Exhibit M

DEPARTMENT OF THE NAVY
COMMANDER
NAVAL SURFACE FORCE ATLANTIC
1430 MITSCHER AVENUE
NORFOLK, VIRGINIA 23551-2494

5830
Ser N01L/035
18 MAR 2011

FINAL ENDORSEMENT or ltr of 5 Jan 11

From: Commander, Naval Surface Force Atlantic
To: File

Subj: COMMAND INVESTIGATION INTO THE FIRE THAT OCCURRED ON USS WHIDBEY ISLAND (LSD 41) ON 5 OCTOBER 2010

1. The findings of fact, opinions, and recommendations of the Investigating Officer are approved with the following exceptions:

a. Enclosures:

(1) Enclosure 80 is corrected to read S9LSD-BH-SIB-050/LSD-41.

(2) Enclosure 88 is corrected to read CNSL Semi-Annual PMS Inspection Announcement, message dated 072037Z Sep 10.

b. Recommendations:

(1) Recommendations 1-3 are disapproved. I will take appropriate administrative action in addition to Recommendation 4.

(2) Recommendations 5, 6, and 8-12 are assigned to Commander, Amphibious Squadron SIX (CPR-6) as a matter under their cognizance.

(3) Recommendation 13 is modified to read "I recommend receive a letter of commendation for his superior performance as nozzleman."

(4) Recommendations 13, 24, and 25 are assigned to CPR-6 as a matter under their cognizance.

Subj: COMMAND INVESTIGATION INTO THE FIRE THAT OCCURRED ON USS WHIDBEY ISLAND (LSD 41) ON 5 OCTOBER 2010

(5) Recommendations 7, 14-17, and 19 are assigned to USS WHIDBEY ISLAND (LSD 41). Report the status 30-days from the date of this endorsement.

(6) Recommendations 20-22 are assigned to Afloat Training Group Atlantic. Report the status of the implementation of these recommendations 60-days from the date of this endorsement.

(7) Recommendation 18 is modified to read "I recommend that be provided mentorship from a seasoned senior IC-man to assist and support as he re-establishes OE06. Recommendation 18 is assigned to the appropriate Assistant Chief of Staff (ACOS) at Commander, Naval Surface Force Atlantic.

(8) Recommendation 23 is assigned to the appropriate ACOS, Commander, Naval Surface Force Atlantic.

2. The report of investigation will be retained at this command in accordance with reference (a). Any future correspondence regarding this matter should be forwarded accordingly.

Copy to:
COMPHIBRON 6
LSD 41

5830
5 Jan 11

From:
To: Commander, Naval Surface Force Atlantic

Subj: COMMAND INVESTIGATION INTO THE FIRE THAT OCCURRED ON USS WHIDBEY ISLAND (LSD 41) ON 5 OCTOBER 2010

Ref: (a) JAGINST 5800.7E CH-2
(b) OPNAVINST 5100.19E
(c) NAVSEAINST 4790.8B

Encl: (1) Appointing letter
(2) USS WHIDBEY ISLAND Deck Log Sheet, 05 Oct 10
(3) USS WHIDBEY ISLAND Engineering Log, 05 Oct 10
(4) WHIDBEY ISLAND In-Port Duty Section, General Watch Bill, Engineering Watchbill and In-port Emergency Team (IET) Bill for 4-5 Oct 10
(5) Afloat Training Group, Norfolk, Training/Assessment Report for TSTA4, 24-28 May 10
(6) Afloat Training Group, Norfolk Damage Control Material Assessment Results of 11-15 Jan 10
(7) Muster and Ship Absences Report 4-6 Oct 10
(8) Engineering Department Eight O'clock Reports, 4 Oct 10
(9) DCWS Engineering Mid-status Report, DC Closure Log and Inoperative Fitting Log, 1-5 Oct 10
(10) WHIDBEYISLANDINST 4791.1, Zone Inspection Bill and Zone Space Assignments
(11) Engineering Temporary Standing Order, 10-02, DC Console, Alarms in Cut-out, 5 Jan 10
(12) Photos taken by COMNAVSURFLANT Photographer and Assistant Investigating Officer on 7 Oct 10
(13) Photos taken by DCA on 5 Oct 10
(14) Photos of DC Central taken on 17 Dec 09
(15) Ship's Schedule Summary, 1 Mar 10 - 4 Oct 10
(16) NAVREG Mid-Atlantic, Final Investigation (Fire Inspector) Report, 7 Oct 10
(17) Summary of Interview of
(18) Summary of Interview of
(19) Summary of Interview of
(20) Summary of Interview of
(21) Summary of Interview of Chief Engineer
(22) Summary of Interview of Navy Region Mid-Atlantic Fire and Emergency Services Response Team

