COB was closest to the ladder and trying to reach it I still had the boat hook in hand pinning my arm behind me, when I turned around for holtz [redacted] was next to him trying to get him up, next thing I knew holtz was swept topside followed my me and the COB, The COB was lying next me with mask over his face I removed it and he was blue and not responsive we were hit by another wave separating us after the wave I saw the hatch and crawled down it, hanging by the lanyard while water rushed in and then I was cut free and carried to the wardroom where I was stripped down and covered with blankets

/s/ [redacted] 1/4/7

[redacted]

ENCLOSURE (91)

10 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 17 years 11 months and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since October, 2003. My job aboard MSP is the LAN Administrator. This statement supplements the one I provided to the investigation team on 4 January 2007.

At the time of the incident, I was the First Lieutenant.

The ladder rigged from the sail was standard procedure. It was attached to the port side.

Knives are purchased on the open market as part of the APL.

We don't always get the captain's permission every time we use the harness rig with the extension used topside.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/ [redacted] 1/10/07

Sworn to and subscribed before me this 10th day of January 2007, at Naval Station Rota.

/s/

[redacted]

ENCLOSURE (92)

CAUTION

ENCL (93)

CONTAINS GRAPHIC WITNESS STATEMENT DISCRETION ADVISED!

This is the official statement of ET2(SS) BRIAN W. TEWART. After getting underway from HMMB Devonport around 1130Z the ship proceeded down the channel to sea. Visibility was limited and the sea-state was mild to moderate. When the ship was approaching the Plymouth breakwater and a merchant ship at one of the mooring buoys along our ~~track~~ track, the CO turned and asked the bridge team (Lookout, IJV, and JA phone talkers) what the status of the FET was. We all reported that the deck was dry with an occasional small amount of water coming on deck. At the time the CO gave the order to send personnel topside to transfer the pilot the sea-state was mild, approximately 5-6 foot swells. The JA phone talker, IJV phone talker and I turned to watch the pilot transfer. Within about 3-4 minutes of the COB, STS1 Sowa, and STS2 Holtz getting topside, they were hit by a large wave, knocking all three men overboard on the STBD side. ETC Wilson and I immediately called away man overboard. The pilot was still in the FET upper hatch and went down below immediately. 5 minutes after men went topside, the sea-state had increased to 10-15 feet and the ship was taking large waves over the FET about every 30-45 seconds.

ENCLOSURE (93)

Within 30 seconds of calling away man-overboard, STS2 Petersen, MM2 Ledford, and SKSA Degles got topside. STS2 Petersen and MM2 Ledford went on deck while SKSA Degles stayed in the FET upper hatch as MM2 Ledford's tender. Meanwhile the COB, STS1 Sowa, and STS2 Holtz were all conscious hanging off the stbd side of the ship by their lanyards and trying to pull themselves back on deck. STS2 Petersen and MM2 Ledford started trying to pull the COB and STS2 Holtz back onboard until they were hit by a large wave and knocked overboard, on the STBD side. STS2 Petersen's lanyard broke and he was washed away from the ship. The OOD immediately ordered RFR to get the screw away from STS2 Petersen and MM2 Ledford. MM2 Ledford had come loose from the ship as well and was swimming towards STS2 Petersen. STS2 Petersen and MM2 Ledford were both recovered immediately thereafter by the pilot boat. By this time the ship was taking very large waves. The COB, STS1 Sowa and STS2 Holtz were all still conscious. They started getting knocked from one side of the boat to the other by waves. After this happened 2 or 3 times STS1 Sowa was washed back on deck. He managed to crawl back to the FET and get below decks.

At this point the ship was taking on too much water to send more men topside. A RN RHIB that had been acting as our escort kept trying to come alongside to help but couldn't get close enough ~~to~~ because of the sea state. By this time the COB had stopped moving. STS2 Holtz was still conscious. The CO called the Pilot back to the bridge and started turning the boat back around to get back inside the breakwater. The ship turned to the right to avoid WEST Light. At some point the Jacob's Ladder had been washed into the FET upper hatch, fouling it. While the ship was driving back inside the breakwater, the Jacob's Ladder came out of the hatch and we were able to shut the FET ~~lower~~ upper hatch. By the time the ship was back inside the breakwater, both the COB and STS2 Holtz had stopped moving. Holtz's head was bleeding. When the ship was in the vicinity of the moored merchant, the COB's lanyard broke and he was immediately picked up by the RHIB. At this point the seas had abated and the CO ~~gave~~ ordered men to go topside to recover STS2 Holtz. While the FET was being drained another RHIB came alongside and started trying to recover STS2 Holtz. Eventually we got the FET open and MM1 Distefano came topside. He cut Holtz's lanyard and STS2 Holtz was recovered by the RHIB. After that all personnel went below, we shut the FET and proceeded out to sea.

ET2(SS) BRIAN W. TEWART
1/4/02

/5/

31 December 2006

To Whom It May Concern:

I [redacted] was assigned as the Corpsman for the man overboard on 29 December 2006, I was not at the piloting brief on 28 December 2006, however I was a Officer/LPO Call later on that day. During Officer/LPO Call we were warned that we should expect 15 to 20 foot waves once we got underway the following day.

At the time of the accident I was in the ship's office and immediately ran to the Crew's Mess. Once on the Crew's Mess I saw a large amount of water coming into the ship from the forward (FWD) Escape Trunk and within a few minutes there was close to a foot of water in the Crew's Mess. Approximately 5 minutes later the first personnel causality emerged from the FWD Escape Trunk [redacted]. I immediately assisted [redacted] to the wardroom and began treating his injuries and removing his wet clothing. Approximately 5 minutes later the second personnel causality [redacted] was brought to the wardroom. I had my Emergency Medical Assistance Team (EMAT) team start removing his wet clothing and start treating him for hypothermia. After [redacted] was stable I went over and assisted in the treatment of [redacted]. A few minutes later [redacted] was brought into the wardroom. I once again had a member of my EMAT begin removing his wet clothing at treating his injuries.

After all the injured personnel were treated I went to control to brief the [redacted] on the status of the injured men. Afterwards I returned to the Wardroom and continued treating and re-evaluating the injured personnel. I remained in the Wardroom area until 0130 on 30 December 2006.

/s/

[redacted]

ENCLOSURE (94)

[redacted]

m: RADIO (USS MINNEAPOLIS SAINT PAUL)
t: Monday, January 01, 2007 5:48 AM
o:
Cc: [redacted]

Subject: My Statement

The following is what I, [redacted] remembers of the events that happened around 1400Z on 29 December 2006:

I was sitting in radio when it all began. [redacted] had walked in and reported that there was about two inches of water in the crews mess. I did not believe it, so [redacted] had all went to nav center and looked down to see that there was a bunch of towels, sheets and various other materials piled to try to keep the water centralized in the crews mess area. We then looked at the subis monitor and saw someone being rescued by a patrol boat. We then went back into radio and told [redacted] o stay on the phones and to stay in radio while we went to help. As I walked out of radi [redacted] was coming out of the fan room with a harness screaming 'get this harness down to crews mess'. I then grabbed the harness and made my way down to crews mess. Once I got there some one screamed out 'get two people in a harness and get topside to help get the guys below'. I then started to get into the harness and asked [redacted] to help me into it. As I donned the harness, [redacted] had made his way down the hatch. When I looked at him he looked terrified, and still had his sound powered headphone on. They helped getting him into the wardroom. Once I was fully donned with a harness I made my way into arthawartships and entered the bathtub following [redacted] As I entered the tub seawater had rushed us, so we backed out for a moment then went in again. As I started to mb the vertical ladder I lost my footing and when the seawater rushed in again, it knocked me down I got up got out of the tub. I then heard some say that we had to get the hatch closed so I knelt down and saw [redacted] trying to shut the hatch, but he could go no more, so I took his place in pumping. Initially I could not find the lever, but with direction I commenced pumping. While pumping the water kept beating and pinning me against the pipes. After about 5 to 10 mins of pumping the pressure had not moved and still read 0psi. I then screamed for someone to check the line up and hit the hatch-positioning switch to ensure that it was in the shut position. After about a few pumps the pressure began to increase. I then continued to pump until I couldn't pump anymore and fought my fatigue and continued to pump. I looked up and saw [redacted] hitting the Jacobs ladder out of the way of fouling the hatch but the waves knocked it back in place he then hit again and finally I was able to shut the hatch completely, the water then stopped rushing in and I screamed out to dogg the hatch the report came back to me that the hatch was shut and dogged. I was then grabbed by a few guys and helped to the wardroom. I was then stripped off of my wet clothes and wrapped in a blanket. After about 30 mins I started to feel a sharp pain on lower right side of my back so I sat down to try not to be affected by it but the pain was too unbearable. After being coved in several blankets DOC had walked into stateroom two and gave me a shot in my right thigh. I remember very little after that, I just know that I would sleep and then be awakened by another person.

[redacted]

ENCLOSURE (97)

4 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 10 years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since November, 2005. My job aboard MSP is the Independent Duty Corpsman at the Medical Department. This statement supplements the written statement I provided the investigation team from 4 Jan 07.

2. [redacted] was pretty hysterical when he first came down and said he was OK.

3. [redacted] was in bad shape when he first came down. I thought he was going to die. He couldn't talk or walk; we had to carry him and get his clothes off of him. We warmed him up and talked to him and said he had seen the COB and couldn't get to him. He got pounded on the ship and that was why he was unable to walk. He was exhausted and very cold; it took a while to warm him back up despite the fact that he was not in the water very long.

4. [redacted] was down below in crew's mess and climbed inside the forward escape trunk and was pumping it out.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/ [redacted]

Sworn to and subscribed before me this 4th day of January 2007, at Naval Station Rota, Spain.

/s/
[redacted]

ENCLOSURE (95)

ENCL 46

CAUTION

CONTAINS GRAPHIC WITNESS STATEMENT. READER DISCRETION ADVISED!

EVENTS OF 12/29/06 MANEUVERING WATCH

I am ETC(SS) James R. Wilson and these are the events of the 12/20/06 outbound Plymouth, England Maneuvering Watch on USS Minneapolis-Saint Paul as I recall them.

I took station on the bridge at approximately 1030 on 29 DEC 2006 as the Bridge JA Phone Talker. Weather Conditions were poor with intermittent rain and high winds. The bridge maneuvering watch was fully manned by approximately 1045 in preparation for an 1130 departure time at high tide.

Once underway, the ship was backed out into the harbor on the SPM and Main Engines and turned into the channel assisted by Royal Navy tugs. Once aligned into the channel, the tugs were cast off and all topside personnel went below and shut the Forward Escape Trunk (FET) Upper Hatch. The OOD then proceeded down-river, assisted by the Royal Navy Harbor Pilot. The 7MC microphone failed due to wetting just after entering the channel, requiring the OOD to man the Long-Cord Emergency 7MC for Bridge-Helm Communications. Sound –powered phones remained operational for the entire duration of the Maneuvering Watch. Due to the high wind noise and intermittent operation of the Bridge Auxiliary Speaker, I was positioned in a crouch just aft of the Harbor Pilot in order to hear the OOD's Helm orders and relay them to Control.

The outbound transit proceeded without further incident until the last leg before clearing the breakwater. A large ship anchored near the breakwater was partially blocking the channel, requiring us to alter our track starboard to clear it. This was discussed by the Pilot, OOD and CO prior to getting underway and the decision was made for the Pilot to stay in the Bridge until clear of the ship, at which point we would send personnel topside to transfer the Pilot to a Royal Navy pilot boat and proceed outbound.

Once clear of the channel obstruction, the order was given for personnel to open the FET Upper Hatch and lay topside for personnel transfer. The OOD was slowing the ship to maximize time behind the breakwater during the evolution. I heard the report from the lookout that personnel were topside for the transfer and looked aft to monitor activity topside. I observed 3 personnel topside latched into the safety track (STS1 Sowa, STS2 Holtz, and the COB). As the topside personnel were preparing to transfer the pilot, a wave broke over the afterdeck from port to starboard, sweeping the 3 personnel overboard to starboard. The personnel were attached to the safety track by their harnesses. I called Man Overboard Starboard

Side to both the OOD in the Bridge and to Control via the JA phones and proceeded to monitor and report on the status of the personnel.

