

2100 Second Street, S.W. Washington, DC 20593-0001 Staff Symbol: CG-0921 Phone: (202) 372-3500

FAX: (202) 372-2311

REAR ADMIRAL JOHN P. NADEAU ASSISTANT COMMANDANT FOR PREVENTION POLICY LESSONS LEARNED FROM THE EL FARO MARINE CASUALTY BEFORE THE HOUSE SUBCOMMITTEE ON COAST GUARD AND MARINE TRANSPORTATION JANUARY 30, 2018

Good Afternoon Chairman Hunter, Ranking Member Garamendi, and distinguished members of the subcommittee. I am humbled to appear before you today to discuss the lessons learned from the EL FARO tragedy.

EL FARO MARINE CASUALTY: COMPREHENSIVE OVERVIEW AND BACKGROUND

On behalf of the U.S. Coast Guard, I would like to offer my sincere condolences to the family and friends of the victims aboard the EL FARO. Not only do I want to express my sympathies for their loss, but I also want to convey that the U.S. Coast Guard will keep this tragedy in the forefront of our minds as we strive to make enhancements to our marine safety program to help the maritime industry avoid future preventable tragedies.

The loss of the U.S. flagged cargo vessel EL FARO, along with its 33-member crew, ranks as one of the worst maritime disasters in U.S. history, and resulted in the highest death toll from a U.S. commercial vessel casualty in almost 40 years. At the time of the sinking, the EL FARO was on a U.S. domestic voyage with a full load of containers and roll-on roll-off cargo bound from Jacksonville, Florida to San Juan, Puerto Rico. As EL FARO departed port on September 29, 2015, a tropical weather system formed east of the Bahamas Islands and rapidly intensified in strength. The storm system evolved into Hurricane Joaquin and defied weather forecasts and standard Atlantic Basin hurricane tracking by traveling southwest. As various weather updates were received onboard EL FARO, the Master directed the ship southward of the normal route to San Juan.

The Master's southern deviation ultimately steered EL FARO almost directly towards the strengthening hurricane. As EL FARO began to encounter heavy seas and winds associated with the outer bands of Hurricane Joaquin, the vessel sustained a prolonged starboard list and began intermittently taking water into the interior of the ship. Shortly after 5:30 AM on the morning of October 1, 2015, flooding was identified in one of the vessel's large cargo holds. At the same time, EL FARO engineers were struggling to maintain propulsion as the list and motion of the vessel increased. After making a turn to shift the vessel's list to port in order to close an open scuttle, EL FARO lost propulsion and began drifting abeam to the hurricane force winds and seas. At approximately 7:00 AM, without propulsion and with uncontrolled flooding, the Master notified his company and signaled distress using EL FARO's satellite distress communication system. Shortly after signaling distress, the Master ordered the crew to abandon ship. The vessel, at the time, was near the eye of Hurricane Joaquin, which had strengthened to a Category 3 storm. Rescue assets began search operations, and included a U.S. Air National Guard hurricane tracking aircraft overflight of the vessel's last known position. After hurricane conditions subsided, the Coast Guard commenced additional search operations, with assistance from commercial assets contracted by the vessel's owner. The search located EL FARO debris and one deceased crewmember. No survivors were located during these search and rescue operations.

On 31 October 2015, a U.S. Navy surface asset contracted by the National Transportation Safety Board (NTSB), using side-scan sonar, located the main wreckage of EL FARO at a depth of over 15,000 feet below the surface of the ocean. EL FARO's voyage data recorder was successfully recovered from the debris field on 15 August 2016, and it contained 26-hours of bridge audio recordings as well as other critical navigation data that were used to help determine the circumstances leading up to this tragic accident.

Following the marine casualty, the Commandant of the U.S. Coast Guard convened an independent Marine Board of Investigation (MBI). The MBI was conducted with a wide transparency to their proceedings. All three public hearings, at which 76 witnesses testified over 30 days, were live streamed. The 10 hours of conversations captured by the Voyage Data Recorder were transcribed and published prior to the conclusion of the investigations conducted by the Coast Guard and NTSB. As a result, some vessel owners and operators, as well as the Coast Guard were able to apply lessons learned in near real time and improve the safety of their operations.

The MBI's Report of Investigation (ROI) was released to the public on October 1, 2017 and included 34 recommendations. The Commandant's Final Action Memorandum (FAM) on the report, including action taken by the Commandant on the MBI's recommendations, was released on December 19, 2017.

In the FAM, the Commandant emphasizes the need for a strong and enduring commitment at all levels of the safety framework – vessel owner/company, Recognized Organizations (ROs) and Authorized Classification Societies (ACS), and the Coast Guard. First, the company must commit to a safety culture by embracing its responsibilities under the International Safety Management (ISM) Code. Second, the ROs and ACS must fully and effectively perform their duties and responsibilities. Finally, the Coast Guard, must, and will, provide the final element of the safety framework with sustainable policy, oversight, and accountability.

MAJOR REPORT SUMMARIES

While many factors contributed to this marine casualty, by far the most prominent was the Master's decision to sail the ship in close proximity to a Category 3 hurricane. There were multiple opportunities to take alternate, safer routes as the storm approached. There was adequate information available regarding the threat posed by Hurricane Joaquin, despite the unusually unpredictable nature of the storm's path and intensity. There were warnings and recommendations from the mates on successive watches recommending the vessel's course be altered to avoid the storm, but these recommendations were not heeded. The combination of these actions and events placed the EL FARO in harm's way near the eye of the storm. In the case of the EL FARO, those conditions led to a chain of events, the effects of which were irreversible.

However, failures within the operating company to embrace a safety culture and fulfill their responsibilities under the ISM Code, coupled with the ACS's inability to uncover or resolve longstanding issues with the vessel, and finally, shortcomings by the Coast Guard to oversee and adequately monitor the classification society, led to a collapse of the safety framework under which vessels and mariners operate.

COAST GUARD ACTIONS RESULTING FROM THE EL FARO

The Final Action Memorandum includes 29 specific actions to address safety recommendations, 4 actions to address administrative recommendations, and 1 enforcement action. These actions include:

- Supplemental flag State guidance regarding the development, implementation, and verification of Safety Management Systems;
- Changes, updates, and improvements to Coast Guard management of the Alternate Compliance Program (ACP) and accountability of Authorized Classification Societies, including establishment of a Third Party Oversight National Center of Expertise;
- Potential regulatory actions related to high water alarms and open lifeboats;
- Overhaul and update of the training and certification of Coast Guard Marine Inspectors;
- Evaluation of mariner training institutions and the Coast Guard credentialing process;
- Engaging the International Maritime Organization (IMO) to address safety issues related to cargo holds and the securing of cargo;
- Discussions with the National Oceanic and Atmospheric Administration (NOAA) regarding improvements to its maritime weather forecasting products;
- Search and rescue (SAR) related equipment changes;
- Civil penalty action against Tote Services Incorporated (TSI) for potential violations.

CONCLUSION

The casualty of the EL FARO points to the need for a strong and enduring commitment from all elements of the safety framework: vessel owner, Authorized Class Society, and the Coast Guard. The lessons from this tragic event provide something for every maritime industry stakeholder to learn and improve upon. As the lead agency of the U.S. Flag Administration, the Coast Guard is ultimately responsible to monitor the performance of third party organizations entrusted with the safety of U.S. ships. The Coast Guard is committed to providing sustainable policy, oversight, and accountability both internally and externally.

Thank you for the opportunity to testify before you today and I look forward to answering your questions.