Subj: COMMAND INVESTIGATION INTO THE FIRE THAT OCCURRED ON USS WHIDBEY ISLAND (LSD 41) ON 5 OCTOBER 2010

(23) Summary of Interview of First Lieutenant and Command Duty Officer
(24) Summary of Interview o Duty Section Leader
(25) Summary of Interview of , Sounding and Security
(26) Summary of Interview of , Mid-Watch OOD until 0200
(27) Summary of Interview of . DCC Watch
(28) Summary of Interview of , onboard Deck Seaman
(29) Summary of Interview of , Rapid Response Leader
(30) Summary of Interview of , #2 Investigator
(31) Summary of Interview of , Rapid Response
(32) Summary of Interview of , IET
(33) Summary of Interview of #1 Nozzleman
(34) Summary of Interview of , IET Team Leader
(35) Summary of Interview of , Supply Officer
(36) Summary of Interview of DCA
(37) Summary of Interview of Repair Locker Officer
(38) Summary of Interview of EDO
(39) Summary of Interview of , Topside Rover
(40) Summary of Interview of , Duty Section MOOW
(41) Summary of Interview of , Duty Section
(42) Summary of Interview of , IET Member and Deck Duty Section
(43) Summary of Interview of , Duty Section
(44) Summary of Interview of , IET Messenger and Duty Section
(45) Summary of Interview of , Duty Section and 1st Division Officer
(46) Summary of Interview of OE06 LPO/WCS
(47) Summary of Interview of , OOD
(48) Summary of Interview of , POOW
(49) Summary of Interview of , BRF
(50) Summary of Interview of Duty GM

Subj: COMMAND INVESTIGATION INTO THE FIRE THAT OCCURRED ON USS WHIDBEY ISLAND (LSD 41) ON 5 OCTOBER 2010

(51) Summary of Interview of , Operations Officer
(52) Summary of Second Interview of
(53) Summary of Interview of , POOW
(54) Summary of Interview of , 2nd Division LCPO
(55) Summary of Interview of , 1st Division LPO
(56) Summary of Interview of , 1st Division LCPO
(57) Summary of Second Interview of
(58) Summary of Interview of , 1st Division DCPO
(59) Summary of Interview of , Ship's Bos'n
(60) Summary of Second Interview of
(61) FLTMPS Grads of Selected Courses Listing
(62) USS WHIDBEY ISLAND, OPREP-3 Navy Blue, Initial and follow up messages
(63) TYCOM EDORM 3540.3A, Change 2, 16 Apr 09, listing required cold iron watches
(64) WHIDBEY ISLAND Command Indoctrination Schedule/Syllabus
(65) WHIDBEYISLANDINST 5100.6N, 27 Oct 00, Electrical Safety and Electrical Tool Issue Program.
(66) WHIDBEYISLANDINST 3120.1S, 7 Sep 10: CO's Standing Orders
(67) WHIDBEYISLANDNOTE 1300, 11 Jan 10: Assignment of Primary and Collateral Duties, Boards, and Committees
(68) DC Plate and drawn layout for Deck Office, 1-29-1-Q
(69) WHIDBEY ISLAND MOB-D Training Documentation.
(70) PQS Qualification Summary Sheets
(71) Investigator's Memorandums for Record dtd 12 Oct 10, 9 Nov 10, 3 December 10
(72) DCA Request memorandum to CO regarding "Compartment Habitation Request," 24 Nov 09
(73) WHIDBEYISLANDINST 3540.22G, 21 Feb 08: Engineering Department Standing Orders
(74) Leadership Biographies
(75) Initial Test Results for the Self-Heating and Spontaneous Combustion of Linseed Oil, 01 Dec 10
(76) USS WHIDBEY ISLAND HAZMAT List and User List
(77) Safety Data and Material Safety Data Sheet (MSDS) for Linseed Oil
(78) WHIDBEY ISLAND Repair Cost Estimates as of 27 Oct 10

(79) NSTM S9086-S3-STM-010, Ch 555
(80) S9LSD-BH-SIB-05f, Vol 3, part 2: General Description of Electrical Equipment and Electrically Operated Auxiliaries
(81) S9LSD-BH-SIB-030/LSD-41, Vol. 2, part 2, Machinery Plant: Auxiliary Machinery Piping Air Conditioning, Ventilation, and Heating Systems
(82) WHIDBEY ISLAND 3M Certification Assessments (3MCA) Report, 07
(83) WHIDBEY ISLAND 3MCA Report, 10 (including pre-look)
(84) Operations Department 21-25 June 10 3MCA Results
(85) Ship-wide PMS Performance Report through 5 Dec 10
(86) OE06 Maintenance Index Pages:
- 4361/001-40. Alarm, Safety, and Warning Systems
- 4361/001-70. Alarm, Safety, and Warning Systems
- 4361/002-70. Alarm, Safety, and Warning Systems
- 4361/006-70. Alarm, Safety, and Warning Systems
(87) MRC Card, SYSCOM: 49 8REF N, MIP: 4361, A-4d
(88) CNSL Semi-Annual PMS Inspection, message dtd 072337Z SEP 10
(89) WHIDBEY ISLAND Semi-Annual PMS Inspection, 14 Oct 10
(90) Recording of Interviews of 19 Oct 10
(91) Recording of Interviews of 09 Nov 10
(92) Recording of Interviews of 09 - 10 Nov 10
(93) Recording of Interviews of 12 Nov 10
(94) Recording of Interviews of 03 Dec 10