The CO took control of the ship ordering a turn to port to place more lee to the afterdeck and ordered the swimmer to lay topside for personnel recovery. At this time, the ship was positioned outside the breakwater and continued to take more waves on the afterdeck and down the Forward Escape trunk. I turned away from the events topside for approximately 30 seconds to assist the OOD in relaying orders to Control. When I again faced aft, I observed one man (STS2 Petersen) swimming away from starboard out toward one of the British Escort RHIBs, which had moved in to assist. STS2 Petersen was recovered by a Royal Navy small boat. MM2 Ledford, the Primary Rescue Swimmer, was also now topside attempting to recover the men, which were still suspended by their lanyards off the Starboard side of the ship. STS1 Sowa had managed to pull himself back up the FET assisted by MM2 Ledford and went below, leaving STS2 Holtz and the COB remaining topside with MM2 Ledford. MM2 Ledford made contact with the COB and attempted to free him from the lanyard, but was quickly swept off the ship by another wave and washed away to starboard to be recovered by a small boat. The COB and STS2 Holtz were intermittently washed up onto the afterdeck and to the Port and Starboard sides of the ship by wave action. I observed the COB at this time to be blue in the face and foaming at the mouth. STS2 Holtz still appeared conscious, but weak, attempting to get to his feet several times, but being swept overboard each time.

The CO then stated that he intended to move the ship back inside the breakwater and called for the Pilot, who was below-decks awaiting transfer, to return to the Bridge. The ship was brought about using the Rudder and SPM to move back behind the breakwater. At this point, the COB and STS2 Holtz had been in the water for several minutes, and were being tossed from Port to Starboard and back again by the wave-motion. De-watering efforts had been commenced in the AMR, with the AMR Deep Bilge being pumped overboard by the Drain Pump. Water was just below the deck-plates aft of the Diesel Generator, with the FET hatch still open. Due to the repeated flow of seawater into the FET and water level now up to the EOG deck-plate in the AMR, I recommended to the CO that the FET Lower hatch be shut due to fouling of the upper hatch by lanyards. The CO then ordered the FET Lower Hatch shut and I relayed this order to Crews Mess. After repeated attempts by MM1 Distefano to shut the FET lower hatch and verifying there were no longer any lanyards obstructing the Upper Hatch, I recommended to the CO that the FET Upper Hatch be shut until the ship was back inside the breakwater. The CO concurred and I passed the order to Crews Mess to shut the FET Upper Hatch, which was then pumped shut.

At this time, the COB had broken loose from the safety track and began drifting aft down the port side toward the rudder. I notified the CO who ordered the shaft stopped and Left Full Rudder. Once the COB was clear of the Stern, AA2/3 was

ordered to move the ship further into the harbor. The COB was recovered by a Royal Navy RHIB.

STS2 Holtz still remained attached to the ship by lanyard and was intermittently conscious. Royal Navy Rescue Personnel aboard a RHIB attempted to approach STS2 Holtz, who was now suspended off the port side of the ship, but couldn't get their boat close enough to cut STS2 Holtz free without risk of hitting him due to the swells. At this point the ship was back inside the breakwater and the order was given by the CO and relayed by me to Crews Mess to open the FET Upper Hatch and send the backup swimmer topside, attached below-decks to a lanyard, to cut STS2 Holtz free of the ship for recovery by Royal Navy Rescue. The FET Upper Hatch was opened and MM1 Distefano, wearing a safety harness with lanyard tended to from below decks, proceeded topside toward STS2 Holtz's lanyard. STS2 Holtz was unresponsive at this time. MM1 Distefano reached STS2 Holtz's lanyard and cut it, allowing STS2 to be recovered by Royal Navy RHIB. The Royal Navy Harbor Pilot had went below when the FET Upper Hatch was re-opened and proceeded to the Royal Navy small boat OPAL while MM1 Distefano was freeing STS2 Holtz. MM1 Distefano then proceeded forward of the FET to Cleat 4 to unlash the Jacob's Ladder and sent it below-decks. MM1 Distefano then layed below, and the FET Upper Hatch was shut.

The CO then ordered the ship about toward open Ocean. Once the FET Upper Hatch was shut, the lookout and I made the MK-43 Machine Gun Condition 4 in preparation for clearing the Bridge. LTJG Hungerford (JOOD) went below with the MK-43, followed by myself with the Ammunition Bag, leaving the CO, OOD, 1JV phone talker, and Lookout remaining in the Bridge.

These are the events of 29 DEC 2006 to the best of my recollection.

/S/ 1/4/07

Wilson, James R., ETC(SS), USN

SUSPECT'S RIGHTS ACKNOWLEDGEMENT/STATEMENT (See JAGMAN 0170)

FULL NAME (ACCUSED/SUSPECT)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ACTIVITY/UNIT			DATE OF BIRTH
MSP (SSN 708)			[redacted]
NAME (INTERVIEWER)	SSN	RATE/RANK	SERVICE (BRANCH)
[redacted]		[redacted]	USN
ORGANIZATION		BILLET	
CSS-22		[redacted]	
LOCATION OF INTERVIEW		TIME	DATE
NAVSTA ROTA		1527	5JAN07

RIGHTS

I certify and acknowledge by my signature and initials set forth below that, before the interviewer requested a statement from me, he warned me that:

(1) I am suspected of having committed the following offense(s): NEGLIGENT DERELICTION OF DUTY /S/

(2) I have the right to remain silent; - /S/

(3) Any statement I do make may be used as evidence against me in trial by court-martial, - - - - - /S/

(4) I have the right to consult with lawyer counsel prior to any questioning. This lawyer counsel may be a civilian lawyer retained by me at my own expense, a military lawyer appointed to act as my counsel without cost to me, or both; and - /S/

(5) I have the right to have such retained civilian lawyer and/or appointed military lawyer present during this interview. - /S/

WAIVER OF RIGHTS

I further certify and acknowledge that I have read the above statement of my rights and fully understand them, and that, - /S/

(1) I expressly desire to waive my right to remain silent; - /S/

(2) I expressly desire to make a statement; - /S/

(3) I expressly do not desire to consult with either a civilian lawyer retained by me or a military lawyer appointed as my counsel without cost to me prior to any questioning; - - - - - - - - - /S/

(4) I expressly do not desire to have such lawyer present with me during this interview; and - - - /S/

ENCLOSURE (98)

(5) This acknowledgment and waiver of rights is made freely and voluntarily by, and without any promises or threats having been made to me or pressure or coercion of any kind having been used against me.- - - -

[redacted] statement of events surrounding personnel transfer at Plymouth, UK on 29 December 2006.

At the Piloting Brief held on 28 Dec 2006, we briefed that the weather was expected to be windy/rough out at sea (during our transit to the dive point). The UK Pilot was in attendance (we had requested he attend our Piloting Brief and he initially refused until I personally called the Pilot Station to request his presence at our brief, then he agreed) and we discussed the Pilot debark point would be on the 250 leg (two legs prior to the 170 leg, the normal pilot pickup/dropoff point). The Pilot agreed that this was standard for the weather expected and that there should be no problems. He also discussed that there would be a ship anchored at the anchorage and we would likely have to go north of track to pass between it and the other mooring buoy (the anchored ship would likely tend to the north). Prior to the 250 leg, we briefed that we would evaluate conditions and man/dress the small boat handling party appropriately as we approached the turn.

On the morning of 29 December, the weather was, as predicted, windy with light rain. Winds were 20-25 kts with visibility 3-4 nm. About 2 hours prior to underway, the XO from HMS TRENCHANT (our host boat) visited me and we discussed the weather and expected conditions as we transited outbound. He stated that this was standard Plymouth weather and he had conducted many transits and Pilot transfers in similar (and even worse) conditions. The Pilot was onboard about the same time and was not concerned about the weather - visibility was 2-3 NM at the breakwater (as reported by Longroom Port Control), NAVAIDS were visible, and conditions supported the underway and the small boat transfer.

The ship got underway with 3-4 NM of visibility (all Navaids visible) and 20-25 kts winds. After an uneventful underway from the pier, the ship transited the outbound track as briefed. As the ship approached the turn to the 250 leg, we noted that, as expected, the anchored ship was tending north and we needed to be north of track to pass between it and the other mooring buoy to the north. The Bridge discussed with Control that the Pilot transfer would occur as soon as we passed clear of the anchored ship. The OOD ordered the Small Boat Handling Party to dress out for Open Ocean Transfer and limit the number of personnel topside. The COB agreed and stated his team was dressed out appropriately and ready to deploy with 3 personnel. The Pilot came down from the Bridge after we passed the anchored ship and made his way to the Crews Mess. He was in no hurry and said

some nice words to the men in Control before going to Crews Mess. I looked out #2 scope at the aft deck (field of view is limited to just forward of the aft escape trunk) as we prepared to send personnel topside to conduct the Pilot Transfer. I noted a good lee to Starboard and occasional water coming over the aft deck (which is substantially lower than the deck by the forward escape trunk (FET))-all was good for the transfer and sending personnel topside. Having executed numerous transfers in the past, the sea state and lee supported a safe transfer. I looked forward to check for any potential change in weather/sea state ahead and saw nothing different than what we were experiencing out to the shoreline ahead. The Bridge sent personnel topside and I observed the Pilot Boat approaching from the STBD side. Due to the limited field of view out the scope, I did not see personnel topside but did note that the conditions over the back deck were the same as my previous observation. During my time on the scope, I remember the standard reports from the COB for opening the FET upper hatch and sending personnel topside. All was as planned and briefed, all was going well. The only part left was for the Pilot Boat to come alongside and transfer the Pilot. I turned the scope back over to the Scope Assistant and went to the chart to look at the next turn and then AIS to determine if any interfering traffic was inbound on the next leg.

As I was looking at AIS for interfering contacts, I felt the ship pitch downward by the bow then pitch upward. I immediately looked at PERIVIEW and saw the aft deck go underwater. No personnel were visible in the field of view. I heard the bridge call man overboard STBD side and I still saw no personnel in the water. I asked for a status of who was topside and received the report that [redacted] Holtz and the COB were tethered to the safety track (I believe the report came from the phone talkers on the bridge). As I took the #2 scope, I heard another man overboard call from the bridge and saw a person waving as he passed astern. He was recovered by one of the escort vessels (I believe this was [redacted] the swimmer, who went topside to assist, but I was not sure at the time who it was). As he was being recovered, another man overboard was called and I saw another person going aft, waving. He too was recovered by an escort vessel (I believe this was [redacted] who also went topside to assist, but I was not sure at the time). I panned down to look at the aft deck, which was again underwater, and still could see no personnel on deck with the limited field of view. It was unclear in Control who was left on deck and who had gone into the water and floated clear of the submarine. I went to Crews Mess (via ladder aft of Control) and observed 6-8 inches

of water on the deck and [redacted] (cold and wet) being taken to the WR for medical attention (he was at the hatch during the waves coming through). [redacted] was already in the WR being wrapped in blankets and treated by DOC-he had made it below. I looked down the non-vertical ladder to the AMR and saw EDMC was in charge. He reported that water was at the deckplates in the AMR, the battery well access was being covered by blankets and mattresses, and that they were lining up to pump the AMR with the Drain Pump. No water had left the AMR. I then went back to the Crew's Mess and heard the order to shut the FET upper hatch from the phone talker in CM. [redacted] and [redacted] were in CM. Someone (I believe [redacted]) went to the FET lower hatch to assist in shutting the FET upper hatch (I later learned that the Jacobs Ladder had washed into the hatch and was preventing the hatch from going shut, and [redacted] was up the FET trunk trying to free it). I asked who went topside, and [redacted] reported that four personnel had gone topside, but he was not sure who was still attached to the deck and who had gone overboard.

I went back to Control to see if it was possible to see anyone on deck/tethered. I could not see anyone at that time. Someone (ANAV I believe) reported he saw glimpses of someone over the stbd side of the sub tethered to the hull. The ship had meanwhile turned around to head back into more protected waters. The bridge reported that Holtz was still attached to the hull by his tether and ordered a person sent topside to cut him away so an escort boat (standing off-he was unable to approach the sub due to the seas) could retrieve him. I went to Crews Mess and ordered [redacted] (a diver) to don a safety harness and dive knife. I ordered [redacted] to open the FET upper hatch and send [redacted] up the trunk, clip in inside the hatch, and go cut away Holtz's lanyard, then come below. After getting the hatch open, [redacted] went up, cut away Holtz (it was reported from the bridge that he was cut free and being recovered by an escort boat), the Pilot went topside, was transferred, and [redacted] came below. The hatch was the shut and I went back to Control. The bridge reported that no more personnel were topside and that all had been recovered by escort vessels.

