

Department of Homeland Security **Office of Inspector General**

The USCG's Oversight of Recommendations from Deepwater Horizon After Action Reports





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Department of Homeland Security

Washington, DC 20528 / www.oig.dhs.gov

FEB 21 2014

MEMORANDUM FOR: Rear Admiral Stephen P. Metruck
Assistant Commandant for Resources and
Chief Financial Officer
United States Coast Guard

Rear Admiral Peter J. Brown
Assistant Commandant for Response Policy
United States Coast Guard

FROM:

Mark Bell 
Acting Assistant Inspector General for Audits

SUBJECT: *The USCG's Oversight of Recommendations from Deepwater
Horizon After Action Reports*

Attached for your action is our final report, *The USCG's Oversight of Recommendations from Deepwater Horizon After Action Reports*. We incorporated the formal and technical comments from the Assistant Commandant for Resources and Chief Financial Officer in the final report.

The report contains two recommendations aimed at improving the oversight and tracking of recommendations in oil spill after action reports and the resultant corrective actions. Your office concurred with both recommendations. Based on information provided in your response to the draft report, we consider the recommendations resolved. Once your office has fully implemented the recommendations, please submit a formal closeout request to us within 30 days so that we may close the recommendations. The request should be accompanied by evidence of completion of agreed-upon corrective actions. Please email a signed PDF copy of all responses and closeout requests to OIGAuditsFollowup@oig.dhs.gov.

Consistent with our responsibility under the *Inspector General Act*, we will provide copies of our report to appropriate congressional committees with oversight and appropriation responsibility over the Department of Homeland Security. We will post the report on our website for public dissemination.

Please call me with any questions, or your staff may contact John E. McCoy II, Deputy Assistant Inspector General for Audits, at (202) 254-4100.

Attachment



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Abbreviations

CGAAP	Coast Guard After Action Program (United States Coast Guard)
CG-CPE	Coast Guard Office of Crisis and Contingency Planning and Exercise Policy (United States Coast Guard)
CG-MER	Coast Guard Office of Marine Environmental Response Policy (United States Coast Guard)
CPS	Contingency Preparedness System
DHS	Department of Homeland Security
DWH	Deepwater Horizon
FOCS	Federal On-Scene Coordinator
ISPR	Incident Specific Preparedness Review
MISLE	Marine Information for Safety and Law Enforcement
NIC	National Incident Commander
OIG	Office of Inspector General
USCG	United States Coast Guard



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Executive Summary

The April 20, 2010, oil spill that followed the explosion of the Mobile Offshore Drilling Unit, Deepwater Horizon, was the largest in United States history. This spill was also the first Spill of National Significance—a spill so complex that it required extraordinary coordination of Federal, State, local, and responsible party resources to contain and clean up the discharge. As the lead Federal agency for oil spill or hazardous material incidents in United States coastal waters, the United States Coast Guard (USCG) served as the Federal On-Scene Coordinator for response to this oil spill. Seven after action reports containing 549 recommendations were issued in the wake of this incident. Our objective was to determine whether the USCG's oversight of recommendations made in Deepwater Horizon oil spill after action reports was effective for tracking corrective actions.

Our initial audit objective was to determine whether the USCG had implemented Deepwater Horizon after action report recommendations. However, we were unable to determine whether the recommendations had been addressed because of inconsistencies in the USCG's process to track progress. Therefore, we sought to understand how the USCG tracked after action report recommendations and why the USCG had difficulty in providing supporting documentation for the recommendations it said were completed.

The USCG did not provide effective oversight of recommendations made to it in Deepwater Horizon after action reports, nor could it provide reasonable assurance that corrective actions for the Deepwater Horizon incident addressed the recommendations in these after action reports. This occurred because management of the process was not fully coordinated and after action report recommendations were not centrally or specifically tracked. In addition, according to a USCG after action report, the USCG could not be certain that actions resulting from previous oil spills had been implemented, and thus, it encountered some of the same issues in response to the Deepwater Horizon incident. This may have affected the response to the oil spill and could affect the USCG's response to future disasters.

The USCG concurred with both recommendations we made to improve the oversight and tracking of recommendations in oil spill after action reports and the resultant corrective actions.