Preliminary Statement

1. Pursuant to enclosure (1) and in accordance with reference (a), I conducted a command investigation into the facts and circumstances surrounding the fire that occurred in USS WHIDBEY ISLAND (LSD 41) on 5 October 2010. This investigation was initiated immediately after voice reports and unit situation reports were received reporting the fire. A request was made to the Naval Criminal Investigative Service (NCIS) to investigate the fire that same day. After assuming the investigation, NCIS requested that I delay all witness interviews until they completed that portion of their investigation. In the meantime, I personally reviewed the Deck and Engineering logs as well as the WHIDBEY ISLAND In-port Duty Section General Watch Bill, Engineering Watch Bill, and In-port Emergency Team Bill for 5 October 2010. I also toured the damaged spaces and was able to interview the Commanding Officer, the Executive Officer (who was also the prospective Commanding Officer at the time), the

prospective Executive Officer, and the Command Master Chief. An extension was granted in order to conduct interviews of first responders and other personnel in WHIDBEY ISLAND once NCIS gave clearance to proceed. In addition, the extension was granted to explore the feasibility that a spontaneous combustion of linseed oil was the possible cause of the fire. At no time did this investigation proceed without permission from the lead NCIS agent, Special Agent . Similarly, there was no interface between this investigation and the Safety Board investigation. To date, I have not viewed the NCIS report or a sanitized version of the Safety Report.

Deputy Force Judge Advocate for Commander, Naval Surface Force Atlantic, acted as legal consultant to this investigation.

Findings of Fact

1. At approximately 0340, smoke was reported to be emanating from WHIDBEY ISLAND's forecastle. notified the Officer-of-the-Deck (OOD), , of the smoke. The OOD notified Damage Control (DC) Central Watch, . [Encls (2), (16), (27), (47), (93)]

2. contacted Sounding and Security (S&S), , via the ship's J-dial telephone. not use the 1MC. [Encls (2), (25), (27), (91)]

3. proceeded to the forecastle and saw heavy smoke emanating from the starboard hatch. then went to the second deck, in the vicinity of Repair 2, and looked up the ladder on the starboard side of the horse shoe. He observed that the Deck Department non-watertight door was on the deck and the space was filled with smoke. [Encls (2), (25), (91)]

4. reported his observations to . The OOD was notified. At approximately 0406, the OOD passed the "white smoke" casualty over the 1MC. The location of the fire was not provided. [Encls (2), (25), (27), (47), (91), (93)]

5. At 0418, Navy Region Mid-Atlantic Fire & Emergency Services (NRMAFES) was dispatched to the ship in response to a call from Joint Expeditionary Base Little Creek (JEBLC) Port Operations. [Encls (2), (16), (22), (90)]

6. At ship's force request, NRMAFES personnel boarded the ship and were escorted to the vicinity of the fire. The actual

location of the fire was not yet confirmed. [Encl. (2), (16), (22), (90)]

7. WHIDBEY ISLAND DC Central Watch Standers (DCWS) do not believe they are authorized to use the installed 1MC to direct S&S or Rapid Response. [Encls (29), (31), (91)]

8. The ship had significant smoke in spaces from the first deck to the 02 level, and from paint issue aft to the forecastle. [Encls (22), (24), (25), (27), (47), (91), (92), (93)]

9. Zone ventilation was not secured by . After he was relieved by the Engineering Duty Officer (EDO), , did electrically isolate the Deck office from the switch board located in Auxiliary Machinery Room 1. [Encls (12), (13), (16), (27), (38), (91)]

10. Rapid Response was led by , with and . Rapid Response was not provided a probable location of the fire from S&S. Instead, Rapid Response noticed fire when they were investigating smoke emanating from the vestibule to the forward AC&R room. [Encls (29), (31), (33), (91), (92)]

11. determined the location of fire when he observed embers falling from the hatch access to the Deck office passageway. Rapid Response identified that they had an out-of-control Class Alpha Fire. [Encls (29), (31), (33), (91), (92)]

12. Due to falling embers, the first rigged hose ruptured. A second hose was rigged, charged, and then used up a ladder to the first deck passageway and Deck office. This approach was selected due to the location of Rapid Response when they discovered the fire. This approach was also below the heat layer and effective in cooling the space. [Encls (29), (31), (33), (91), (92)]

13. The nozzleman did eventually get to the top of the ladder, using direct and indirect fire techniques to gain control of the fire and reduce heat. The hose team was able to extinguish visible flames and cool the space. [Encls (29), (31), (33), (91), (92)]

14. While initial responders were fighting the fire, and joined the hose team. and his team effectively managed their rotations, including SCBA management. and other responders changed bottles locally (in the vicinity of Repair 2) to support continued fire-

fighting efforts. [Encls (29), (31), (32), (33), (42), (91), (92), (93)]