I ordered [redacted] to get a shipwide muster and ordered the BTB operator contact the escort vessels to get a count/names of those recovered. Longroom Port Control called up to request if we still required/desired a search and rescue helicopter to respond (one had been dispached by UK authorities). Not yet having a full head count on board and positive verification of those recovered by escort vessels, we responded yes, and the helicopter continued its transit toward us (still 5 minutes out

as reported by Longroom).

After many call-ups to each escort vessel (and some relays via Longroom Port Control), it was determined that four personnel (COB, [redacted] and Holtz) had been recovered by the escorts and/or tugboats and they were all being taken to get medical attention. It was reported that [redacted] appeared to be fine, but we did not receive any positive assessment WRT the condition COB or Holtz-only that all personnel were being transported to the hospital for treatment. Once a full muster of personnel was made onboard, the only four missing were the COB, [redacted] and Holtz and we released the search and rescue helicopter.

During this time (after the pilot was transferred to the Pilot Boat), the ship had turned back around to head to sea. Tides and weather no longer supported returning to Plymouth.

The DOC stabilized [redacted] All were being warmed back up, resting well, and eventually released by DOC. [redacted] had suffered possible back injuries from the hatch being pushed down on him by the waves (multiple times). He was immobilized and treated by DOC. He recovered over time under constant supervision and eventually regained limited mobility.

This statement is my best recollection of the events surrounding the personnel transfer on 29 Dec 2006.

/S/ 1/4/07

[redacted]

06 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

I have been in the Navy for fifteen years and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) for since March 2005. My job aboard MSP is Executive Officer. This statement supplements the one I provided to the investigation team on 4 January 2007.

I have had extensive experience with personnel transfers throughout my career. As a Junior Officer, I was frequently OOD on the surface. I conned the submarine out of both Charleston and Groton, and had conned the ship in very rough weather. As Department Head, I was Navigator on the USS LOUISIANA (SSBN 743B) out of Kings Bay; there I was involved with all personnel transfers in that position. On MSP, we have done numerous personnel transfers during local operations, workups for deployment, and on deployment at numerous stateside and foreign ports under various conditions.

As we came into Plymouth on 22 December 2006, conditions that evening were fairly smooth. The transfer of the pilot onboard was uneventful. MSP was in port in Plymouth from late Friday, 22 December until 29 December 2006. The COB and I set the ship's liberty policy while we were in port to ensure the crew was rested and ready to get underway on Friday. We experienced no problems with sailors violating this policy or reporting for our underway on 29 December in any condition less than fit for full duty at 0730. I slept on the boat the night before we got underway as is my regular practice.

Prior to going to bed on the night of 28 December I noted topside at approximately 2300Z that the weather had not yet started to deteriorate as the weather message we had used for the piloting brief had predicted. I concluded that we may be ahead of the forecast and that we may have better conditions for the underway.

The next morning, I read the 28 December 2006 DTG WEAX message, which was routed to my Outlook inbox at 0551Z, 29 December 2006, at approximately 0630Z. I understood this message and the other weather data we had on hand to say that we were going to have a

rough transit to the dive point once in open ocean. We were expecting seas from the southwest in "exposed waters" - south of Penlee point. Upon going topside after reading the message, the weather conditions at the time appeared to support my conclusion that we may be ahead of the forecast.

The ship was ready to get underway early. We wanted to be ready to go early because we were aware of our very narrow tidal window. I talked to the XO of our host ship, the HMS TRENCHANT (an UK SSN) that morning; he said the weather that morning was normal for Plymouth and that he had gone out in worse. The XO also said the pilot was likely to get off between the anchorages (on the 250 leg) because it the sea state would start to increase on the 170 leg (passing Penlee point). This was in accordance with our plan to disembark the pilot on the 250 leg, as discussed with the pilot at the piloting brief the previous day. I concluded that weather conditions supported getting underway, which was supported by my discussions with the pilot, XO TRENCHANT, communications with Longroom port control, and my weather observations compared to the weather messages. Had I known that British surface ships were not allowed to get underway on 29 December, I certainly would have objected to getting underway.

During the planning stages for our outbound transit, we identified the large river turns as obvious hazards. We also were concerned about the ship moored at the "Charlie" buoy that might be tending to the north close to our track. We discussed the fact that there was plenty of good water to transit around the moored vessel north of our track. We were also aware that the conditions could change quickly on the 170 leg out to the dive point as we passed Penlee point. We discussed getting the bridge de-rigged early so that the watch could be brought down quickly if necessary. We expected conditions to worsen rapidly once we passed Penlee point.

We were not concerned that the pilot transfer would be an issue, nor was the pilot. The pilot was very informative and involved at our piloting brief. At the piloting brief, we discussed the expected building seas/wind from the southwest from the forecast message we had received earlier that morning. During the planning process and piloting brief, we identified, as always, that we would not conduct the transfer if there was heavy water

over the deck at the transfer point, if the pilot boat was not ready, or if we were too close to a turn. We also discussed the need to minimize personnel sent topside and what gear they would go topside with. I don't recall the planned and briefed speed for the pilot transfer. I expected the pilot transfer would take between three to five minutes (this would have been consistent with the pilot transfer on the way in to Plymouth). I was confident that we had enough room on the 250 leg to safely transfer the pilot off of MSP.

On ORM in general, we incorporate ORM into the evolutions we conduct on a regular basis. I am not sure when the last time general shipwide training on ORM had been conducted. There was a new ORM training product available (we had received a message in late October/November identifying this training product but we were unable to download it until we got to Rota). We planned to download it in Rota and train the entire crew once back out to sea from Rota. I, as the XO, am designated as the ORM manager. I discuss ORM as part of my standard check-in procedure with new sailors.

I was not aware of any navigational equipment failures that affected the events on 29 December 2006. The navigation team did not have any difficulty maintaining the ship's position. I don't recall exactly what set and drift we were encountering on the 250 leg. I did not observe any sea state changes past the end of the breakwater along our track. At one point the bridge asked how far past the scheduled turn we could safely remain on the 250 leg to safely execute the pilot transfer. The Navigator responded, "800 yards," which, after looking at the chart, I agreed with. We did not want to turn to the next leg with the pilot boat alongside.

I do not recall hearing the bridge call the pilot boat in to execute the transfer, although I may not have heard it. I could see some occasional water lapping over the far aft deck, and I was comfortable executing the transfer as scheduled. I looked ahead as far as I could through the scope, and did not see any apparent change in condition. Growing up sailing in open ocean, I am familiar with wind lines and swells/sea state, and I did not see anything looking ahead and over the breakwater off of our port bow that caused me concern. As the personnel transfer was executed, I shifted my focus to the chart to see where we

were in relation to the shoal water I knew to be in the vicinity. When the men went topside, I recall seeing the pilot boat start to move into position to execute the transfer.

I was at the starboard side of Control looking at AIS for any interfering contacts on future legs when I felt the bow of the ship go pitch downward. I saw the back deck awash in water. I heard "man overboard" called away from the bridge, but I did not know who had gone overboard - initially, I assumed the pilot had been washed over, but then I saw the pilot boat standing off the starboard side. I heard the report that all men topside were tethered to the safety track, which made sense because I had not seen anyone drift back towards the rudder. I heard two more calls of man overboard. After the first of these later calls, I looked out the scope and could see that the swimmer was in the water, waving his arms. After the second man overboard call, I saw a man in topside gear in the water off the port side of the ship. Both were recovered by escorting small boats.

I heard an order to shut the Forward Escape Trunk (FET) upper hatch. After looking at the chart and noting that the Navigator was very focused on keeping the ship safe, I went down to Crew's Mess to evaluate the situation there. In Crew's Mess, there were 6-8 inches of water on the deck. I still didn't know who remained topside. I saw [redacted] go by wet and shivering to the Wardroom, apparently injured. I went to the Wardroom where the Doc [redacted] and the Emergency Medical Assistance Team (EMAT) were tending to [redacted]. I asked [redacted] who was still topside, but he was not sure. I didn't know at the time that [redacted] was in the FET attempting to free the Jacob's ladder from the upper hatch. He was finally able to free the ladder and the hatch was shut.

I then headed down to the Machinery Room to see what the conditions were there. The EDMC [redacted] identified himself as the man in charge, stated he had the situation under control, and I did not have to issue any direction. EDMC informed me that water was up to the deck plates and they were pumping the bilges. The battery well access hatch was covered to prevent water from entering.

I then returned to the Control Room. At this point, I was trying to verify who was still topside. I knew [redacted]

[redacted] had made it below, but had not seen the COB or Petty Officer Holtz and was not sure who else had gone topside since the first man overboard call. I looked through the scope at the starboard side where I had heard there was still someone attached to the deck and saw glimpses of someone tethered over the side. I knew that we needed to return to protected water so that someone could go topside and cut the man loose. To do so, we were going to turn around, and I told the Navigator that we needed to turn right. He arrived at the same conclusion, as did the bridge. Accordingly, we turned to the right. I did not look at exact set and drift direction and speed, but I knew we were being set toward the breakwater given our position and the direction of the seas. I don't recall what speed was being used to execute the turn, but the ship was turning at a sufficient rate.

The bridge ordered a diver topside to cut away the man tethered to the deck. After looking at the chart and determining that the ship was in good water, I went to Crew's Mess and ordered [redacted] to suit up in a harness and two lanyards and go topside with a knife to cut the man loose. Some people recommended sending him up through the bridge hatch, but I knew this would not be successful. I said no and ordered [redacted] to go up through the FET hatch. He did and cut Petty Officer Holtz loose. Because we were back in calmer water and not taking water over the deck, the pilot was transferred off of the ship at this point with [redacted] assistance.

I then needed to verify who had been topside and who had been recovered. I knew the COB was not on the boat, but I didn't know if he had been picked up. I was concerned that he had drifted free of MSP and had not been seen by the bridge or the escort boats. I went to Control and ordered the bridge-to-bridge operator to get data from all escorts as to who had been recovered by name. I also ordered a muster of the crew onboard. I finally heard that the COB had been picked up and was now on the shore in an ambulance headed for the hospital. I recommended continuing to sea, as I knew that we were beyond our tidal window to return to the pier. Our muster revealed that the COB, Petty Officer Holtz, [redacted] and [redacted] were the only four not on board, and bridge-to-bridge communications confirmed that all four had been recovered and were being transported to the hospital.

After we were headed back to sea away from restricted waters, we had all men accounted for, the crisis had passed, we sent out an OPREP-3 message.

I have extensive training with man-overboard exercises throughout my career, but I do not have training with respect to man overboard exercises with a man still attached to the ship by a lanyard. I don't believe I have even heard the scenario discussed in prior training or schools. The general thinking is that if a man falls off the ship attached to a lanyard, men on the deck will pull him back up. I remember discussing the USS OLYMPIA incident, involving people swept overboard in Dubai. The Lessons Learned as I remember from that incident involved too many people being topside which resulted in too many people going overboard, which was beyond the capabilities of escorts to rescue.

With regard to officer watchbill manning, we used the same team for outbound as we did for the inbound. The Engineer was the OOD and is the best ship driver onboard aside from the CO. I was not aware at the time that the officer assigned to NavEval was manning the bridge-to-bridge while the bridge-to-bridge operator was rigging the forward compartment upper level for dive. I learned later that when the first man overboard was called, the assigned bridge-to-bridge operator returned to his station and the NavEval officer assisted him at the bridge-to-bridge.

The Navigator regularly downloads Lessons Learned from the COMSUBLANT website, including Lessons Learned for all of the ports we knew we would or could be visiting on deployment. Onboard MSP, we regularly use Lessons Learned in our own training and planning. We used Lessons Learned for Plymouth for our inbound/outbound piloting briefs, navigation plan, and chart preparations.