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Background

According to the USCG, since 1978, it has captured lessons learned and best practices identified during contingency exercises and actual events, and it has recommended actions to improve its response. The Coast Guard Office of Crisis and Contingency Planning and Exercise Policy manages and oversees the Coast Guard After Action Program (CGAAP). The USCG, through this program, documents and acts on lessons identified in exercises and contingency operations, which are incidents, threats, or events requiring capabilities beyond that of normal operations.

The USCG used various systems to store and retrieve this information until 2003 when it launched its database, the Contingency Preparedness System (CPS). The USCG used CPS to link its contingency plans, exercise planning, and after action reports. CPS supports the CGAAP, and, according to the USCG, this program enables it to positively identify, promptly remediate, and learn from problems or issues identified during operations, exercises, and training.

In response to the April 20, 2010 explosion of the Mobile Offshore Drilling Unit, Deepwater Horizon (DWH), 7 after action reports, which included 549 recommendations, were issued. These reports were prepared by the USCG, oil spill response and industry experts, and the presidentially-created National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling. Appendix C contains more information on these reports. The recommendations in these reports covered topics such as facilitating communications among oil spill response stakeholders and establishing or improving prevention and response policies and procedures. According to a March 2011 USCG memorandum, DWH after action reports provided perspectives and opinions that the USCG could evaluate to “identify further opportunities for positive, effective preparedness improvements.”

Results of Audit

The USCG did not provide effective oversight of recommendations made to it in DWH after action reports, nor could it provide reasonable assurance that corrective actions for the DWH incident addressed the recommendations in these after action reports. This occurred because management of the process was not fully coordinated and after action report recommendations were not centrally or specifically tracked. In addition, according to a USCG after action report, the USCG could not be certain that actions resulting from previous oil spills had been implemented, and thus, it encountered some of the same issues in response to the DWH incident. This may have affected the response to the oil spill and could affect the USCG’s response to future disasters.



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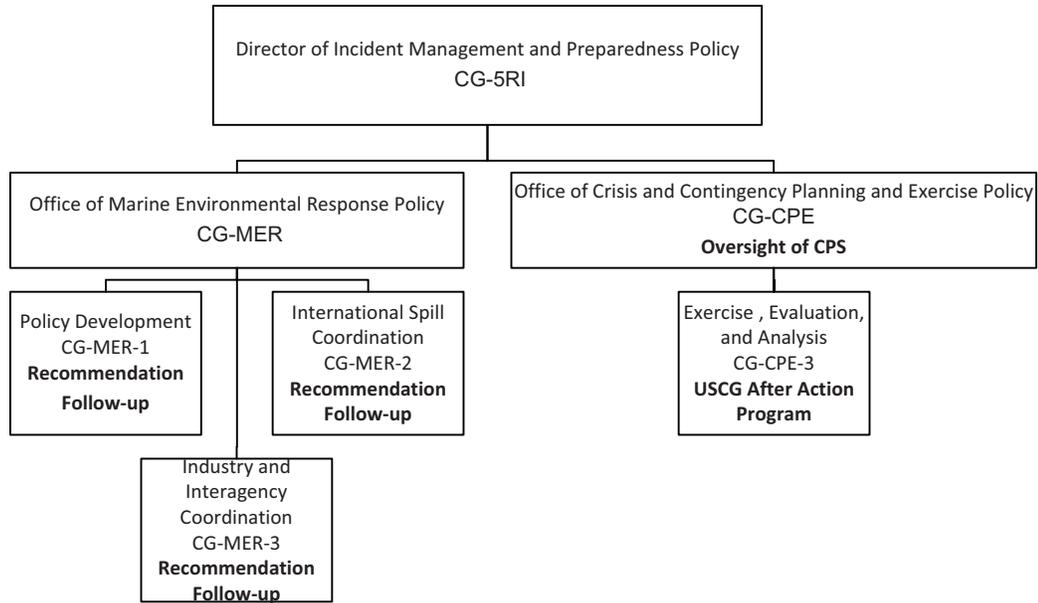
Oversight of Recommendations

Oversight of recommendations and corrective actions stemming from the DWH incident was fragmented and ineffective because the USCG program offices responsible for managing the process did not fully coordinate with each other on the status of recommendations. According to USCG officials, they did not have one central program office to oversee all DWH after action report recommendations. USCG officials also said that policy oversight of crosscutting issues was addressed by a senior leadership effort to prioritize, assign, and track recommendations across multiple offices and directorates. As shown in figure 1, several USCG offices, under the Director of Incident Management and Preparedness Policy, are responsible for various aspects of the process, including oversight and tracking of recommendations. For example, according to USCG guidance, the Office of Marine Environmental Response Policy (CG-MER) is responsible for developing guidance on applying specific DWH findings and recommendations to all levels of the USCG. According to the USCG, three offices under CG-MER are tasked with recommendation follow-up. The Office of Crisis and Contingency Planning and Exercise Policy (CG-CPE) has oversight of CPS, the system of record for after action reports and recommendations. An office under CG-CPE—Exercise, Evaluation, and Analysis—is responsible for the CGAAP. Interviews with some personnel involved in the process showed that their offices could only address the status of DWH after action report recommendations under their oversight and not the overall status of all DWH recommendations.



