



All Hands Messages

Commandant's All Hands – Final Action on CGC HEALY MISHAP

To the men and women of the Coast Guard:

On 17 August 2006, we lost two of our shipmates assigned to CGC HEALY, LT Jessica Hill and BM2 Steven Duque, in a tragic diving accident in the Arctic. There are valuable lessons to be learned by all of us regarding leadership, risk management, training and program oversight that apply to all Coast Guard operations. Therefore, I am directing all personnel to read my entire report. To help ensure public access to the report on the Internet, Coast Guard members with access to a CG Standard Workstation should view my report posted on CG Central at: (<http://cgcentral.uscg.mil>). Anyone without CGSW access can view a copy of the same report online at: [http://www.uscg.mil/foia/uscg_healy.asp].

Consistent with my commitment to the families of LT Hill and BM2 Duque, each family was provided a copy of my report and has been personally briefed by the Coast Guard Chief of Staff, VADM Papp, earlier this week. We once again express our deepest sympathies as the entire Coast Guard continues to mourn the loss of these two dedicated, hard working individuals. Please keep them, their families and the HEALY crew in your thoughts and prayers. I understand that there is nothing which will make up for the loss of LT Hill and BM2 Duque. We will honor our lost shipmates by taking timely action, at all levels, to improve our dive program.

In addition to this administrative investigation, a Commandant's Vessel Safety Board has been convened to prevent any similar mishap in the future. Its work is ongoing. The results of that mishap analysis will be disseminated via ALCOAST upon its completion in the coming months.

Concurrent with the public release of this investigation today, the Pacific Area Commander, VADM Wurster, is briefing HEALY crewmembers and the media in the cutter's homeport of Seattle. As the convening authority, VADM Wurster has taken action to hold HEALY's Commanding Officer, Executive Officer and Operations Officer accountable for failing to meet their personal responsibilities surrounding this mishap.

This is a brief summary of what occurred. In the late afternoon hours of 17 August 2006, three Coast Guard divers from HEALY attempted to conduct two, 20-minute cold water familiarization dives at 20-foot depth during an ice liberty stop in the Arctic ice approximately 490 nautical miles north of Barrow, Alaska. After one of the divers exited the water due to equipment malfunction, the other two divers continued the dive in 29-

degree Fahrenheit waters. The divers quickly descended to depths far exceeding their planned depth, one diver descending to 187 feet and the other diver descending to at least 220 feet. Once it became evident that too much tending line had paid out to support a 20-foot dive depth, the divers were brought to the water surface. The divers were recovered with no vital signs and were pronounced dead after extensive resuscitative efforts failed. Final autopsies report cause of death for both LT Hill and BM2 Duque as “Asphyxia with pulmonary barotraumas with possible air embolism” (lack of oxygen with severe air pressure damage to the lungs, including possible air bubbles in the circulatory system).

The bottom line is that this dive should have never occurred. The investigation revealed numerous departures from standard Coast Guard policy that should have precluded diving under the circumstances. Had HEALY’s Commanding Officer, Executive Officer, Operations Officer and dive team followed policies established in Coast Guard and Navy Diving manuals, they would not have permitted diving operations.

HEALY had only two qualified and current divers that day; this dive evolution required at least three qualified and current divers, and one qualified Dive Supervisor not actually diving. Additionally, the Diver Tenders were not qualified. Despite these problems, the dive plan was approved by the Commanding Officer without a pre-brief, an operational risk assessment or any medical evacuation plan, as required by Coast Guard and Navy policy.

A critical factor in the loss of the divers was that neither diver wore a weight belt, as required by the Navy Diving Manual. Instead, both divers carried approximately 60 pounds of weight in the pockets of their buoyancy compensation devices (BCD), approximately 2-3 times more weight than normally used by experienced divers in similar cold water and ice dive conditions. The BCD has pockets to carry and, if necessary, jettison weight. However, LT Hill and BM2 Duque filled not only the weight pockets, but also the equipment pockets of the BCD. Thus, much of the divers’ weight was not easily jettisonable. Although LT Hill had some experience diving in the Arctic, this was her first SCUBA dive in the Arctic. This was BM2 Duque’s first cold water dive.

Adding to the risk of the operation, the ship was holding “ice liberty” at the same time, and in close proximity to the dive evolution. The ice liberty included “polar bear plunges,” football and consumption of both alcoholic and nonalcoholic beverages. Neither LT Hill nor BM2 Duque consumed alcohol prior to diving.

The deaths of LT Hill and BM2 Duque were preventable and resulted from failures at the Service, unit and individual levels. The investigation revealed failures in leadership within the chain of command aboard HEALY, as well as numerous departures from standard Coast Guard policy. Had a proper risk assessment been conducted, this tragedy could have been avoided. As a Service, we failed to exercise sufficient programmatic oversight of the dive program, including failures to adequately staff our dive units and conduct annual dive safety surveys. This mishap further highlighted our need to improve dive expertise in unit dive lockers and address shortfalls in dive program policy, guidance, training and experience. As a result, we will elevate program management on

par with other high risk, training-intensive operations such as aviation. A comprehensive list of the corrective actions I have ordered, including those that have been completed, is contained in my report posted online.

We cannot prevent every Coast Guard casualty. Despite the professionalism, bravery, and dedication of our workforce, in rare cases we suffer a serious injury or death in the line of duty. As Coast Guard men and women we accept that risk, but we will not accept preventable loss or injury. This tragedy has prompted us to re-examine our dive program to ensure it is as well managed and safe as such inherently dangerous operations allow. The safe conduct of Coast Guard training is fundamental to Coast Guard readiness. Without it, there can be no successful Mission Execution. When it comes to dangerous operations such as diving, “good enough” is never good enough. We can do better. We will do better.

The sacrifices LT Hill and BM2 Duque made in service to their Nation will never be forgotten. Their loyalty and dedicated service will forever be appreciated by the U.S. Coast Guard.

Admiral Thad Allen