I think two principle factors contributed to this incident - the wave/swell that knocked the men overboard was unforeseen and that the two men died because they were tethered to the deck. Until the wave/swell swept the men overboard, everything had been playing out smoothly and as planned. I don't know why or how something up ahead changed after I had looked out the scope

and saw no change in sea state along our current track. It is clear that the pilot did not see the change in sea state ahead, as he was in no hurry to get to Crew's Mess after leaving the bridge and did not appear concerned at all.

In order to prevent similar incidents in the future, I would recommend changing the procedures regarding when to use lanyards to stay tethered to the ship for small boat transfers. When surrounded by escort boats that can recover a man overboard, I recommend doing away with the tethers completely. I also recommend a quick-release for the lanyards.

I believe that we planned and executed the personnel transfer as well as we could with the information we had, but were overcome by unforeseen circumstances.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/S/ 16/07

[redacted]

Sworn to and subscribed before me this 06th day of January 2007, at Naval Station Rota.

/S/

[redacted]

Statement of [redacted]

Events of 29DEC06

I was the 1JV phone talker in the aft port corner of the bridge.

I attended the piloting brief, which contained weather, expected sea conditions and piloting track. The sea state was expected to be 15-22 ft swells in open ocean, wind gusts of 30kts, strong current in the channel due to the tidal change and proximity to landmarks during the navigation from port.

Initially we started in port Plymouth England. The weather was windy and rainy, visibility was approximately 5000 yds. We backed out into the channel as briefed and the channel had a strong cross current from stbd to port (also briefed). Once in the channel, there was a very strong head wind (approximately 30 kts) and it was still raining. Approximately half way down the second leg, the wind increased to the point that it was very difficult to communicate. Later on that leg, the wind died down and the rain stopped. Visibility opened up to about 6000 yards. The wind gusts alternated directions and strength as we continued down the subsequent legs. The wind shifts did not seem to be based on our direction or the outlay of the land.

When we neared the mouth of the channel, personnel were sent topside to assist the pilot to his boat, which was approaching on the stbd side. [redacted] COB, Holtz and [redacted] went topside and the pilot remained in the hatch. At this time, we were only taking some minor spray to the FET. A wave that was significantly larger than the others came (it was about 6-12 inches higher than the hatch) and knocked everyone overboard but the pilot. [redacted] and I called man overboard stbd side simultaneously. The OOD (ENG) ordered all stop and right full rudder. [redacted] lanyard broke or he was not lanyarded in and the current carried him off.

Three more waves came in quick succession, all three going over the hatch. The pilot went down and [redacted] came into the hatch and tried to retrieve people. Initially, [redacted] cob hand Holtz were holding onto the boat hook. At some point, before [redacted] came topside, the boat hook was broken and released. Once the boat hook was released, the three in the water held each other's lanyards.

[redacted] went by the rudder with about 20-30 yards and was picked up by a security boat. [redacted] COB and Holtz (fwd to aft) were overboard stbd side and were holding on to each other's lanyard. The swimmer [redacted] came topside to assist and was sent overboard by a wave. A wave came from stbd to port and put [redacted] on the boat. [redacted] made it into the hatch; I didn't see how because I was watching [redacted] go by the rudder/screw.

ENCLOSURE (101)

[redacted] tried to assist Holtz but a wave that was larger than the first took [redacted] over the stbd side again. [redacted] swam back to the boat and tried to climb topside. While he was climbing up the boat, a wave took him overboard again and the current carried him off. Man overboard stbd side was called again and the current carried [redacted] away. The OOD ordered right full rudder, B1/3, Z. The COB and Holtz (fwd to aft) remained tethered topside but were still overboard stbd.

Several bell and course changes were ordered that I don't remember. COB and Holtz were being lifted up and dropped against the boat by the waves and significant water was taken down the hatch. Waves were coming from port, stbd and periodically from fwd. COB and Holtz were holding on to each other until broken apart by a strong wave from stbd that put Holtz on the nonskid aft of the FET. Holtz tried to get up and was knocked off the boat by a wave from port. The waves were pounding both of them against the stbd side and both were under water numerous times. The cob and Holtz looked unconscious after one of the larger waves, but Holtz started moving again after a few seconds. From this point on, the cob did not move, but was limp and moving only because of the water.

The waves were getting higher and we received a report that the water level in AMR was to the EOG. The CO ordered the FET upper hatch shut. Shortly after the hatch went shut, the wave height increased by 2-5 feet and continued to alternate directions. Holtz was washed onto the ship approximately three times and the COB once. When on deck, the cob was turning blue and completely unconscious. I lost sight of Holtz and cob on several occasions due to the height of the waves.

The water calmed and then shifted directions putting Holtz on port and the COB on top of the boat just aft of the FET. Holtz still appeared unconscious and the COB was very blue and foaming at the mouth. A small wave came from port reviving Holtz and washed the foam off the cobs mouth, but left him on the FET. [redacted] in a security boat on the port side encouraged Holtz to keep fighting and told him to let us know he was conscious by putting his hands on his head. Holtz responded by putting his hands on his head. Another wave came from port and took Holtz and cob to the stbd side. Holtz put his hands back on his head and spit out water.

A large wave came from stbd bringing COB and Holtz to port. While going from stbd to port, Holtz hit cleat five very hard on the right side of his mid section. [redacted] encouraged Holtz when he came back to stbd side, but this time, Holtz could not move his right arm; he put his left arm on his head momentarily and then it dropped but he continued to spit out water. The COB, appearing dead at this point was very blue and foam continued from his mouth but at a much slower rate than at first. A wave came from port and carried both of them over to the stbd side Holtz hitting cleat five with his left side but harder than the first time. They alternated sides several more times, Holtz hitting the cleat each time and both submerging for several seconds each time. Each time however, Holtz didn't react to hitting the cleat; he was just limp. A large wave took them from stbd to port breaking the COB's lanyard.

I called man overboard port side and the rudder was ordered frozen and the shaft ordered stopped. The COB passed by the rudder with approximately 5-10 yds. The small boat picked up the COB and rushed him away. Several waves came, but the magnitude died down and Holtz remained on the port side. The small boat finally returned and we hailed it to cut Holtz loose. Distefano was ordered to the FET to cut Holtz loose. The small boat made several attempts, but the waves and the direction change of the water didn't allow them to get close enough to his lanyard to cut it. While they were attempting to free Holtz. [redacted] came topside. Initially his lanyard was too short, or he was not given enough rope. He had to go back to the hatch to get more lanyard before he was able to cut Holtz's lanyard. [redacted] retrieved the remaining portions of the lanyards and then was ordered below decks. The sea remained calm, so [redacted] was ordered topside again to retrieve the Jacobs Ladder. He assisted the pilot and brought the Jacobs Ladder below and the FET was shut.

Visibility had closed significantly on the landside and we turned to go from land. Very quickly, the sea state worsened significantly and we were receiving more and more splash to the sail. [redacted] and I were quickly ordered down by the CO because of the worsening sea state.

From the first man overboard until the small boats recovered all men, the lowest sounding I remember was 28 feet beneath the keel.

/S/ 4JAN07

04 Jan 07

From: [redacted]
To: JAGMAN Investigation Team

Subj: COMMAND INVESTIGATION INTO THE DEATHS OF SENIOR CHIEF THOMAS HIGGINS AND PETTY OFFICER MICHAEL HOLTZ ONBOARD USS MINNEAPOLIS-ST PAUL (SSN 708) ON 29 DECEMBER 2006

1. I have been in the Navy for 6 years, 6 months and have been aboard USS MINNEAPOLIS-ST. PAUL (SSN 708) since April, 2003. My job aboard MSP is an Electrician's Mate in the Electrical division. This statement supplements the written statement I provided the investigation team from 4 Jan 07.

2. At the time of the incident, I was the phone talker on the 1JV.

3. I was up on the bridge during the incident.

4. I was in the aft port corner of the bridge; the decision on matters regarding the pilot transfer would have been made in the forward part of the bridge.

5. The weather was changing as we headed out. The wind got so strong on the first leg of the transit down the river that we had to stop talking. The wind and rain was so strong it was coming through the holes on my mask and eventually the wind stopped.

6. I didn't notice a change in the seas on the way down the river but the wind had died down. The seas weren't bad. We weren't taking any spray to the hatch and the waves were, at most, halfway between the waterline and top center.

7. The first big wave that I saw that we took was the one that washed the guys over. When the men went overboard, 3 were still lanyarded to the boat. Once we had done our second man

ENCLOSURE (102)

overboard and done our second turn, West marker was roughly 500 to 1000 yards off the port forward quarter.

8. I attended the piloting brief. The pilot mentioned that the currents were going to be strong due to the surge of water from the rising tide. There were several turns that that would have an effect on. It seemed when we first left that the current wasn't as strong as we had expected; we were expecting to back out and the current to push us but the current didn't push us as much as we anticipated.

9. The pilot didn't mention weather. There was a weather portion of the brief. We expected 15-22' seas once we got out into the open ocean.

10. I can't say for certain if lifejackets inflated. [redacted] was floating away pretty high in the water.

11. While the ship was maneuvering in the south leg of the route, the COB and Holtz were overboard for the majority of the time. Holtz was washed onto the deck several times and knew he was out of the water and would try to turn and every time he tried to turn, another wave would take him back overboard. They weren't alongside the ship; the seas were coming from port and they were unable to see the seas coming because they were on the other side. The waves would come over them and then slam them into the boat. Initially it wasn't so bad because they had the hook they were holding onto. Somehow that hook broke loose and then they went to hold onto each other's lanyard; once they lost contact with each other they never came back together. They ended up about 10'-15' aft of where they started. They never

went as far back as the aft escape trunk. They started out 3 to 4' aft of the forward escape trunk.

12 [redacted] had two lanyards hooked together; the rest only had one. He had two because his lanyard was going into the trunk instead of being attached to the track.

13. The response of the escort vessels, we had a big police boat on port aft quarter, another on starboard aft quarter, and a small 3-man RHIB boat that was all over the place. He was usually aft of us, sometimes parallel with us. The tugs started back when the breakwater started opening up. Until then, they had stayed parallel to us on either side.

14. The visibility - I could see both shorelines. Visibility was opening up as we got further out.

15. The captain issued the order to close the forward escape trunk lower hatch; [redacted] and I both radioed it. When it was not reported that the forward escape lower trunk was not shut, he issued an order to shut the forward escape trunk upper hatch. The amount of water that appeared to be coming down the hatch seemed to be more than I'd ever seen before.

16. The tugs that were escorting us could both push and pull; however, they could only push with the aft end of the boat. These boats were the Careful and the Faithful.

17. I've never heard of anything like this happening before. The MSP is my first ship.

18. I've been on the bridge for 10 or 15 maneuvers in and out, so 30 or so total maneuvers.

19. The pilot made it topside and was sitting in the hatch with his legs on the ladder and was holding onto the forward escape trunk when the first wave came.

20. We had mentioned the pilot staying onboard and joked about taking him to Rota with us. This was before the incident took place.

I have read and understand the above statement. I have been given the opportunity to make any changes or corrections I desire to make and have placed my initials over the changes or corrections. This statement is true and correct to the best of my knowledge.

/s/

Sworn to and subscribed before me this 04th day of January 2007, at USS MINNEAPOLIS-ST. PAUL (SSN 709).

/s/

[redacted]

WITNESS STATEMENT

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3)(a) and 5B; MC Rules 1981, r.70)

Statement of [redacted] ..... URN: | | | | |

Age if under 18 **Over 18**..... (if over 18 insert 'over 18') Occupation: **Admiralty Pilot**

This statement (consisting of: ... **17** .... pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything in it which I know to be false, or do not believe to be true.

Signature: ..... Date: .....

Tick if witness evidence is visually recorded ✓ *(supply witness details on rear)*

I am the above described person, I reside at :

I am enployed by the Ministry Of Defence in the capacity of Admiralty Pilot. I have been a civil servant since May 1978.

As an Admiralty Pilot, my duties are to carry out pilotage duties involving all types and classes of Royal Navy Ships including nuclear submarines aircraft carriers and assorted surface vessels. I also conduct pilotage of Royal Fleet Auxilliary vessels and commercial vessels to/from Ministry of Defence berths, buoys, basins, anchorages and jetties. I also assume full responsibility for the ships when carrying out cold moves of vessels (the moving of ships around the harbour solely with the use of tugboats).My duties also involve pilotage of foreign or visiting ships.