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Figure 1. USCG Offices Responsible for Deepwater Horizon After Action Report Recommendation Oversight



Source: DHS OIG analysis of USCG information

Although the CGAAP falls under the Office of Incident Management and Preparedness Policy, some recommendations in DWH after action reports required other programs to take corrective actions. For example, 13 of the recommendations from one of the USCG’s after action reports, *BP Deepwater Horizon Oil Spill Incident Specific Preparedness Review (ISPR)*, were directed to the USCG’s Office of Governmental and Public Affairs, but personnel from the office said that they did not address the recommendations in that report. They said their office only addressed report recommendations in the USCG’s *Strategic Lessons Learned* report, as assigned by the USCG’s Office of Incident Management and Preparedness Policy. A comparison of the recommendations in these two reports showed similarities between the recommendations related to governmental and public affairs.

Responding to and Tracking Recommendations

The USCG informally tracked five of seven after action reports issued after the DWH incident. The *Deepwater Horizon Strategic Lessons Learned After Action Report* was tracked in CPS, and the USCG’s investigation of the Deepwater Horizon mishap was entered into the Marine Information for Safety and Law Enforcement (MISLE) system, as required by USCG policy.



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CG-MER officials said they did not have a formal process to respond to DWH after action report recommendations, nor were recommendations tracked in a central database. The absence of a formal process and a centralized system of record hindered the USCG's ability to determine whether its corrective actions addressed the DWH recommendations.

To respond to recommendations, CG-MER officials described an informal process in which staff reviewed the five after action reports for which they were responsible, determined which recommendations were relevant to their office's mission, and through discussion with subject matter experts, decided on the appropriate corrective actions. According to CG-MER, it did not enter recommendations from the five reports it oversees into a formal system of record, such as CPS. The office first grouped the DWH recommendations from the five reports into like categories and then placed the categorized recommendations under three initiatives—People, Policy, and Equipment.¹ By rolling up the recommendations into more general initiatives, CG-MER officials said they could not track the corrective actions back to the more specific recommendations. For example, officials were able to state that corrective actions were aimed at improving the USCG's marine environmental response program performance and its leadership. However, they had difficulty providing documentation to support that corrective actions corresponded to and addressed the original recommendations because, to identify the recommendations, staff had to deconstruct the overarching initiatives.

Based on our review of all seven after action reports, documentation provided by the USCG, and other information, we identified that not all corrective actions addressed after action report recommendations. Through our review of the after action reports, we first determined that the USCG was fully or partially responsible for addressing 534 of 549 recommendations. According to USCG officials, they had completed 127 of the 534 recommendations. USCG documentation also showed that 247 recommendations were in progress, which we did not verify because of time limitations. We reviewed documentation provided by the USCG and other information and determined that 51 (40 percent) of these 127 corrective actions addressed the recommendations. For the remaining 76 recommendations, the USCG provided incomplete documentation, potentially because it had to deconstruct initiatives into original recommendations to respond to our request. Therefore, the team could not determine whether the corrective actions addressed these recommendations.

¹ According to the USCG, it used this process to develop the USCG's *Marine Environmental Response Mission Performance Plan*, a July 2012 formal report to Congress.



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According to CG-CPE, CPS could be used as a central system of record to track recommendations from all DWH after action reports and to task corrective actions to USCG units, but only one of the seven DWH after action reports had been entered into the system. Instead, the USCG used CPS for certain after action reports, such as those created at the field level by USCG units involved in contingency preparedness and response. According to the USCG, headquarters-level after action reports were not entered into CPS. USCG guidance at the time of the DWH incident neither excluded nor mandated entering higher-level reports, such as those we reviewed. This guidance did require submitting an after action report to CPS within 21 days of a unit's participation in an actual operation, an exercise, or a training event. However, officials from one USCG program office said that they did not enter after action reports into the system because it was "only for exercises." One DWH ISPR recommended a review of the USCG's Corrective Action Program to ensure that lessons learned from all incidents and exercises were captured and communicated throughout the USCG and the response community. At the time of our audit, according to the USCG, the five DWH after action reports it was informally tracking were not entered into CPS, the system of record for the CGAAP. After the conclusion of fieldwork, USCG officials reported that these five reports were now located in CPS; we did not verify this statement.