15. After , and were relieved from the primary attack hose, they went to the 01 level (the deck directly above the deck office), aft paint issue, and faked-out a 2 ½" hose (the closest available). All three entered the passageway and actively fought the fire, moving forward towards the vent cleaning shop and fan room above the deck office. When the heat and smoke became too great and they could no longer see flames, they backed out from the space. [Encls (25), (31), (33), (91), (92)]

16. The Supply Officer, , along with and , took the same 2 ½" hose and re-entered the 01 level passageway, forward the athward ship breezeway. While progressing to the vent cleaning shop (01-29-7-Q), opened the Training office (01-43-1-A) and storerooms (01-39-1-A and 01-35-3-A) to verify that the fire was not spreading. [Encls (31), (32), (35), (91), (92)]

17. The fire spread to the R-Division Fan Room located directly above the Deck Office. Fire was observed in ventilation when the fire department hose team was in the Deck Office. The fire in the R-Division fan room was extinguished by the base fire department. (Encls (12), (13), (22), (90), (91), (92)]

18. WHIDBEY ISLAND's Damage Control Assistant (DCA) arrived at approximately 0515 and assumed control of the fire at approximately 0522. After establishing positive control of the fire, DCA restored lighting on the turntable and moved control efforts to the turntable. Prior to his arrival, there was no effective centralized command and control of fire-fighting efforts. [Encls (2), (36), (92)]

19. The Class Alpha fire was contained and extinguished at approximately 0530. Final extinguishment of the fire in the Deck office (1-29-1-Q) was accomplished by NRMAFES. NRMAFES determined that no further support was needed at 0710. [Encls (2), (16), (22), (62), (90)]

20. The hose team fire-fighting dress-out consisted of a helmet (with no light), flash gear, gloves, working coveralls, and boots. Fire-fighting ensembles (FFEs) were not used by Rapid Response, the hose team reliefs, or other personnel responding to the fire. The lack of FFE and the intense heat prevented the

nozzleman and the #1 hoseman from fully accessing the Deck office. [Encls (25), (31), (33), (36), (91), (92), (93)]

21. , at prompting, assumed duties of Repair 4 Locker Officer, with acting as the locker leader. They did contribute to assisting in dressing-out fire party reliefs; however, they did not put fire party members in FFEs. [Encls (4), (37), (92)]

22. Donning FFEs is a scene leader's decision and no request was received by or from the scene leader. [Encls (37), (92)]

23. Neither or were on the watchbill as in-port emergency team (IET) members. was assigned as the Anti-Terrorism Watch Officer. The ship's IET watchbill does not assign a Repair Locker Officer. [Encls (4), (37), (92)]

24. The current Executive Officer, , had recently reported as the prospective Executive Officer and was living in WHIDBEY ISLAND. He did not respond to the scene despite seeing smoke in the forecastle. was retrieved from his stateroom by the CHENG/DCO after 0500. [Encls (20), (21), (90)]

25. CHENG/DCO allowed himself to be removed from the DC problem immediately after arriving on the ship. [Encl. (21), (90)]

26. The fire, originating in the Deck office (1-29-1-Q), spread forward and aft along the first deck passageway and vertically to the R-Division fan room (01-29-1-Q). As of 27 October 2010, damage was estimated at $9 million. [Encls (2), (3), (9), (12), (13), (78)]

27. The Final Investigation Report from NRMAFES established the point of origin as the rear left side of the Deck office. Burn patterns and metal damage indicated a long burn time. Nothing distinguishable was located that could be linked to the cause of the fire. [Encl (16)]

28. DC Central and the EDO did not order, plot, or manage primary or secondary fire and smoke boundaries. Nor did they establish a SCBA change-out area. The CDO also did not order these actions. Prior to DCA's arrival, any efforts in these areas were ad hoc, driven by and other IET members. [Encl (23), (35), (36), (37), (38)]

29. DC Central, EDO, CDO, and the OOD failed to effectively use the ship's 1MC to communicate the status of the fire, or to direct the actions to be taken to set fire and smoke boundaries. [Encls. (23), (36), (38), (47), (92)]

30. WHIDBEY ISLAND's ventilation systems are designed on a zonal concept, with the capability to secure all ventilation located on DC Central Console. [Encls (80), (81)]

31. ATGN provided a Tailored Ship Training Availability (TSTA) for IETs 1, 2, and 3; the Flying Squad (FS); and Repair Lockers (R) 2, 4 and 5 in May 2010. Fire and smoke boundary establishment were assessed as not effective. [Encl. (5)]

32. The installed sound powered phone systems were not effectively used by Rapid Response, DCWS, OOD, CDO, DCA, DCO, which resulted in Rapid Responders serving as messengers. Ship's force did not understand how to "jumper" SP phone circuits, nor did they understand the capabilities of the ship's installed X50J (AFFF) circuit. [Encls (23), (35), (36), (37), (38), (47), (80), (81)]