I am based at the Longroom Port Control Station, Plymouth, I have full functional authority of the Queens Harbour Master to undertake these duties.

In order to maintain my office and position, I am required to requalify in certain aspects of the job description and have prepared a comprehensive and detailed list of current qualifications including dates and descriptions of courses attended. I produce this document KMB/1.

I have further produced a copy of my curriculum vitae which outlines dates of qualification in various aspects of my maritime career and gives a comprehensive overview of my experiences and triaining to

Signature: ..... Signature witnessed by: [redacted] .....

carry out my current role. I produce this document also KMB/2.

I have further produced a personal history of my maritime history illustrating detail of positions held within various maritime organisations and including detail of vessels commanded and relative dates. This document is labelled KMB/3.

I have records confirming that I have piloted vessels into and out of the Port of Plymouth on two thousand 0ne hundred and sixty times.

Following an incident at sea in the area of the Plymouth Sound on the 29th December 2006 in which I have been directly involved in the capacity of Pilot, I have been asked by the police to provide a detailed account of my involvement in the departure from the Port of Plymouth of USS Minneapolis-Saint-Paul on that date.

USS Minneapolis-Saint-Paul is a nuclear powered Los Angeles class attack submarine enumerated SSN 708. The vesssel has been on a visit to the Dockyard at Devonport Plymouth, and was scheduled to depart one hour prior to the high tide at lunchtime on Friday 29th December 2006. The vessel was berthed at No 9 wharf at Devonport dockyard during the visit.

The task of departing the vessel was allocated to me personally prior to its arrival and as a consequence, I had been in preparation for the departureof this vessel for several days prior to the departure date.

I have had personal experience in piloting this class of vessel over the past 15 years and on a number of previous occasions, I believe that I have piloted this type and class of vessel in and out of the Plymouth Dockyard. I do not recall the last occasion on which I piloted this class of vessel but estimate that the time duration is probably two years or more.

As part of the departure plan, on Thursday 28th December 2006, I attended a prearranged meeting onboard the ship at 1400hrs. This followed a telephone request from the ship to the Flag Port Control Station specifically requesting my attendance.

Continuation of Statement of [redacted] .....

Accordingly, I attended the ship on that date and was greeted by a Naval Officer whom I believe was a [redacted] I believe that the man was [redacted] but was not the [redacted] Minneapolis Saint Paul.

This officer escorted me via the forward hatch down into the vessel where I was escorted to a briefing room which also doubled as the ships canteen/messroom.

Present at the meeting were most of the senior staff commanding the vessel. The Captain [redacted] was in attendance, he personally introduced himself to me and we shook hands. Also present were the navigating officer and, I assume, all department heads responsible for the safe operation of the ship.

There was no formal roll-call at the meeting.

The man who introduced himself to me as the navigating officer, commenced the meeting and gave an explanation to the delegates of the proposed means by which the submarine was to depart the port. This was without any prior consultation with me whatsoever and this was the first occasion that I was to learn of his proposals.

I am not aware of any persons present recording any notes or minutes of what was said during the meeting.

Following the navigators presentation, I was invited to give my own presentation for the proposed departure plan.

During the meeting, I gave a presentation to all present on the proposed departure plan for the vessel, proposed for the following day, the 29th.

I am unable to recall any specific details of exact conversation at the meeting, since this briefing was in every respect, similar to many previous such briefings.

Signature: ..... Signature witnessed by: [redacted] .....

Continuation of Statement of [redacted] .....

I gave a presentation to all present using a chart affixed to the bulkhead for that purpose. I used a broken coffee stirrer to represent the vessel as I explained the course, direction and proposed exit plan from the Hamoaze. The chart illustrated the Hamoaze only and not the Plymouth Sound itself.

The briefing also centred on what are known in nautical terms as the variables, weather predictions, potential hazards encountered en route to open water and the proposed point at which I would disembark the vessel upon completion of safe pilotage. I informed the briefing that I would depart the vessel at a point 'within Plymouth Sound'.

This statement was deliberately open-ended since the point at which I disembark is wholy dependant upon conditions on departure and as explained previously, my disembarkation point is a 'variable'.

I gave a detailed brief as to where the tugs would be operating in relation to the ship to assist departure and also I gave an explanation of the phenomenon known as the 'bank effect' which is peculiar to the Plymouth departure route downriver.

I explained to the delegates that the 'bank effect' was peculiar to this course of exit from the Port of Plymouth and what affect the route would have on the handling or steerage of the ship. The banks of the river would have the effect of pushing against the ship and affecting the point at which direction changes are initiated.

Also at the briefing, I informed delegates of the presence of the RFA vessel Cardigan Bay and the location at which she was lying. All present were therefore aware that the departure course would take the Minneapolis St Paul, close to the RFA Cardigan Bay.

The tactical departure meeting was concluded and at that meeting, it was established between the captain and myself that I would depart the vessel at a point 'within Plymouth Sound', once I was satisfied, in my mind, that the ship was on the correct bearing for departure and was travelling at a safe transfer speed in order for me to leave the vessel.

I was then given a tour of the ship in order to familiarise myself with the layout of the vessel.

Signature: ..... Signature witnessed by: [redacted] .....

Continuation of Statement of [redacted] .....

This is not mandatory but I accepted the invitation out of interest. During the tour of the ship, I was not advised of any specific route through the vessel that I would need to follow in order to disembark, at sea the next day.

I met with the captain [redacted] and he gave me a commemorative souvenir of the ship for which I thanked him.

After the meeting, I had walked the upper casing in order to familiarise myself with the securing points on the vessel to ascertain the best way of securing tugs.

The departure of the vessel was confirmed 'as planned' for the following day, the 29th one hour before high tide. The ultimate decision to continue the departure on schedule, was agreed by all concerned parties.

On Friday 29TH December 2006, at approximately 08.00hrs, I received a telephone call from the Flag Port Control Station at the Dockyard. The call was to establish whether or not the proposed departure was to take place as scheduled.

I had been contacted by the Flag office Plymouth, I discussed the departure with my chief pilot, [redacted] Although the wind conditions were predicted as being unsuitable for the safe departure of a surface vessel, there are no written guidelines available for wind conditions in direct relation to submarines since the majority of the vessel is submerged and is little effected by surface air movement or windage.

The Chief Pilot and I discussed the departure and he told me that he would support my decision to depart on schedule, either way.

The Longroom Port Control Station then contacted me with an up-to-date weather forecast and we discussed the SSN check-off list. This is a list of all preparations required to be considered prior to the departure of a nuclear submarine. This document will be available if required.

Signature: ..... Signature witnessed by: [redacted] .....

I was aware that during the night previously, a standby tug had been dispatched as an emergency precaution to attend the Royal Fleet Auxilliary vessel Cardigan Bay secured to Charlie Buoy within the Sound. I know that this vessel was so moored since I had positioned her there on arrival.

Charlie Buoy is a mooring located almost centrally within the Plymouth Breakwater and is often used to 'tie up' large vessels.

I was aware that the tug performing standby duty on Cardigan Bay was the tug 'Forceful'. I know the captain of that vessel, he is an experienced vessel master [redacted]. I spoke with him by telephone and obtained from him a verbal account of weather conditions at his location, this gave me a rough guide to the conditions at the point at which I had in mind to disembark the Minneappolis Saint Paul. I was informed that the windspeed was determined to be 40-45 knots decreasing to 35knots from the South Southwest but decreasing throughout the forenoon (navtex machine) for the area.

I subsequently telephoned the Minneappolis Saint Paul.

I was connected to a navigator on the vessel, I do not know the mans name but I am aware that the vessel carries a number of persons responsible for navigation of the ship. I asked the navigator if he had seen the weather forecast and had any particular reservations concerning the departure. He had none. I told him therefore that the departure would continue as planned.

I subsequently drove to Number 9 wharf where the vessel was berthed arriving at around 10.30 on the morning of the 29th in order to commence the departure. Once on the vessel, I examined the drawings of the ship which is not a procedural formality, however, I chose to do so on this occasion.

I was able to gain the necessary information from the American officer concerning the submerged extremeties of the submarine in order to accurately plan the positioning of tugs in order to assist in pushing the vessel. This included the location of potentially vulnerable areas on the casing.

I attended the bridge of the vessel where I was present when the engines and propulsion systems were tested. This included the main turbine propulsion system and backup or standby diesel engines. I

positioned myself at the top of the conning tower or fin where I had a good view of my surroundings through 360 degrees. I was to remain there throughout departure.

On the conning tower of the vessel were a number of technical devices to assist with the operation of the ship. I saw a ships compass, an electronic charting display information system (ECDIS), voice controls and a VHF radio. There is no equipment which might enable the vessel to be steered from that location.

Due to the size, draught and established best handling speed of this type of submarine, It was agreed verbally between the captain and I that a safe speed in the water of between 8 and 9 knots would best suit the conditions of the day. This could be determined or deemed as slightly excessive for a safe transfer at sea, but, having due regard to the handling of the ship, this type of vessel becomes extremely unresponsive to steerage at lesser speeds and the maintainence of the correct heading is more easily achieved at that speed.

Satisfactory tests were conducted on propulsion systems. I met with the captain on the bridge and explained to him the method by which the vessel was to be cast off from the wharf.

At approximately 11.30 hours that morning, the lines were let go and the vessel was manouvred from the berth by use of the two tugs present and whose services were at my disposal.

Cast off procedure was carried out without incident, I am able to give a detailed account of departure from the wharf if subsequently required so to do. This can include the positioning of tugs. The security cordon of bouys around the submarine was removed by the port authority by prearrangement.

During backing out, I engaged the captain in conversation, we spoke about times and details of high water, weather, and the location of tugs positioned for the task.

Having cast off, the submarine was manoevred backwards into the river coming to rest. The vessel was pushed onto the appropriate heading before setting off downriver under her own propulsion.

[redacted] asked me "what speed do you recommend"? I advised him "between 8-10 Knots, 10

knots being the maximum speed limit". The vessel accellerated to a speed of approximately 9 knots at my suggestion.

I am able to describe in detail the subsequent journey and course/speeds etc that the vessel was to follow on its journey downriver if required. This journey was undertaken without incident and is 'textbook' or 'bread and butter' to me having made the journey so often previously.

Visibility on the day was poor at best and it was anticipated that the captain and bridge staff might get a good view of the Hoe and Plymouth shoreline but this proved disappointing due to the poor weather. The vessel had arrived in Plymouth under a different pilot in darkness.

I will continue the detailed account of the departure journey at a point passing through Smeatons Pass where under normal circumstances for instance, when piloting a British submarine, I would begin the process of handing sole control of the vessel to the master.

In this instance, I had made a prior decision that since this particular vessel was a visitor to the United Kingdom and its captain being unfamiliar with the Port Of Plymouth, that I would remain onboard considerably longer with the captain to ensure that he was accurately positioned to make good her departure from Plymouth Sound.

At this point in the journey, it is worthy of note that the other crew members on the bridge at that time were wearing 'ski masks', such was the weather condition at the time.

On the conning tower at this time were the Captain, a person whom I assumed to be the navigator, myself, and two other seamen below me at a lower level. Also, there were two other persons standing on a higher level behind me.

Having negotiated Smeatons Pass, still sailing at approximately 8-9 knots on a bearing of 169-172 degrees, before I prepared to perform the manoevre to turn to starboard on to course of 250 degrees, I spoke with [redacted] I spoke directly to the captain and told him exactly what to expect as marker buoys came into view. At this time, I was unable to see Cardigan Bay due to heavy mist. Marker bouys

then came into view as we travelled along 169 degrees as expected. Each was acknowledged in turn by [redacted]

During this leg of the journey and before the turn onto 250 degrees, RFA Cardigan Bay came into view through the mist.

[redacted] "What side do you want the pilot ladder"?

I responded, "Starboard side"

[redacted] "When are you getting off?"

I replied, "On the 250 degree leg". I did not inform him exactly where.

At this point, [redacted] asked me, "Whats that?", indicating the Breakwater. This concerned me greatly and did little to allay my fears that the captain and navigator were not at ease with departing the vessel from harbour unaided. The Plymouth Breakwater is a land mass a mile long and is clearly charted.