According to USCG officials, the only DWH after action report in CPS was the May 2011 *Deepwater Horizon Strategic Lessons Learned After Action Report*, which included 227 recommendations, and which was created to identify challenges and corrective actions. According to CG-CPE, it prioritized the report's top 50 recommendations, grouped them into five initiatives, and chartered working groups to determine and implement the corrective actions. These were the only DWH report recommendations that the CGAAP tracked using CPS; however, only personnel in CG-CPE had access to them, which limited information sharing. According to CG-CPE, once the recommendations were implemented, the information would be released for general USCG use. After the conclusion of fieldwork, USCG officials reported that Quarterly Progress Reports for the top 50 recommendations were replicated in CPS to provide status information; we did not verify this statement.

The USCG used MISLE to track recommendations from its joint DWH investigation with the Bureau of Ocean Energy Management, Regulation and Enforcement. Use of MISLE is required to support the USCG's marine safety, security, environmental protection, and law enforcement programs. However, according to our May 2013 report, *Marine Accident Reporting, Investigations, and Enforcement in the United States Coast Guard, OIG-13-92*, the USCG could



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not ensure that all corrective actions were addressed because there were not complete processes and dedicated resources to track, review, and implement recommendations for all investigations. In response, the USCG planned to establish a national policy to track all actions on safety recommendations and update MISLE to carry out this requirement.

Integrating all USCG after action reports into one system of record could increase visibility into the lessons learned process and help the USCG ensure that its corrective actions address recommendations from DWH after action reports.

Addressing Past Recommendations

According to the DWH ISPR report, the USCG had not completed many recommendations from ISPRs of two previous oil spills and, as a result, the same issues caused difficulties for the USCG during the DWH incident. The DWH ISPR also reported that had some corrective actions been implemented, they would have had a positive impact on the response to the incident.

In discussing the application of lessons learned from prior oil spill responses and exercises, the DWH ISPR specifically mentions six prior recommendations that were not completed. For example, the ISPR of the 1996 *SS Cape Mohican* oil spill in the San Francisco Bay included recommendations to train USCG responders thoroughly, develop a decision-making process for sensitive area protection, and set up a joint information center at the first indication of moderate media interest. According to the DWH ISPR, these recommendations were not completed. The DWH ISPR also discusses lessons learned and associated recommendations from the ISPR following the 2007 *M/V Cosco Busan* oil spill in the San Francisco Bay that were not completed.

Table 1 shows similar recommendations regarding outreach to local entities, stakeholders, and government officials that were included in all three ISPRs. According to the DWH ISPR, this recommendation was not completed following either of the two earlier ISPRs; a similar recommendation was included in the DWH report.



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Table 1. Comparison of USCG ISPR Recommendations

Recommendation	Report	Year of Incident
Area Committees need to engage these local area entities, encourage their participation in planning meetings, and exercise with them, occasionally filling Incident Command System positions with local area resources.	<i>MV Cape Mohican</i> Oil Spill ISPR	1996
Committee chairs [should] conduct outreach and aggressively pursue participation by stakeholders and trustees and communicate the importance of their participation in the Area Committee.	<i>MV Cosco Busan</i> Oil Spill in San Francisco Bay	2007
The USCG should undertake an aggressive outreach program to engage State Governors, parish, county, and city officials, tribes, and emergency managers and local non-governmental organizations in the Area Contingency Plan planning process.	BP Deepwater Horizon Oil Spill ISPR	2010

Source: DHS OIG based on USCG information

Conclusion

The USCG had difficulty tracking the status of specific recommendations contained in after action reports prepared in response to the DWH oil spill. Because of challenges to the CGAAP, the USCG could not provide reasonable assurance that corrective actions for the DWH incident addressed the recommendations in after action reports. According to the DWH ISPR, the USCG also could not be certain that it implemented corrective actions to address recommendations from past oil spill ISPRs. Without such improvements to the CGAAP, the USCG may have difficulty overcoming challenges to its oil spill response and may be missing opportunities to enhance its response to future oil spills.

