



**TESTIMONY OF ADMIRAL BRIAN SALERNO
DEPUTY COMMANDANT FOR OPERATIONS**

BOEMRE/U.S. COAST GUARD JOINT INVESTIGATION TEAM REPORT

BEFORE THE HOUSE COMMITTEE ON NATURAL RESOURCES

OCTOBER 13, 2011

Good Morning Chairman Hastings, Ranking Member Markey, and distinguished members of the Committee. I am honored to appear before you today to discuss the Coast Guard's Final Action on the Coast Guard Volume – Volume I – of the Joint Investigation Team report.

INVESTIGATIVE ACTION SUMMARY

Immediately following the explosion and sinking of the DEEPWATER HORIZON Mobile Offshore Drilling Unit (MODU), the Department of Homeland Security, through the U.S. Coast Guard, and the Department of Interior, originally through the Minerals Management Service (MMS), now the Bureau of Ocean Energy Management, Regulation and Enforcement (BOEMRE), convened a formal investigation with the purpose of gathering evidence and examining the circumstances surrounding the tragic incident. The Joint Investigation Team (JIT) was comprised of and co-chaired by members from the Coast Guard and BOEMRE.

The Coast Guard members of the JIT examined five aspects of the disaster relating to areas under Coast Guard jurisdiction: the explosions; the fire; the evacuation; the flooding and sinking of the MODU; and the safety systems of the DEEPWATER HORIZON including the safety management system implemented by owner-operator, Transocean. The investigative findings, conclusions and recommendations of the Coast Guard members of the JIT were publicly issued on April 22, 2011, in Volume I of the JITs report. In the Final Action Memo (FAM), released on September 14, 2011, the Commandant accepted Volume I and commented on its findings, conclusion, and recommendations.

SUMMARY OF FINDINGS

Although the sinking of DEEPWATER HORIZON was triggered by a loss of well control, the investigation revealed numerous system deficiencies and acts and omissions by Transocean and the DEEPWATER HORIZON crew that adversely impacted opportunities to limit the magnitude of the disaster. These included poor maintenance of electrical equipment that may have ignited the explosion, bypassed hydrocarbon gas alarms and automatic shutdown systems, and training shortfalls in critical areas such as engine shutdown and emergency well disconnect procedures. These and other deficiencies indicate that a flawed safety management system and safety culture aboard DEEPWATER HORIZON may have contributed to this disaster.

COMMANDANT FINAL AGENCY ACTION PROCESS REGARDING VOLUME I

To ensure the JIT investigation was conducted in a methodical, thorough, and transparent manner, the Coast Guard applied longstanding Service processes and principles. This includes the completion of an independent investigation by members of a Marine Board of Investigation (Board) and submission of a written report containing investigative findings, conclusions, and recommendations to the Commandant. Upon receipt by the Commandant, the report is further reviewed by technical experts who have policy and oversight responsibility for the actions and conditions identified by the Board as causal factors in the incident. The technical experts provide key policy insight and recommendations into the development of the Final Action. This second level of independent review by technical and policy experts is critical in determining the Commandant's Final Action on all recommendations, including potential implementation.

In the Final Action, the Commandant may address the facts, opinions, and conclusions of the report and provide a response to each recommendation. When the Commandant concurs with a recommendation, a description of the action he intends to take is included in the Final Action. If he does not concur with a recommendation, the reason for his non-concurrence is also included.

During the course of the Board's investigation, parties in interest (PIIs) are afforded certain statutory rights, including the right to counsel, to introduce evidence, and to call and cross-examine witnesses. Typically, however, the Board's report and the review process are not open to any PIIs or the general public until the Commandant's review is finished and the Final Action completed. Once the Commandant's Final Action is complete, it is appended to, and released simultaneously with, the Board's original report.

In the case of the DEEPWATER HORIZON incident, the process was modified in order to provide increased transparency into the investigation of a marine incident that had a direct impact on unprecedented numbers of American citizens. The Coast Guard released Volume I of the JIT Report in April, before the Commandant's Final Action was complete. The Commandant's Final Action was issued in September. The comments from the PIIs were carefully considered in developing the Commandant's Final Action and a summary of those comments and the Coast Guard's response is included as an enclosure to the FAM.