I gave the captain instructions as to the timing of the turn which he in turn communicated to the helmsman and the vessel turned without incident exactly as planned onto course 250 degrees heading towards the west end of the Plymouth Breakwater.

At this point, I was able to confirm information already known to me about the location of shipping in the Sound and I was able to confirm my intended route out of the harbour without deviation. It is worthy of note at this time, that the vessel Cardigan Bay, which is a sizeable ship (176 metres in length), was lying as expected on Charlie Buoy. Due to the strong winds at the time, Cardigan Bay was lying in a situation almost facing due south, the stern of the vessel therefore lying some distance 'into' the channel available for my vessel to depart,(ie-0n 250 degrees).

Having turned to starboard and settled on the bearing of 250 degrees, a course which would take my vessel directly across the Sound and close to the rear end of Cardigan Bay, I began to point out to the captain the points that he would need to be aware of in order to safely leave harbour at the western end of the Breakwater.

I indicated to the captain the location and position of the 'New Ground' buoy off to my starboard side. Beyond that, I pointed out the position where he could soon expect to see the 'Queens Ground' buoy also to the starboard side. I explained to the captain that these buoys must be maintained to the starboard side of the vessel during departure [redacted] acknowledged my instructions.

I said to [redacted] that I would be making my arrangements to depart the ship at a point at, or near the rear end of Cardigan Bay, once, and only once, he was content to depart the vessel from Plymouth Sound unaided.

Ordinarily, I would then advise the captain of the Breakwater Light to the port of the vessel which would identify the safe route between left and right. However, due to the position in which Cardigan Bay was lying, facing due south, the Breakwater Light was obscured by the ship on the buoy. It was therefore necessary to delay my departure from the bridge until a point, whilst heading on 250 degrees across the rear of Cardigan Bay, when the port Breakwater Light came into view from behind the ship at anchor.

I again repeated my instructions to [redacted], again pointing out the left and right perameters of safe exit, he convinced me to my satisfaction that he was now aware of his bearings and was without doubt, aware of the safe bearing and course for departure.

I told him that I was now leaving the ship, he thanked me for my help in pilotage, We shook hands and I left the bridge. The speed of the vessel at the time remained constant at around 8-9 knots.

On a british submarine with which I am most familiar, the method of disembarkation would be via an internal wet ladder down the inner skin of the fin and through a small door opening onto the casing and leading directly onto the ladder to the pilot boat. This operation taking maybe one minute or so from

beginning to end. However departure from this submarine was to take considerably longer.

Due to the design of the submarine, it was necessary for me to be escorted by a seaman dedicated to that task from the bridge, to the aft hatchway. Accordingly, I met my escort in the control room of the vessel having descended the internal ladder from the bridge into the ship. He escorted me at first through several compartments before descending a further ladder to another deck below. I then followed him some distance along a lower corridor of the ship where I arrived in a mess or social area at the foot of another ladder leading to a deck hatch.

I am totally unable to describe the seaman escort.

After a short wait, I was granted permission to disembark the submarine from a seaman at the foot of the ladder. There was another seaman in this room wearing radio headphones, a non white male, sitting in the corner, I have no idea of his responsibility but would describe the headphones as being used for functional purposes connected with the vessel as opposed to entertainment.

I ascended the ladder some two decks or so to the open hatch on the aft deck. I estimate that this route to the outer casing had probably taken four or five minutes to complete. In hindsight, this was a period of time for which I had not planned to be below decks.

I stood on the top rung of the ladder for just a few seconds to orientate myself and to locate the Pilot boat which was standing off to starboard.

It was apparent to me that the ladder was not fully rigged, which explained why the pilot boat was not alongside.

I stood, still on the top rung of the ladder with my hands clutching the upper edge of the open hatch cover in front of me.

I was aware of a significant wave brewing to my port side. I turned to face it to realise without doubt that the wave was large enough to pass clear over the submarine, and likely several feet over me also as

I stood, still in the hatchway.

I gripped the hatch cover before me to steady myself and in doing so, could see over the top edge of the hatch cover, four or five members of a boat party assembled on deck attempting to secure a ladder intended for my departure.

The wave struck, in fact it passed clear over the casing and for a short while, I was submerged in sea water. The wave 'dumped' on me and a good volume of seawater passed through the hatch past me. I was thrown backwards to a seated position at the head of the ladder with the heavy hatch cover pressed against me still as I held on to it.

I recovered myself to the standing position on the top rung as before, reopening the hatch cover to its full extent in doing so. I had sustained a facial injury where the falling hatch cover had caused me to bite through my upper lip.

By now, a second wave was almost upon me, it also came from my port side although the angle with the submarine was slightly less, the captain had obviously put the vessel into a steep port turn. As I watched the second wave travel along the casing towards me, from the port front side of the vessel rearwards, I saw the wave appear on either side of the conning tower in front of me.

Unlike the first wave, this wave had struck the ship almost 'head on' and the seamen exposed on the rear casing were not this time protected by the fin. The wave swept two crewmen into the sea to my starboard side. Both crewmen were swept to the extent of their respective tethers and were 'flopping' around in the sea adjacent to where I stood on the ladder. They were however several feet below me and the casing had no physical means by which the men could hang on to anything or extract themselves.

The second wave struck me as it swept the seamen overboard, the force of the seawater was as before, except that this time I was able to prevent the hatch from striking me. I called aloud, 'Man overboard'

My automatic lifejacket inflated upon contact with the water.

I realised the uselessness of my situation within the hatchway, I could do nothing to assist the seamen in the water, and as a consequence, I retreated back down the ladder into the mess below. I estimate that I was topside in the hatchway for the passing of at least 5 or 6 waves before descending.

The mess below was in chaos. There was approximately 18 inches of seawater slopping from side to side and some of the fluorescent lighting had flickered and then failed. There was a computer teminal switched on in the mess which sparked and went dead with a flash, as did a stereo stack system which had formerly been flashing with display lights to the front when I ascended the ladder initially.

Whilst I waited in the mess, two of the deck party followed me down the ladder from topside. They arrived at the foot of the ladder soaking wet and both appeared to be injured. Crewmen in the mess covered both men in blankets and both were ushered away from the mess to the wardroom. I did not see either again. I am unable to describe eather seaman.

There came a message from the bridge, 'Pilot to the Bridge', to which I responded immediately with an escort. I retraced the route followed previously to the bridge and on arrival, I took up a position high on the railing giving good 360 degree peripheral vision. I again greeted the captain. The captain had clearly made a decision in my absence to return to the Sound and was coming about to starboard which explained the slopping of the water from side to side whilst I was below decks.

The captain said to me, "I am going back in". I could see the tethered seamen being tossed around in the wake of the ship. They were being tossed from side to side completely over the casing and occasionally being dumped on the deck. The tethered seamen were being thrown around like 'rag dolls', the captain asked me, "Can you get the police launch to cut them off"? There was absolutely nothing that they could do, the Police Rib was attempting to close onto the casing to free the men but there was again, absolutely nothing that could be done due to the sea state. I told [redacted], "There is absolutely no way they can get in".

I called the pilot boat as requested but received the response expected, that there was nothing that the pilot boat could do since it could not get in close enough.

I saw one of the still tethered sailors at one point whilst deposited on deck by the sea, still moving, he was trying to protect his head from the deck with his arm using it to cushion his head from the casing.

The other seaman appeared lifeless at that time.

The rear hatch cover now was closed.

I could not look directly down at the sides of the fin due to the presence of wings located on the conning tower itself. However, I could see the after casing and the propulsion systems to the rear and as I looked rearwards, I saw a further seaman washed overboard being bounced along adjacent to the port casing towards the rear submerged guidance and propulsion systems.

[redacted] responded immediately at seeing the man overboard and gave a direct order below to 'full port rudder', which had the effect of 'slewing' the rear of the submarine very quickly from the path of the floating seaman. He was washed beyond the rear of the vessel into open water having passed very close to the rudders. I later saw this seaman picked up by a small vessel accompanying the flotilla, probably a police boat.

I then, although with great difficulty, turned my attention away from the activity at the rear of the boat and concentrated my attention on safely piloting the vessel back into harbour.

I contacted both tug vessels and issued instructions via VHF radio. I wanted the tugs in a specific position to be able to again turn the submarine safely in the water at the rear of Cardigan Bay. Exact conversation will be recorded at the Longroom if required. I explained to the captain what to expect once we had returned to flat water.

Once in calm water, a further problem was apparent in that the submarine had retracted the securing bollards for departure, they were still stowed and there was nowhere for the tugs to secure to the submarine.

I recall requesting a helicopter by VHF radio, I recall communication with the tugs, exact speech will be

recorded and is available if required.

The submarine now turned to port and faced back out to sea mainly under its own power. The police Rib, though still attempting valiantly to reach the tethered men, ran a significant risk of crushing the men against the casing and therefore stood off.

There seemed to be an inordinately long period of time elapsing before the rear hatch opened on the submarine.

Open it eventually did, and two seamen emerged to cut the tethers. The hatch could have been opened at least 5 minutes earlier. I saw the lines cut, the bodies of the seamen in the water were recovered into the police launch.

I had by now positioned a tug on the bow to assist in turning the submarine to face back out to sea.

This provided exactly the required position of the boat, it provided a lee for the sailors to recover the bodies and the submarine was secured against the southerly wind.

The vessel turned to face open water. The submarine was stopped in the water.

I said to the captain, that this was my time to disembark, I confirmed with [redacted] that he was aware of his route out of the Sound and he agreed that the time for my departure was 'now'.

I again returned with an escort via the same route to the rear hatch where I waited for permission from the bridge to climb out. I was at first refused permission and was kept waiting for several minutes.

I knew the sea state above and expressed to the seaman controlling the lower ladder that the captain had given permission for my departure. I was still not permitted to climb.

I exchanged my lifejacket for one from the submarine since mine had activated and would make any future attempt at climbing the ladder difficult.

Finally, I was permitted to follow a seaman and began to climb the ladder to daylight above, the hatch was opened for me. The mess was in my opinion not a safe place to be in view of the vast quantity of seawater in which I had been standing. Furthermore, I was becoming stressed for the safety of the ship, I did not know what the tugs were doing or where they were, I needed to be topside.

On the casing, there was no ladder rigged for obvious reasons since the seamen rigging it were all washed overboard or dead, the pilot boat came alongside and I stepped between the vessels as I had done many times before.

In the pilot boat, was a US Diver still in his wetsuit. He had injured and bleeding legs. The diver told me that at some time during the confusion, that he had pushed past me on the ladder and exited the vessel before me, I do not recall this happening.

I was conveyed to shore by pilot boat where I subsequently attended hospital for treatment to a minor lip injury.

To assist any future enquiry, I have produced and marked on some old admiralty charts, the direction and points of referrrence at different stages of the departure journey. I exhibit chart 30, with the course downriver highlighted thereon, KMB/6.

I further produce old Admiralty chart 871 upon which I have highlighted the route and resultant position of the submarine when I disembarked. I have also marked on the chart in green, the periods of time when I was below decks in preparation for my disembarkation. This chart is exhibited KMB/4.

I further produce a photograph of a Los Angeles Class Submarine upon which I have illustrated the relative positions of the hatch and deck ladder, and also some additional featured submerged features of this type of vessel. This is exhibit KMB/5.

I have handed all documentary exhibits to [redacted] at 1400 hours on Saturday 30th December 2006.

Signature: ..... Signature witnessed by: [redacted] .....

Continuation of Statement of [redacted] .....

Signature: ..... Signature witnessed by: [redacted] .....

RESTRICTED – FOR POLICE AND PROSECUTION ONLY
(when completed)

Home address: .....

..... Postcode: .....

Home telephone number ..... Work telephone number **AA**.....

Mobile/pager number ..... Email address: .....

Preferred means of contact: **MOBILE 24/7** .....

(delete as applicable) Date and place of birth: .....

Former name: ..... Height: ..... Ethnicity Code: .....

Dates of witness non-availability **TBA**

.....