33. WHIDBEYISLANDINST 3540.22G, Engineering Department Standing Orders, Order Number 15, Damage Control Watch Supervisor Routine, provides succinct guidance for effective functioning of DC Central. Standards and procedures described are not adhered to. [Encl. (73)]

34. DC Console was not fully operational and was replete with material issues such as: cut-out, disabled, or non-operable alarms; IC Alarm switchboards were set to audible mode only; and the DC Console had inoperable lights. There was no capability to monitor the fire main, reliably secure ventilation, or operate other control functions. [Encls (14), (71)]

35. The DC Watch Stander (DCWS) Engineering Mid-Status Report of 04 October 2010 listed the following alarms in either stand-by or cut-out: eye wash (2-121-1-Q and 6-98-2-L); flooding (4-6-0-W); HI-TEMP Alarms (6-98-1-Q, 04-52-3-Q, 04-35-2-Q, and 03-41-1-A); and Compressor Fail (5-53-1-Q). [Encl. (9)]

36. Engineering Department Eight O'clock Reports for 04 October 2010 did not include a listing of any inoperative DC Central alarms, controls, or monitoring systems. The reports were not signed or initialed by Engineer, EDO, or CDO. There is no indication that the reports were routinely passed to, or

reviewed by, the Commanding Officer or Executive Officer. [Encl. (8)]

37. WHIDBEY ISLAND Temporary Standing Order (TSO) 10-02, dated 05 January 2010, identifies the following HI-TEMP alarms as OOC: 02-59-2-L, 04-35-2-Q, 02-49-4-L, 02-51-2-L, and 01-35-2-L. These alarms are listed as the "only" inoperative alarms. [Encl. (11)]

38. My inspection of the IC Alarm switchboard revealed that approximately 51 alarms or sensors were not operating correctly. DC Central console had 31 obvious discrepancies, including using the light cover securing bar to permanently depress the alarm acknowledgement button. With the alarm permanently depressed, this prevented watch standers from assessing new alarms. [Encls (11), (71)]

39. The DCWS did not have a comprehensive listing of discrepancies or a mitigation plan to support DC efforts. [Encls (11), (71)]

40. WHIDBEY ISLAND did issue casualty reports (CASREPs) on the IC Alarm panels and switchboards; however, my DC Central assessments on 09 November 2010 and 03 December 2010 indicated that ship's force effort at correction was minimal. [Encl. (71)]

41. Afloat Training Group-Norfolk (ATGN) provided a DC Material Assessment (DCMA); however, DCMA does not assess or inspect DC Central control and alarm systems. [Encl. (6)]

42. A watchbill signed by the Commanding Officer could not be produced. The watchbill from the quarterdeck was provided; it is unsigned. The requirement for a signed watchbill is in support of anti-terrorism force protection (ATFP) procedures. [Encls (4), (18), (19), (21), (24)]

43. The Senior Watch Officer is the Chief Engineer/Damage Control Officer (CHENG/DCO). The Section Leader writes watchbills and approves changes to the watchbill. [Encls (4), (18), (21), (24)]

44. No one in the duty section stated that they saw a signed watchbill. Not all personnel in duty section are assigned duties. Minimum watches and IET duties were sourced. [Encls (4), (18), (19), (21), (24)]

45. Deck Department leadership is confused over who is responsible for the Deck Office. The 1st Division Officer adamantly believes it is a 2nd Division Space. WHIDBEYISLAND INST 4791.1 establishes it as a 1st Division responsibility. [Encls (10), (60)]

46. The ship's Zone Inspection Instruction and program is in place. Neither the Commanding Officer nor the Executive Officer inspected the Deck Office from April to present. [Encl. (10)]

47. The ship's training schedule was adequate. [Encl. (15)]

48. Ship had adequate firefighting school graduates. [Encl. (61)]

49. The ship did assign adequate engineering watches per CNSFINST 3540.3A, CH-2, 16 Apr 1009, Engineering Department Organization and Regulations Manual. [Encls (4), (63)]

50. WHIDBEY ISLAND Indoctrination Schedule includes lessons on HAZMAT, NAVOSH, 3M, and Basic DC. [Encl. (64)]

51. WHIDBEY ISLAND did conduct routine IET Training. [Encls (17), (18), (19), (21), (23), (29), (31), (32), (36)]

52. WHIDBEY ISLAND did adequately track PQS qualifications. [Encl. (70)].

53. DCA provided a memorandum requesting the Commanding Officer's authorization of DC Storage in the Fan Room (01-29-1-Q); however, the request did not include the Fan Room in the listing. [Encl. (72)]

54. On 04 October 2010, one gallon of Linseed Oil, about one-third full, was placed under the 2nd Division LCPO's desk between 1800 and 1830 by . Rags were placed on top of the can. This practice was common with storage items rotating between the Deck office and Boatswain Locker. First Lieutenant, 1st Division Officer, anc were aware of this practice. The Leading Chief Petty Officer (LCPO) and Ship's Boatswain claimed a lack of knowledge of this practice. [Encls (23), (44), (45), (52), (54), (56), (59)]

