MAZIE K. HIRONO
HAWAII

United States Senate
WASHINGTON, DC 20510-1104

COMMITTEE ON ARMED SERVICES
COMMITTEE ON ENERGY & NATURAL RESOURCES
COMMITTEE ON THE JUDICIARY
COMMITTEE ON SMALL BUSINESS & ENTREPRENEURSHIP
COMMITTEE ON VETERANS' AFFAIRS

November 14, 2023

The Honorable Lloyd Austin
Secretary of Defense
7300 Defense Pentagon
Washington, D.C.
20301

Dear Secretary Austin,

Over the last half decade, the Department of Defense has experienced a spate of major disasters during routine operations that have cost Servicemembers their lives and taxpayers billions of dollars. Examples can be found across multiple Services:

In 2017, the Navy lost seventeen Sailors in the USS *McCain* and USS *Fitzgerald* collisions. The 2020 in-port fire onboard USS *Bonhomme Richard* caused the loss of a two billion dollar warship. On May 6, 2021 and November 20, 2021, petroleum spills at the Red Hill Bulk Fuel Storage Facility ("Red Hill") tainted the water supply for more than 93,000 people and to date have cost over two billion dollars, which does not account for costs associated with closure and environmental remediation. In 2020, the Marine Corps lost eight Marines and a Sailor when an Amphibious Assault Vehicle (AAV) sank during a training incident. This year, the Army lost nine Soldiers when two UH-60 Blackhawk Helicopters collided while training over Kentucky.

As you know, DoD has established a system for classifying serious incidents as mishaps, pursuant to Department of Defense Instruction 6055.07, last updated in 2018. The most serious mishap classification—a Class A Mishap—is reserved for incidents resulting in death, total disability, damage equal to or greater than two million dollars, or the destruction of an aircraft (excluding certain unmanned aerial vehicles).[1] DoD delegates the process of investigating these mishaps to each Service, with each creating its own process and governance for safety investigations. As a result, each Service has implemented DODI 6055.07 differently.[2] Each

[1] DoD Instruction 6055.07, "Mishap Notification, Investigation, Reporting, and Record Keeping," June 6, 2011 (Incorporating Change 1, August 31, 2018).
[2] *See* OPNAV Instruction 5102.1E, "Navy Safety Investigation and Reporting Program," Sept. 23, 2021; Marine Corps Order 5100.29C, "Navy and Marine Corps Safety Investigation and Reporting Manual," Sept. 27, 2021; Department of the Air Force Instruction 91-204, "Safety Investigations and Reports," Nov. 10, 2022; Department of the Army 385-40, "Army Mishap Investigations and Reporting," July 24, 2023.

Service has independently determined whether and how any additional administrative investigations—which inform recommendations and accountability—will be conducted.[3]

Each Service has developed a unique process for conducting administrative investigations; however, they all provide wide discretion over the level and breadth of the investigation. Leaving these decisions in the hands of individual commanding officers leads to significant differences in the quality and scope of each investigation. What's more, because administrative investigations into Class A Mishaps are often of high visibility, they frequently are conducted by senior leaders within the affected Service, specifically general or flag officers. Due to the limited number of these senior leaders, the investigating officer is often the peer of someone in the chain of command of the mishap. Investigating other general or flag officers is challenging because of existing relationships, parochial interest in preserving the stature of the Service, and the reality that these senior officers often lack the time and expertise necessary to conduct complex investigations. DoD mandates that its Components cannot initiate an investigation into allegations against senior officials without first reporting the allegations and then coordinating with OIG for these very reasons.[4]

While I recognize that military operations are often inherently risky, and that there are existing investigative and legal processes for mishaps within the Services, there are disasters so calamitous as to require a higher level of mishap classification than presently exists with concomitant oversight and accountability. These "major mishaps" could be defined by the loss of five or more lives and/or damages exceeding one billion dollars. Catastrophes of this magnitude require in-depth, independent investigations and true accountability. Such accountability should include actions against the individuals directly responsible for major disasters to penalize them for their specific failures. It also requires penalties severe enough to deter others from similar failures in the future. True accountability, more broadly, should also include punishment that reflects the magnitude of the harm caused by the disaster and address the often-systemic failures that a root cause analysis reveals.

Though major disasters have occurred across all the Services, the mishap at Red Hill provides a particularly instructive example of inadequate processes and the Services' inability to hold its own leaders fully accountable. In this case, the Naval Supply Command directed the Deputy Officer in Charge, Naval Petroleum Office, to conduct the first investigation into the May 2021 release at Red Hill. After a second release occurred in November 2021, Admiral Paparo, Commander, U. S. Pacific Fleet reviewed this initial investigation and deemed it inadequate. Unfortunately, the inadequate quality of the initial investigation was only brought to light once the Navy had contaminated the drinking water of over 93,000 individuals on Oahu. Subsequently, Admiral Paparo directed Rear Admiral Cavanaugh, then Director, Maritime Headquarters and of Sustainment for Commander, U.S. Pacific Fleet, to conduct an investigation

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[3] *See* JAG Instruction 5800.7G, *Manual of the Judge Advocate General*, Jan. 15, 2021; Army Regulation 15-6, *Procedures for Administrative Investigations and Boards of Officers*, April 1, 2016; Department of the Air Force Manual 1-101, *Commander Directed Investigations*, April 9, 2021.