Witness care

a) Is the witness willing and likely to attend court? **Yes**. If 'No', include reason(s) on MG6. What can be done to ensure attendance?

b) Does the witness require 'special measures' as a vulnerable or intimidated witness? **No**. If 'Yes' submit MG2 with file.

c) Does the witness have any specific care needs? **No**. If 'Yes' what are they? (Healthcare, childcare, transport, disability, language difficulties, visually impaired, restricted mobility or other concerns?)

Witness Consent (for witness completion)

a)	The criminal justice process and Victim Personal Statement scheme (victims only) has been explained to me	Yes ☐	No ☐	
b)	I have been given the leaflet 'Giving a witness statement to police — what happens next?'	Yes ☐	No ☐	
c)	I consent to police having access to my medical records in relation to this matter:	Yes ☐	No ☐	N/A ☐
d)	I consent to my medical record in relation to this matter being disclosed to the defence:	Yes ☐	No ☐	N/A ☐
e)	I consent to the statement being disclosed for the purposes of civil proceedings e.g. child care proceedings (if applicable)	Yes ☐	No ☐	N/A ☐
f)	The information recorded above will be disclosed to the Witness Service so they can offer help and support, unless you ask them not to. Tick this box to decline their services:		☐	

Signature of witness: .....

Statement taken by (print name): [redacted] .....

Station: [redacted] .....

Time and place statement taken: [redacted] .....

Signature of witness: .....

WITHHELD IAW

5 USC 552(b)(5) and

5 USC 552(b)(6)

WITHHELD IAW

5 USC 552(b)(5) and

5 USC 552(b)(6)

To view mai · data, click a station on the map below:

Conditions at 62107 as of 1500 GMT on 12/29/2006:

Unit of Measure: English Time Zone: Station Local Time Select

Click on the graph icon in the table below to see a time series plot of the last 24 hours of that observation.

Wind Direction (WDIR):	SSW (200 deg true)
Wind Speed (WSPD):	33.0 kts
Wave Height (WVHT):	20.0 ft
Average Period (APD):	11 sec
Atmospheric Pressure (PRES):	29.62 in
Pressure Tendency (PTDY):	-0.06 in (Falling)
Air Temperature (ATMP):	54.3 °F
Water Temperature (WTMP):	53.1 °F
Dew Point (DEWP):	53.1 °F
Visibility (VIS):	2.5 mi
Combined plot of Wind Speed, Gust, and Air Pressure	

Conditions at 62103 as of 1500 GMT on 12/29/2006:

Unit of Measure: English Time Zone: Station Local Time Select

Click on the graph icon in the table below to see a time series plot of the last 24 hours of that observation.

Wind Direction (WDIR):	S (190 deg true)
Wind Speed (WSPD):	28.0 kts
Wave Height (WVHT):	14.1 ft
Average Period (APD):	9 sec
Atmospheric Pressure (PRES):	29.67 in
Pressure Tendency (PTDY):	-0.04 in (Falling)
Air Temperature (ATMP):	54.3 °F
Water Temperature (WTMP):	53.6 °F
Dew Point (DEWP):	51.4 °F
Visibility (VIS):	2.5 mi
Combined plot of Wind Speed, Gust, and Air Pressure	

end (1)

Freeze or Thaw Depth

Freeze or thaw depth may hamper movement over the beach and construction support.

State of the Sea

State of the sea may preclude landing or resupply of landing forces and may cause debarkation to be canceled. It may endanger the use of landing craft. Severe conditions can degrade naval gunfire support.

Temperature (Water)

Cold temperatures decrease survivability of personnel in the water. Survival in sea water temperatures in excess of 70 °F depends more on fatigue factors than on hypothermia.

Figure E-2. Effects of Weather on Amphibious Operations (Continued).

Table E-1. 50% Survival Rate Times (hours).

Sea Water Temperature (°F)	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**
Without Immersion Suit	1.2	1.3	1.4	1.4	1.5	1.6	1.7	1.8	1.8	1.9
With Immersion Suit	1.5	1.7	1.9	2.1	2.3	2.5	2.7	2.9	3.1	3.3
Sea Water Temperature (°F)	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**
Without Immersion Suit	2	2.2	2.3	2.5	2.6	2.8	2.9	3	3.2	3.3
With Immersion Suit	3.5	4	4.4	4.8	5.3	5.8	6.2	6.7	7.1	7.6
Sea Water Temperature (°F)	**50**	**51**	**52**	**53**	**54**	**55**	**56**	**57**	**58**	**59**
Without Immersion Suit	3.5	4.3	5.2	6.1	6.9	7.8	8.6	9.4	10.3	11.1
With Immersion Suit	8	9.2	10.4	11.6	12.8	14	15.2	16.4	17.6	18.8
Sea Water Temperature (°F)	**60**	**61**	**62**	**63**	**64**	**65**	**66**	**67**	**68**	**69**
Without Immersion Suit	12	12.9	13.7	14.6	15.4	16.3	17.1	18	18.8	19.6
With Immersion Suit	20	21.2	22.4	23.6	24.8	26	27.2	28.4	29.6	30.8

To view mai data, click a station on the map below:

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Unit of Measure: English Time Zone: Station Local Time Select

Click on the graph icon in the table below to see a time series plot of the last 24 hours of that observation.

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Combined plot of Wind Speed, Gust, and Air Pressure

Conditions at 62103 as of 1500 GMT on 12/29/2006:

Unit of Measure: English Time Zone: Station Local Time Select

Click on the graph icon in the table below to see a time series plot of the last 24 hours of that observation.

Wind Direction (WDIR):	S (180 deg true)
Wind Speed (WSPD):	28.0 kts
Wave Height (WVHT):	14.1 ft
Average Period (APD):	9 sec
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Pressure Tendency (PTDY):	-0.04 in (Falling)
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Dew Point (DEWP):	51.4 °F
Visibility (VIS):	2.5 mi

Combined plot of Wind Speed, Gust, and Air Pressure

end. (1)

5830
Ser 07/003
22 Jan 2007

From: [redacted]
To: Investigating Officer
Via: [redacted]

Subj: WEATHER INFORMATION WRT THE INVESTIGATION OF USS MINNEAPOLIS ST PAUL MISHAP DTD 29 DEC 2006

Ref: (a) MAGTF Meteorological and Oceanographic Support, MCWP 3-35.7

Encl: (1) Buoy Observations (#62107 and #62103) dtd 29 Dec 2006

1. The following water survival rate times are calculated using the sea surface temperature of 53 F obtained from the closest buoys to Plymouth, UK (encl. 1), and the Survival Rate Tables from reference (a).

Without Immersion Suit: 6.1 hrs (50% survival rate)
With Immersion Suit: 11.6 hrs (50% survival rate)

2. POC: [redacted]
comm.:

/S/
[redacted]

Copy to:
NAVOCEANASWDET NAPLES

ENCLOSURE (11D)

29 Jan 07

From: [redacted]
To: Commander, Submarine Group 8

Subj: HMS Sovereign Incident in Plymouth Sound

1. On 17 Jan 2007, a Royal Navy submarine officer assigned to a NATO unit in Naples, Italy informally reported a weather-related incident involving the Royal Navy submarine, HMS Sovereign, in Plymouth Sound during the summer of 2006.

2. HMS Sovereign entered Plymouth harbor to pick up a training assessment team. After the personnel were aboard three members of ship's company remained topside to stow gear and make topside ready for submerged operations. As part of this procedure, two members of ship's company entered the superstructure of the ship to stow gear. At about the same time the ship transited beyond the breakwater lee and began taking waves over the main deck. This action caused the auto inflation of the life jackets of the personnel in the superstructure, effectively "trapping" them in the small area in which they were working. As the crewmembers could not be freed due to the weather, the boat was maneuvered back around into a protected portion of the harbor. This maneuvering took about 20-30 minutes. During this time the crew members were injured to the point where they had to be evacuated and hospitalized overnight.

3. Litigation relating to the incident is apparently pending, and no official Royal Navy lessons learned have been issued thus far. The essential facts of this incident have been confirmed to me by several Royal Navy officers.

/S/
[redacted]

ENCLOSURE (11)

[redacted]

From: [redacted]
Sent: Thursday, February 15, 2007 9:58 PM
: [redacted]

Subject: RTD:R 152143Z FEB 07 COMSUBFOR NORFOLK VA MAN OVERBOARD LESSONS LEARNED// UNCLAS C:\TEMP\WTF1CAE.tmp

Importance: [redacted]

RATUZYUW RUCBKMC7435 0462143-UUUB--RUCBKMC RUCBKME.
ZNR UUUBB ZUI RUCOMCB5917 0462213
RUCBKME T CTF 84
R 152143Z FEB 07 RTN 655980I33
FM COMSUBFOR NORFOLK VA//JJJ//
TO ALSUBFOR
BT
UNCLAS FOUO //N05132//

THIS IS A 2 SECTION MESSAGE COLLATED BY DMDS*

GID/GENADMIN/COMSUBFOR NORFOLK VA/-/FEB// SUBJ/MAN OVERBOARD LESSONS LEARNED//
/A/OPNAVINST 3500.39B/CNO/YMD:20040530// AMPN/OPERATIONAL RISK MANAGEMENT (ORM)//
C/MICHAEL W. BROWN/CAPT/COMSUBLANT/LOC:NORFOLK, VA /TEL:(757)836-1225// RMKS/1. THE FOLLOWING ARE LESSONS LEARNED (LL) FOR A RECENT MAN OVERBOARD INCIDENT. COMMANDING OFFICERS ARE DIRECTED TO REVIEW THIS MESSAGE, CONDUCT TRAINING AND TAKE OTHER ACTION AS SPECIFIED BELOW.
ISICS ARE DIRECTED TO ENSURE THAT TRAINING IS EFFECTIVE AND THAT SHIPS TAKE REQUIRED ACTION.
2. CHART 37004 PROVIDES A GOOD BACK DROP TO THE TRAINING DISCUSSIONS. THIS CHART IS PART OF THE REQUIRED HOLDINGS FOR MOST LANT SUBMARINES. IF NOT HELD ONBOARD, THE CHART CAN BE ORDERED VIA THE NORMAL WEBREQ PROCESS AT PAGE 02 RUCBKMC7435 UNCLAS FOUO
HTTPS:/WWW.DAAS.DLA.MIL/WEBREQ/LOGIN.ASP. ALTERNATELY, DNC 20 LIBRARY A2/35370 COVERS THE SAME AREA, AND CAN DOWNLOADED ON THE SIPRNET AT HTTP:/WWW.GEOINT.NGA.SMIL.MIL.
3. REVIEW SSORM ARTICLE 4318 AND CO'S STANDING ORDERS ARTICLE 0345 FOR REQUIREMENTS WHILE CONDUCTING PERSONNEL TRANSFERS AT SEA. CSF IS REVISING THE SSORM TO REQUIRE HEAD PROTECTION
(CRANIALS) WHENEVER HARNESSES ARE USED FOR PERSONNEL OUTSIDE WHILE UNDERWAY.
4. VERIFY THAT A SUFFICIENT AMOUNT OF SAFETY EQUIPMENT (I.E. KAPOK, CRANIALS, AND LANYARDS) IS ON BOARD TO SUPPORT A SMALL BOAT HANDLING TEAM DURING A PERSONNEL TRANSFER.
5. CSF IS ADDING GUIDANCE TO THE SSORM TO RELAX THE REQUIREMENT FOR HARNESSES WHEN SUFFICIENT SMALL BOATS TO RECOVER OVERBOARD PERSONNEL ARE IN THE VICINITY OF THE PERSONNEL TRANSFER.
6. WHILE CONDUCTING THE PILOT TRANSFER UPON EXITING PLYMOUTH, ENGLAND HARBOR A TOTAL OF FIVE PERSONNEL WERE WASHED OVER THE SIDE AS THE SHIP EXITED THE LEE OF THE PLYMOUTH BREAK WATER DURING HEAVY SEAS. TWO OF THESE SAILORS DIED.
A. DETAILS OF THE INCIDENT:
1) GEOGRAPHIC DESCRIPTION OF INCIDENT
RE 03 RUCBKMC7435 UNCLAS FOUO
CATION: PLYMOUTH HARBOR CONSISTS OF A RIVER MOUTH FACING DUE SOUTH ON ENGLAND'S UTHWEST COAST. DUE TO ITS GEOGRAPHIC PROXIMITY TO THE NORTHERN ATLANTIC OCEAN, THERE IS ONE MILE LONG BREAKWATER EXTENDING ROUGHLY WEST TO EAST ALONG THE HARBOR ENTRANCE. THE BREAKWATER ALLOWS A 1000 YARD WIDE PASSAGE TO THE WEST AND AN 800 YARD WIDE PASSAGE TO THE