55. Linseed Oil is susceptible to spontaneous combustion. Per reference (b), Linseed Oil is not authorized on surface ships. [Encl. (76)]

56. First Lieutenant procured Linseed Oil with his own money to better support presentation during a port visit to Baltimore. [Encl. (57)]

57. The Navy Research Lab - Chesapeake Beach supported a short-notice request to analyze and confirm the possibility of linseed oil spontaneously combusting under conditions similar to those present in Deck Office on the night and morning of the fire. [Encl. (75)]

58. Analysis established that significant heat was generated in the rags and on the can during the experiment. The experiment did not produce flames. [Encl. (75)]

59. understanding of the departmental 3M responsibilities is that he is not included for accountability purposes. This is incorrect. Reference (c) states that the "Department LCPO shall be accountable to the Department Head for the proper operation of the 3-M system in their department." Similarly, "the Division LCPO shall be accountable to the Division Officer for the proper operation of the 3-M system within their division." [Encl. (56)]

60. ATGN conducted a 3M Certification Assessment (3MCA) of WHIDBEY ISLAND from 18-22 June 2010 with satisfactory results; however, ineffective Administration Effectiveness Review and Equipment file Validation Verification programs were specifically identified discrepancies. [Encls (46), (83), (84)]

61. OE06 (the work center responsible for conducting PMS on DC Central control and HI-TEMP alarms, among other equipment) received a 23.6% in Recorded Accomplishment Rate (RAR) and 37.18% in Administrative Effectiveness Review (AER). [Encls (83), (84)]

62. OE06 received zeros for current MIP pages, pen/ink changes, incorrect line-outs, work-center deck of MRCs, EGL management, EGLS filled out, situational requirement management, scheduling, and IEM. [Encls (83), (84)]

63. WHIDBEY ISLAND's 3MCA was conducted underway. As a result, ATGN's 3MCA report was not provided to the ship at the 3MCA debrief. The naval message erroneously stated that it was provided. An electronic copy was sent to the ship on 01 July 2010 and instead of a formal debrief, daily debriefs were conducted. [Encl. (83)]

64. Normally, three major items are provided to a ship at the completion of 3MCA: a detailed, hand-written report of deficiencies used by ATGN inspectors, with specific items noted for ship's force use and follow-up; a naval message outlining the ship's overall performance on the 3MCA; and an electronic "packet" containing all reports and spread-sheets, including the naval message listed above. [Encl. (83)]

65. My review of WHIDBEY ISLAND's 3M Sked program revealed that from the beginning of the calendar year, and as of 11 October 2010, approximately 439 PMS checks were not done by OE06. The ship's 3M Sked Program Cycle Board is functional. The Sked Program Completion Report is replete with non-accomplished PMS checks. [Encls (46), (83), (84)]

66. The current OE06 work center supervisor (WCS) is . His first day of work was 04 October 2010. Prior to his arrival, OE06 WCS was . [Encl. (46)]

67. The Operations Officer, , reported in June 2010. He claimed that he was not aware of the major PMS issues in OE06 identified by ATGN. When shown the MRC accomplishment report, he was not sure if those checks had been completed. [Encl. (51)]

68. In the 3MCA process, the Total Weighting Factor (TWF) in the Command (Department) Total Score (CTS) is based on the number of completed PMS checks. If a division does not do the checks, then the TWF is lower, thereby enabling stronger division's TWF to mask the missed checks in the final score. This enabled Operations Department to have an overall RAR of 90.16%, while OE06 had a RAR of 23.68%. [Encl. (84)]

69. The cause of the fire cannot be conclusively determined. [Encls (16), (75)]

Opinions

1. Since the cause of the fire cannot be conclusively determined, the two theories set forth by the NRMAFES Fire Inspectors and the Navy Research Laboratory - Chesapeake are equally probable. Linseed Oil, spray paint cans, and perhaps other flammables were under the LCPO's desk and would have certainly added to the intensity of the fire, but causation of fire was not, with certainty, established. [FF (27), (54), (55), (56), (57), (58), (69)]

2. The OOD failed in his duties when he did not immediately call away "white smoke." By opting to use a very slow telephone to ask for an S&S investigation and then have the S&S report to DCWS, who in turn reported the findings to the OOD, the OOD effectuated a delay that affected Rapid Response Team's ability to locate and respond to the fire. [FF (1), (2), (3), (4), (7), (9), (29), (32)]

3. DCWS's failure to use the 1MC at any time to expedite the notification process created delays that significantly affected Rapid Response Team's ability to respond to the fire. [FF (2), (4), (7), (29), (32)]

4. The failure of DCWS to secure the ventilation allowed the fire to actively feed until the base fire department extinguished the fire. [FF (9), (30), (34)]

5. The DCWS, EDO and CDO failed to effectively order or establish smoke and fire boundaries around the source of the fire, which allowed the fire to spread from Deck Office to the R-division fan room. [FF (17), (28), (29)]