[4] DoD Directive 5505.05, "Investigations of Allegations Against Senior DoD Officials," June 6, 2013, Incorporating Change 1, Effective April 28, 2020.

that included the November release and to re-investigate the May 2021 release. This investigation was completed on January 14, 2022 and is often referred to as "the Cavanaugh Report." Remarkably, even though the Cavanaugh Report was much more comprehensive than the first investigation, Admiral Lescher, then Vice Chief of Naval Operations deemed the Cavanaugh Report insufficient and directed Rear Admiral James Waters, Director, Military Personnel Plans and Policy, to conduct a third investigation, as the Pacific Fleet investigation "did not include a sufficient review" of previous spills from the Red Hill fuel facility. This third investigation was completed on June 13, 2022.

That same day, Admiral Lescher, in his role as Vice Chief of Naval Operations, appointed Admiral Caudle, Commander, U.S. Fleet Forces, as the Consolidated Disposition Authority, which delegated to him the authority and discretion to review all relevant information related to the two Red Hill releases and take administrative or disciplinary actions at all echelons, including against his four-star counterpart. On September 28, 2023—over fifteen months after the establishment of the CDA, eight months after the completion of the second investigation, and two years and four months after the initial May 2021 release—the Honorable Carlos Del Toro, Secretary of the Navy announced Secretarial Letters of Censure for three retired admirals who were previously in the Red Hill chain of command, and Admiral Caudle announced non-judicial punishments and non-punitive letters of censure for a number of Servicemembers involved in the mishap. Some of these actions have little or no effect, as they have been imposed on retired sailors. In other cases, the punishment will not even be documented in the individual's official record.

While only a review of one specific example of the outcome of a major mishap, it is clear that the actions taken by Navy leadership to date are not sufficient to address the root causes of this catastrophe. To that end, I have consistently called for changes from the DoD related to accountability and independent investigations. In addition to calling for an Inspector General investigation into the Navy's handling of Red Hill in 2021,[5] I wrote a letter to the Secretary of the Navy in July 2022 describing my concerns with the Navy's command and control processes leading up to the Navy's recent major disasters.[6] This past January, I wrote a third letter requesting updates on the Navy's implementation of Admiral Samuel Paparo's investigation into Red Hill, focusing on both his objective recommendations and his longer-term cultural and systemic recommendations.[7] Finally, in multiple Senate Armed Services Committee hearings, I have expressed my concern with the Department of Defense's culture of accountability. For example, on April 18, 2023, I asked Secretary Del Toro about ways to enhance accountability

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[5] *See* Letter from Senator Mazie K. Hirono to Sean O'Donnell, Acting Inspector General, Dept. of Defense, December 6, 2021, https://www.hirono.senate.gov/imo/media/doc/20211206hawaiidelegationsupplementallettertododoigrequestingabroadevaluationoftheredhillfacilityfinal.pdf

[6] *See* Letter from Senator Mazie K. Hirono to Carlos Del Toro, Secretary of the Navy, Department of the Navy, July 28, 2022, (on file with author).

[7] *See* Letter from Senator Mazie K. Hirono to Carlos Del Toro, Secretary of the Navy, Department of the Navy, July 26, 2023, (on file with author).

within the Navy to prevent the types of systemic failures that led to the spills at Red Hill.[8] On July 11, 2023, I asked General Charles Q. Brown Jr. during his nomination hearing about the burden of command, leadership, and accountability.[9] Despite my continued engagement on this issue, I do not believe the Navy has adequately addressed my concerns.

This sequence of events and the actions of Navy leadership have led to my conclusion that the existing processes related to major mishaps are insufficient to ensure independent investigations, adequate discipline, or implementation of appropriate governance changes by the Services to prevent these types of mishaps in the future. Accountability cannot only mean identifying bad actors and administratively punishing them for their behavior, it must also include significant changes to address the underlying causes of the mishap and the culture that permitted the mishap to occur. In this case, the limited administrative punishment offered does little to recognize the magnitude of the harm this mishap caused, deter others, or demonstrate that the Navy understands its responsibility for the systemic failures that caused the Red Hill spills.

For these reasons, I propose you make changes to the way DoD investigates and executes accountability actions for major disasters. I believe there are specific changes you can make to ensure better accountability to prevent future disasters, including:

1. Establishing a new designation of "major mishaps" for mishaps that surpass $1 billion dollars in damage or incur a loss of 5 or more lives.

2. Placing responsibility for investigations into major mishaps completely out of the impacted Service.

3. Elevating the disposition authority for major mishaps above the Service Secretary of the impacted Service

4. Creating mandatory processing for administrative separation for Servicemembers materially involved in major mishaps.

5. Expanding administrative options to hold Servicemembers and civilians accountable for their role in these major mishaps.

6. Contemplating accountability for the Service Secretary and/or Service Chief for large-scale mishaps.

7. Providing quarterly reports to Congress on accountability and remediation measures for

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[8] *Open and Closed hearings to examine the posture of the Department of the Navy in review of the Defense Authorization Request for fiscal year 2024 and the future years defense program Before the Senate Armed Services Committee*, 118th Cong. (2023), https://www.congress.gov/event/118th-congress/senate-event/334010.

[9] *Hearing to consider the nomination of General Charles Q. Brown, USAF, for reappointment to the grade of general and to be Chairman of the Joint Chiefs of Staff Before the Senate Armed Services Committee,* 118th Cong. (2023), https://www.congress.gov/event/118th-congress/senate-event/334423.

all major mishaps.

8. Requiring all criminal referrals or decisions on administrative punishment for major mishaps to be decided within 12 months of the incident.

I welcome your thoughts on these proposed changes, and ask for your own insights, to include legislative proposals, into any additional ways the DoD may ensure adequate accountability for major mishaps in the future.

Sincerely,

Mazie K. Hirono

Mazie K. Hirono
United States Senator
Chair, Subcommittee on Readiness and Management Support