Enclosure (112)

EAST. THE WESTERN PASSAGE IS NOT ONLY NAVIGABLE TRAFFIC IS FOR DEEP DRAFT VESSELS.
A) INCIDENT DESCRIPTION: DURING A RECENT ENTERWAY TO PLYMOUTH, THREE SAILORS WERE SWEPT OVERBOARD AS THE SHIP EXITED PROTECTED WATERS BEHIND THE LEE OF THE [illegible] BREAKWATER WITH PERSONNEL TOPSIDE AND THE FORWARD ESCAPE TRUNK (FET) HATCH OPEN.
TWO ADDITIONAL SAILORS WENT OVERBOARD WHILE ATTEMPTING TO PROVIDE ASSISTANCE. FOUR WERE EVENTUALLY RECOVERED BY SMALL BOATS OPERATING WITH THE SHIP. ONE WAS ABLE TO REENTER THE SHIP. A CONTRIBUTING FACTOR IN THE TWO FATALITIES WAS PERSONNEL REMAINING TETHERED TO THE SHIP'S DECK WHEN WASHED OVERBOARD IN HEAVY SEAS.
B. OBSERVATIONS:
1) ONE CAUSE OF THE INCIDENT WAS THE FAILURE OF THE SHIP IN BOTH PRE-PLANNING AND EXECUTION TO RECOGNIZE HIGH SEAS WHICH EXIST JUST OUTSIDE THE PROTECTED LEE OF THE BREAKWATER.
PAGE 04 RUCBKMC7431 UNCLAS FOUO
A)THE LAST WEATHER REPORT RECEIVED AND REVIEWED BY THE SHIP PREDICTED 18-20 FT SEAS AND 35 KNOT WINDS OUTSIDE OF THE HARBOR ENTRANCE. THE SHIP FAILED TO RECOGNIZE THESE CONDITIONS WOULD BE EXPERIENCED UPON LEAVING THE LEE OF BREAKWATER. FURTHER, THE COMBINATION OF PREVAILING SOUTHEASTERLY SEAS AND THE GEOMETRY OF THE BREAKWATER REDUCED THE EFFECTIVE SIZE OF ITS LEE.
B) THE CHALLENGING NAVIGATIONAL ASPECT OF PLYMOUTH, INCLUDING THE IMPACT OF A MERCHANT MOORED AT MOOR "C", WAS THE PRIMARY ORM FOCUS OF THE SHIP. CONSEQUENTLY, THE PILOT TRANSFER EVOLUTION WAS NOT ADDRESSED WITH SUFFICIENT RIGOR AND QUESTIONING ATTITUDE.
C) DURING THE TRANSIT, THE SHIP DID NOT RECOGNIZE OBVIOUS INDICATORS OF THE HIGH SEAS PAST THE BREAKWATER. THESE INDICATORS INCLUDED CONSTANT WAVES CRASHING OVER THE BREAKWATER AND WAVES VISIBLY BREAKING ON THE SHORELINE WEST OF THE INTENDED TRACK.
2) POTENTIALLY CONTRIBUTING TO THE SEVERITY OF THE INJURIES FROM THIS INCIDENT:
A) PERSONNEL WORE AN EXTRA LANYARD, COMMONLY REFERRED TO A WORKING LANYARD. THE EXTRA LANYARD INCREASED THE OVERALL LENGTH OF THEIR TETHERS FROM THE APPROVED 6 FT LENGTH (SSORM REQUIREMENT) TO 12 FT AND SUBSEQUENTLY TO 16 FT ONCE THEIR DYNABRAKES WERE EXTENDED.
PAGE 05 RUCBKMC7431 UNCLAS FOUO
B) OPERATIONAL PLANNING ASSUMED THE PERSONNEL TRANSFER WOULD BE CONDUCTED IN PROTECTED WATERS THUS CRANIAL HELMETS WERE NOT WORN.
B) THE SHIP OPERATED FOR OVER 15 MINUTES IN HIGH SEAS WITH THE FET HATCH OPEN.
A) THE JACOB'S LADDER WAS PLACED CLOSE TO THE HATCH AND AS A RESULT FOULED THE FET UPPER HATCH WHEN REPEATEDLY SWEPT INTO IT BY THE SEAS.
A) THE FET LOWER HATCH WAS SLOW TO BE SHUT DUE TO FOULING BY AN UNNECESSARY TEMPORARY MAIN LINE AND THE DOUSING OF PERSONNEL BY LARGE QUANTITIES OF WATER TAKEN DOWN THE HATCH.
LESSONS LEARNED:
1) SEAMANSHIP:
A) ANALYSIS OF A PORT REQUIRES AN IN DEPTH LOOK AT NOT ONLY THE NAVAIDS AND NAVIGATION HAZARDS BUT ALL OTHER SIGNIFICANT HAZARDS INCLUDING EXPECTED SEA STATE. IN THIS CASE, THERE WAS EXTENSIVE DISCUSSION ABOUT THE NAVIGATION IN AND OUT OF THE HARBOR BUT VERY LITTLE DELIBERATE DISCUSSION ABOUT THE EFFECTS OF WEATHER AND SPECIFICALLY WHERE THOSE EFFECTS WOULD BEGIN TO BE FELT.
B) PROPER INTERPRETATION OF WEATHER REPORTS IS KEY TO A SUCCESSFUL PLAN. IF THE NAVIGATION PARTY IS UNCLEAR ON THE SIGNIFICANCE OF WHAT PAGE 06 RUCBKMC7431 UNCLAS FOUO IS REPORTED, THEN DEMAND THAT EXPERTS FULLY EXPLAIN THE SITUATION.
IN THIS CASE, THE WEATHER REPORTS WERE ACCURATE; HOWEVER THE SHIP DID NOT INTERPRET THEM CORRECTLY.
C) WAVE HEIGHT IS DIFFICULT TO DETERMINE FROM A CONTAINER BRIDGE.
BOWDITCH CHAPTERS 32 AND 36 PROVIDE GOOD INFORMATION ON WAVES AND THE RELATION OF WIND AND SHOULD BE REVIEWED AS PART OF THIS TRAINING.
D) STATIONARY FEATURES SUCH AS SHORELINES, BREAKWATERS AND LIGHTHOUSES ARE USEFUL TO JUDGE THE SEA STATE AND THE SEVERITY OF THE WEATHER. FOR INSTANCE, WAVES BREAKING ON AN OBJECT OF KNOWN HEIGHT MAY AID IN THE ASSESSMENT OF THE SEA STATE.
2) OPERATIONAL RISK MANAGEMENT (ORM):
A) USE OF DELIBERATE ORM AS DISCUSSED IN REF (A) MUST INCLUDE AN ASSESSMENT OF ALL SIGNIFICANT HAZARDS.
B) THE USE OF DECISION POINTS IN A WORST CASE SCENARIO MUST BE UTILIZED DURING THE PLANNING PROCESS FOR MOST NAVIGATION EVENTS.
TYPICALLY THESE ARE EXPRESSED AS 10-15-30 MINUTES IN A TRAFFIC LEVEL.
C) TRIPWIRES SHOULD BE ESTABLISHED TO INDICATE THAT ASSUMPTIONS USED IN THE PLANNING PROCESS ARE NO LONGER VALID.
BASIC SUBMARINER:
THE CREW EXHIBITED A GENERAL UNFAMILIARITY WITH AN ARTICLE ON [illegible] FROM NAVFAC NORFOLK VA/-/FEB/ 4310, WHICH JUDGES HOW TETHERED PERSONNEL SHOULD BE ABOARD MAY REMAIN ON THE DECK. THE ARTICLE MENTIONS THAT THIS PROCEDURE IS FEASIBLE AT SPEEDS UP TO 4.5 KNOTS. THIS KNOWLEDGE DEFICIENCY, AS WELL AS GENERAL UNFAMILIARITY WITH THE USE OF SAFETY

LANYARDS, BEIN[illegible] EMPHASIS THE [illegible] OF [illegible] SAFETY.
5) SMALL BOAT HANDLING PARTY
- POSITION THE JACOBS LADDER IN A MANNER TO PREVENT IT BEING WASHED [illegible] THE FEET.
- STATION PERSONNEL TOPSIDE WITH THAT A 360 DEGREE VIEW IS POSSIBLE. IN THIS CASE, PERSONNEL TOPSIDE WERE ALL FACING THE STBD SIDE. THE WAVE THAT TOOK THE PERSONNEL OVERBOARD CAME FROM THE PORT SIDE, TAKING THEM BY SURPRISE.
[illegible] COMMUNICATIONS
- INEFFECTIVE COMMUNICATIONS ALLOWED THE NAVIGATION PARTY AND PAGE [illegible] RUEBKMC7436 UNCLAS FOUO BRIDGE TEAM TO BELIEVE THAT SET AND DRIFT WERE HAVING A MORE SIGNIFICANT EFFECT THAN ACTUAL. AS A RESULT, THE SHIP DID NOT CONSIDER ALL POTENTIAL MANEUVERS TO RETURN TO PROTECTED WATERS.
- WHEN THE [illegible] BECAME UNUSABLE [illegible] THE SET [illegible] HE SHIP [illegible] LOST [illegible] VIGATION [illegible] AN INEFFECTIVE PHONE TALKER.
D. TRAINING TOPICS:
1) TRAIN THE SMALL BOAT HANDLING PARTY PERSONNEL IMMEDIATELY ON THIS MESSAGE, AND THEN ON A PERIODIC BASIS TO INCLUDE:
A) SPECIFICS OF THE USE OF LANYARDS
B) SPECIFICS OF THE REQUIRED USE OF CRANIAL HELMETS
C) DESIGN AND USE OF TURN-AROUND LINES
D) SPEED LIMITS FOR PERSONNEL TO REGAIN THE DECK WHEN SWEPT OVERBOARD BUT TETHERED.
2) TRAIN ON SEA STATE RECOGNITION, EFFECTIVE USE OF WEATHER REPORTS IN PLANNING AND USE OF STATIONARY FEATURES IN DETERMINING THE SEVERITY OF SEA STATE- BOTH SWELLS AND WIND EFFECTS.
SLC IS DIRECTED TO INCORPORATE THIS TRAINING TOPIC INTO OFFICER TRAINING PIPELINE COURSES.
3) CONDUCT SPECIFIC TRAINING ON THE ORM PROCESS AND ITS ASSOCIATED OPNAV INSTRUCTION (REF A), WITH EMPHASIS ON ITS USE IN PAGE 03 RUEBKMC7436 UNCLAS FOUO DECISION POINT DETERMINATION AND THE USE OF RISK ASSESSMENT CODES TO PRIORITIZE THEIR ACTIONS AND PLANNING.
4) DISCUSS DURING TRAINING SESSIONS OTHER OPTIONS AVAILABLE TO THE SHIP TO MITIGATE THE RISK, SUCH AS: KEEPING THE PILOT ON THE PILOT VESSEL TO PRECLUDE A TRANSFER, CONDUCTING THE TRANSFER AT SLOW SPEED WITHIN THE PROTECTION OF THE BREAK WATER, DELAYING THE UNDERWAY FOR BETTER WEATHER.
5) THE USE OF DECK CRAWLERS WITH PERSONNEL TOPSIDE REMAINS AT CO'S DISCRETION BUT REQUIRES AN ADDITIONAL ORM ASSESSMENT WHEN PERSONNEL TRANSFERS ARE TAKING PLACE IN THE PROXIMITY OF ESCORT BOATS. IN THIS INCIDENT, ALL PERSONNEL WHO WERE SWEPT OVERBOARD TETHERED WERE RECOVERED QUICKLY AND WITH ONLY MINOR INJURIES.
[illegible]. OPERATIONAL COMMANDERS SHOULD IMPLEMENT SPECIFIC ORM PROCESSES TO EVALUATE THE EFFECTS AND IMPACT OF HEAVY WEATHER ON PLANNED OPERATIONS.// BT
#7436
NNNN