6. The Rapid Response Team and IET Hose Team, once notified, reacted quickly and professionally. Their efforts, combined with the base fire department, were the driving force in controlling and extinguishing this fire. [FF (9), (10), (11), (12), (13), (14)]

7. Comprehensive Damage Control Command and Control was not established until the ship's DCA arrived, and assumed fire-fighting efforts from the EDO. [FF (18)]

8. Ship's force's knowledge and use of installed sound powered phone systems was unsatisfactory which led to an arcane process where Rapid Response/IET members had to leave the scene to act as messengers to DC Central. [FF (7), (29), (32)]

9. The ship's Heat Sensing Device (HSD) in the Deck Office did not work, was ignored, or was in cutout so it would not be noticed. OE06 is responsible for these systems. [FF (34), (35), (37), (38), (61)]

10. Even more significant than the OOD's slow response was the fact that there was no response to the HSD alarm in the Deck Office. This directly contributed to a long gestation period for the Alpha Fire. [FF (34), (35), (37), (38)]

11. The general condition of DC Central alarms and console is unsatisfactory and should have been obvious to the CO, XO, DCO/CHENG, Operations Officer, DCA, and any other khaki walking in to DC Central. [FF (34), (35), (36), (37), (38), (39), (40), (41)]

12. The claim by ship's force that all of the deficiencies "just happened" is not supported by photographs taken on 17 December 2009, or the assessment I made after the fire. [FF (36), (37), (38), (39), (40), (41)]

13. Alarms not being worked by MHI and in completely different zones are still deficient. During my last tour of DC Central, DCWS could not (and did not know how to) monitor the fire main on the 03 level loop, or secure ventilation in any zone of the ship. Nor did he know how to secure ventilation locally. All DC Central Console zone ventilation shut down was tagged out. Simple ship's force duties, such as replacing out light bulbs, were not done. DCWS was under the impression that MHI Ship 51 was/is fixing "everything." There is no "list" that DCWS can look at to determine what the contractors or ship's force is working on. [FF (34), (35), (38), (39), (40)]

14. WHIDBEY ISLAND ship's force systematically ignores their DC Central Watch station instruction. [FF (33)]

15. OE06 PMS program failure was never clearly articulated to the ship, ADCON ISIC, or TYCOM and instead was buried in a very large 3MCA report. The ship's 3MC was aware of OE06's deficiencies. [FF (60), (61), (62), (63), (64), (65), (67), (68)]

16. The Operations Officer (newly reported in June 2010) and the ship's 3MC failed in their duty to identify and notify all concerned of this dire failure. The Operations Officer does not understand the significance of IC systems on a ship, whether they are in Operations, Damage Control, Engineering, or Ballast Operations. [FF (34), (40), (41), (60), (61), (62), (67), (68)]

17. Current OE06 WCS, , reported the day of the fire and is not responsible for the dire state of OE06. Unlike the ship's current 3MC, who is an ICC, he understood the significance of the non-accomplished PMS checks on other IC systems, such as main control and ballast systems. [FF (66)]

18. Deck Department is splintered. Ship's First Lieutenant, First Division Officer, Petty Officers, and Seamen knew of the

common use of Linseed Oil, and were very forthcoming in providing information in this area. Ship's BMCS and CWO4 claimed to not be aware. In addition, BMCS and CWO4 are under the erroneous impression they have little to no role in Deck Departmental/Divisional PMS. [FF (54), (56), (59)]

19. The manufacturer's warning of Linseed Oil "spontaneous combustion" was not heeded and the provided disposal guidelines were not followed which is why the Linseed Oil cannot be excluded as a possible cause of fire. [FF (54), (55), (57), (58)]

20. There was an apparent lack of effort to improve on deficiencies noted during fire-fighting training, particularly in establishing smoke and fire boundaries. ATG input appears to have been systematically ignored. [FF (28), (29), (31)]

21. Watchbill management is ineffective. While the CO, XO, SWO, and Department Heads believed there was a signed watchbill due to recent ATFP guidance, it could not be produced and was not used as a practical matter. [FF (42), (43), (44)]

22. The Watchbill coordinator believed that not assigning all personnel in section to duties, including additional personnel to IET, was acceptable. [FF (43), (44)]

Recommendations

1. I recommend that , the former Commanding Officer, be taken to nonjudicial punishment for dereliction of duty, specifically for ineffective oversight of Damage Control Central installed alarms and monitoring systems and the failure of OE06 PMS as a functioning work center.

2. I recommend that , the new Commanding Officer and the Executive Officer at the time of the fire, be taken to nonjudicial punishment for dereliction of duty, specifically for ineffective oversight of Damage Control Central installed alarms and monitoring systems, ineffective oversight of duty section training (particularly C2 aspects), and the failure of OE06 PMS as a functioning work center.

3. I recommend that , the Operations Officer, be taken to nonjudicial punishment for dereliction of duty for the condition of OE06 and his failure to notify the chain of command after assuming his duties and/or receiving his department ATG 3MCA report.