FINAL AGENCY ACTIONS ON RECOMMENDATIONS - SUMMARY

In addition to determining the causal factors of this incident, the JIT was empowered to make recommendations to reduce the risk of similar incidents in the future. These recommendations can be broadly categorized as: recommendations regarding domestic or international standards; recommendations regarding oversight to ensure compliance with standards; and administrative recommendations. Within these broad categories, there were three primary areas addressed in the safety recommendations:

1. The adequacy of international and domestic safety regimes;
2. The adequacy of the Flag State oversight of recognized organizations that are delegated authority to act on behalf of the Flag State; and
3. The adequacy of recognized organizations.

In the FAM, the Commandant concurs in whole or in part with the vast majority of safety recommendations made by the JIT. Some of the actions directed by the Commandant will impact domestic regulations and inspection or oversight practices, as discussed in the Implementation section below; others will potentially impact the ongoing work at the International Maritime Organization (IMO) to develop standards for MODUs and for the organizations that oversee compliance with the standards.

The Commandant did not concur with nine of the JIT's recommendations, and thus did not direct any specific action relating to those recommendations. The recommendations with which the Commandant did not concur fall into three categories:

1. Those that the Commandant determined were not directly supported by the facts provided in the report;
2. Those that the JIT related to problems with the standards, but the Commandant determined to be compliance or oversight issues; and,
3. Those that the Commandant determined were adequately addressed by action directed in response to other recommendations in the report.

Volume I of the investigation revealed that, with certain identified exceptions, the Coast Guard-regulated safety systems aboard the MODU were generally effective despite the extreme nature of the event. Of the 126 persons on board, 115 survived the explosions and subsequent fire. Most of the survivors were able to evacuate the MODU using the installed lifesaving equipment. A few of the survivors jumped from the rig into the water and were rescued. Even though significantly damaged by the explosions and the ensuing fire, the DEEPWATER HORIZON was able to stay afloat for more than 48 hours.

While the Coast Guard-regulated safety systems generally performed well under extreme conditions, the Commandant determined that additional action can be taken to protect the sea and those who work on it.

IMPLEMENTATION OF ACTIONS DIRECTED BY THE COMMANDANT

The Coast Guard has already taken action to enhance safety and stewardship on the U.S. Outer Continental Shelf (OCS). Earlier this year, the Coast Guard published a policy for risk-based targeting of foreign flagged MODUs. The policy allows field commanders to target limited resources to highest risk operations and ensure a uniform, high level of safety for all vessels operating on the U.S. OCS. In addition, Coast Guard regulations for construction, equipment and operation of vessels on the OCS are being updated to reflect the current and emerging state of technology, and to address lessons learned from DEEPWATER HORIZON.

Internationally, the Coast Guard has engaged the IMO through its Flag State Implementation Sub-Committee with regard to the provisions of the proposed new Code for Recognized Organizations. The Coast Guard anticipates that the new Code will be ready for adoption in 2012, will be mandatory, and will include more specific and detailed requirements and guidelines for Recognized Organizations covering their management and organization, resources, certification processes, performance measurement, analysis and improvement, and quality management system certification. The U.S. delegation at IMO, led by the Coast Guard, will work to ensure the results of this investigation are considered in IMO's development of the Code.

On Oct. 1, 2011, the Department of the Interior formally established two new, independent bureaus – the Bureau of Safety and Environmental Enforcement (BSEE) and the Bureau of Ocean Energy Management (BOEM) – to carry out the offshore energy management and safety and environmental oversight missions previously under the jurisdiction of BOEMRE. The Coast Guard and BSEE are working to harmonize offshore spill response plans with the Area Contingency Plans to maximize awareness and preparedness to respond to future spills from offshore facilities, including enhanced understanding of worst case discharge scenarios.

CONCLUSION

The FAM is the result of long standing Coast Guard procedures with minor modifications, designed to accommodate the complexity of this investigation, and to ensure the investigation was conducted in a methodical, thorough, and transparent manner. The Coast Guard is now taking action domestically and through international engagement to carry out the actions directed by the Commandant.

Thank you for the opportunity to testify before you today and I will be pleased to answer your questions.