Recommendations

We recommend that the Assistant Commandant for Response Policy (CG-5R):

Recommendation #1:

Identify or develop a process to ensure that USCG initiatives and subsequent corrective actions, especially those developed as a result of recommendations from DWH after action reports, can be tracked back to individual recommendations.



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Recommendation #2:

Evaluate the use of CPS or other USCG systems of record for tracking recommendations and corrective actions from oil spill response after action reports. Consider expanding the use of the identified system of record to all USCG after action reports.

Management Comments and OIG Analysis

The USCG provided comments on the draft of this report. Appendix B includes a copy of the response in its entirety. The USCG also provided a separate document with technical comments to our report. We reviewed the technical comments and made minor changes in the report when appropriate.

Management Comments to Recommendation 1. The USCG concurred with the recommendation. The USCG noted that, following response operations across the full range of its statutory missions, it may receive a variety of reports from governmental and non-governmental entities. According to the USCG, these reports may contain a multitude of suggested recommendations, and it is its prerogative to determine which reports and suggested recommendations it will consider, select, prioritize, and track.

To clarify its policy, the USCG said that it plans to include the following wording in an upcoming revision of the instruction, *COMDTINST 3010.19C, Coast Guard After Action Program*, to be implemented by December 31, 2014:

In addition to the development and processing of Coast Guard After Action reports described in this instruction, the Coast Guard may charter or receive other post-incident reports, such as Incident Specific Preparedness Reviews (ISPR), Federal On-Scene Coordinator Reports (FOCS), National Incident Commander (NIC) Reports, reports from other agencies, and/or industry group reports. The Coast Guard Headquarters office with policy oversight responsibility for the contingency that generated these reports will have responsibility to determine and prioritize which of the report(s) recommendations the Coast Guard will act on, and to track the accomplishment of the selected recommendations using the Contingency Preparedness System (CPS). The Office of Contingency Preparedness and Exercise Policy (CG-CPE) can advise the office with policy oversight responsibility on methodologies for prioritization of recommendations and for tracking within CPS the resolution of recommendations selected for pursuit.



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OIG Analysis. We consider the USCG's proposed corrective actions to be responsive to the recommendation. The recommendation is considered resolved and will remain open until the USCG provides us with the updated *COMDTINST 3010.19C, Coast Guard After Action Program*.

Management Comments to Recommendation 2. The USCG concurred with the recommendation. The USCG said it is already considering how CPS can be used to capture lessons learned beyond those generally captured in contingency preparedness exercises and response operations. According to the USCG, CG-CPE is fully engaged with the USCG Strategic Management Directorate as a member of the USCG Knowledge Management Work Group. A key element of this group's work is to explore the broader nature of lessons learned as an element of overall USCG knowledge management.

According to the USCG, its policy was strengthened in the November 2012 release of *COMDTINST 3010.19C, Coast Guard After Action Program*, which specified the development of USCG action reports for any response operations characterized as Type 1 or Type 2 events, as described in Incident Command System publications, or for Type 3 incidents with significant lessons learned.

The USCG also said that, recognizing it may receive a variety of reports from other governmental and non-governmental entities following a major event, it plans to include the following wording in an upcoming revision to *COMDTINST 3010.19C, Coast Guard After Action Program*, to be implemented by December 31, 2014:

In addition to the development and processing of Coast Guard After Action reports described in this instruction, the Coast Guard may charter or receive other post-incident reports, such as Incident Specific Preparedness Reviews (ISPR), Federal On-Scene Coordinator Reports (FOCS), National Incident Commander (NIC) Reports, reports from other agencies, and/or industry group reports. The Coast Guard Headquarters office with policy oversight responsibility for the contingency that generated these reports will have responsibility to determine and prioritize which of the report(s) recommendations the Coast Guard will act on, and to track the accomplishment of the selected recommendations using the Contingency Preparedness System (CPS). The Office of Contingency Preparedness and Exercise Policy (CG-CPE) can advise the office with policy oversight responsibility on methodologies for prioritization of recommendations and for tracking within CPS the resolution of recommendations selected for pursuit.



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OIG Analysis. We consider the USCG's proposed corrective actions to be responsive to the recommendation. The recommendation is considered resolved and will remain open until the USCG provides us with the updated *COMDTINST 3010.19C, Coast Guard After Action Program*.