4. I recommend that a Letter of Instruction (LOI) be issued to , the current Executive Officer, for failing to meet the leadership standards demanded and expected of a Surface Warfare Officer. As the PXO, living in a stateroom with a non-functional 1MC, LCDR Stanfield made no effort to have the 1MC in his stateroom repaired. His subsequent use of the broken 1MC as an excuse for not responding to the fire is sub-par. Further, the CHENG (who drove in from home to respond to the fire) had to divert his attention as DCO to personally "fetch" the ship's prospective Executive Officer. further failed as a leader by "hanging out" with the duty section because he "hadn't officially" taken over as the Executive Officer.

5. I recommend that a LOI be issued to , First Lieutenant, for his ineffectiveness as the Command Duty Officer and for procuring and using non-authorized and hazardous material, the linseed oil, for shipboard use. I do not recommend disciplinary action for the simple reason that was the only officer who was completely forthcoming during this investigation. He provided assistance without hesitation and was determined to understand the cause and identify his own shortfalls.

6. I recommend that a LOI be issued to , DCO, for his inability to ensure DC Central systems operate according to standards and that his orders are followed by the watch standers. Also, his oversight as Senior Watch Officer was not effective. As both DCO and SWO, his response to initial indications of "white smoke" was simply unsatisfactory.

7. I recommend that the Chief Engineer be relieved as the Senior Watch Officer. His copious hard administrative requirements simply do not afford him the time required to effectively oversee inport duty sections.

8. I recommend that a LOI be issued to , Ship's Bos'n, for his failure to address deviations from Navy standards on the deck plates, including PMS and HAZMAT issues.

9. I recommend that a LOI be issued to , 1st Division LCPO, for his failure to address deviations from Navy standards on the deck plates, including PMS and HAZMAT issues.

10. I recommend that a LOI be issued to , the ship's Damage Control Assistant, for the material condition of DC Central; ineffective supervision of DCWS; ineffective

training of IET, to include Command and Control; lack of DCWS training; and his and DCWS lack of knowledge of the installed ventilation, electrical isolation, use of 1MC in emergencies, and use of installed SP Phone systems. While his ability to lead and organize chaos was very good, his knowledge of the ship was poor.

11. I recommend that a LOI be issued to , the OOD on the morning of the fire, for failing to immediately call away the first report of "white smoke" which resulted in a possible 26-minute delay before fire-fighting efforts began.

12. I recommend that a LOI be issued to . for failing to read the linseed oil warning, not complying with disposal instructions, and for blindly obeying his chain of command when told to improperly dispose of hazardous material.

13. In addition to receiving a LOI for improperly handling hazardous material, I recommend be commended for his superior performance as nozzleman. He succeeded in getting the Class Alpha fire under control.

14. I recommend removal of qualification as DCWS until he demonstrates effective knowledge of systems and emergency response procedures, to include all DCWS in his re-qualification process.

15. I recommend removal of qualification as EDO until she can demonstrate the ability to serve as DCA, in DCA's absence. All EDO training should be included in her requalification training process.

16. I recommend immediately changing DCWS rules to allow use of the 1MC to direct S&S to investigate an alarm. Walkie-talkies are an inefficient means to manage S&S. S&S should make rounds and return to DCC.

17. I recommend that DCWS and EDO be fully assessed during IET drills.

18. I recommend that be provided immediate assistance from a seasoned senior IC-man (preferably LDO) to supervise, assist and work in reestablishing OE06 as a functioning PMS work center. One of the senior IC-man's key duties should be to protect OE06 from senior WHIDBEY ISLAND leadership until it is functioning well on a routine basis. I do not believe the CO, XO, Operations Officer, CHENG, or 3MC are

capable of providing this assistance. They do not understand the systems, and will impede a rapid reset. After OE06 is re-established, I recommend it be allowed to simply "start over."

19. I recommend that the OE06 work centers be returned to the Engineering Department as IC01.

20. I recommend that ATG add a DC Central assessment to DCMA. The functionality of this can be completed in less than one hour.

21. I recommend that ATG provide a plain language paragraph (in the 3MCA report) that specifically identifies "failed" work centers. I am not convinced that the current process, while clearly identifying shortfalls on deck plates, alerted the ship, Commodore, or TYCOM to the conditions found in OE06.

22. I recommend that ATG re-assess the plethora of administrative reports in the current process and eliminate reports that distract from deck plate execution of PMS.

23. I recommend that Commander, Naval Surface Force Atlantic issue an ALSURFLANT message reiterating the prohibition of linseed oil from shipboard use, as well as reiterating standing Navy policy regarding the use of unauthorized HAZMAT.

24. I recommend that , , , and receive Navy Commendation Medals for their superior perrormance while fighting a Class Alpha fire, which imposed great risk to their own safety.

25. I recommend letters of commendation for and for stepping forward and establishing Repair 4, although neither was assigned to this duty.