Appendix A

Objectives, Scope, and Methodology

The Department of Homeland Security (DHS) Office of Inspector General (OIG) was established by the *Homeland Security Act of 2002* (Public Law 107-296) by amendment to the *Inspector General Act of 1978*. This is one of a series of audit, inspection, and special reports prepared as part of our oversight responsibilities to promote economy, efficiency, and effectiveness within the Department.

This report provides the results of our work to determine whether the USCG's oversight of recommendations made in DWH oil spill after action reports was effective for tracking corrective actions.

Our initial audit objective was to determine whether the USCG had implemented DWH after action report recommendations. However, we were unable to determine whether the recommendations had been addressed because of inconsistencies in the USCG's process to track progress. Therefore, we sought to understand how the USCG tracked after action report recommendations and why the USCG had difficulty in providing supporting documentation for recommendations it said were completed.

We reviewed 7 reports (see appendix C) and determined that 534 of 549 recommendations required USCG involvement to resolve. According to the USCG, it had completed 127 of the 534 recommendations. We analyzed supporting documentation for the 127 recommendations provided by the USCG as well as documentation obtained by the team from the USCG website. We conducted interviews with program personnel at USCG headquarters in Washington, DC, to help us understand the recommendation tracking and oversight process.

We conducted this performance audit between January 2013 and July 2013 pursuant to the *Inspector General Act of 1978*, as amended, and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based upon our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based upon our audit objectives.



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Appendix B
Management Comments to the Draft Report

U.S. Department of
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7501

DEC 18 2013

MEMORANDUM

From: 
S. P. Metruck, RDML
COMDT (CG-8)

Reply to: Audit Manager
Attn of: Mark Kulwicki
(202) 372-3533

To: Anne L. Richards
Assistant Inspector General for Audits
Department of Homeland Security (DHS)

Subj: DHS OIG DRAFT REPORT: "THE USCG'S OVERSIGHT OF
RECOMMENDATIONS FROM DEEPWATER HORIZON AFTER ACTION
REPORTS"

Ref: (a) OIG Project No. 13-057-AUD-USCG, dated November 18, 2013

1. This memorandum transmits the Coast Guard's response to the draft report identified in reference (a).
2. The Coast Guard concurs with the two recommendations in the draft report. Our response contained in enclosure (1) also highlights the extensive prioritization and implementation effort taken to address the most significant lessons highlighted in the seven Deepwater Horizon lessons learned reports. This effort of taking corrective actions is not fully explained in the OIG report. The report is narrowly focused on how the Coast Guard processed recommendations rather than the outcome of actions taken on the highest priority recommendations.
3. If you have any questions, my point of contact is Mr. Mark Kulwicki who can be reached at 202-372-3533.

#

Enclosure: (1) USCG response



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**UNITED STATES COAST GUARD RESPONSE FOR DHS OIG DRAFT REPORT:
THE USCG'S OVERSIGHT OF RECOMMENDATIONS FROM DEEPWATER
HORIZON AFTER ACTION REPORTS (OIG PROJECT NO. 13-057-AUD-USCG)**

1. The U. S. Coast Guard (USCG) is always ready to foster maritime safety, maritime security, and maritime stewardship through the performance of its eleven statutory missions. Through its policies and prevention activities, the USCG ensures the safety of tens of thousands of mariners, millions of passengers on ferries and other vessels, and tens of millions of recreational boaters. At the same time, the USCG prevents, prepares and responds to threats to the marine environment from oil and chemical spills. The USCG is committed to the continuous improvement process by assessing and improving our performance across these missions.
2. The USCG appreciates the efforts of the DHS Office of Inspector General audit team that examined the Service's oversight of recommendations for improved response in the wake of the Deepwater Horizon (DWH) oil spill. The USCG acknowledges and generally concurs with the audit team's recommendations that its system and process for tracking and documenting lessons learned recommendations can be improved. We also concur that the USCG could have done a better job documenting the linkage between each individual recommendation and the initiatives pursued by the Service to most effectively strengthen its spill response program. Implementation of the OIG's recommendations may help the USCG enhance its lessons learned process, improving its future readiness to perform maritime safety, security, and stewardship missions.
3. The USCG is concerned that the overarching message of the OIG report is missing key components of the Service's approach and achievements in this case. The OIG's audit focused on method over outcome. The report concluded that the USCG had not effectively employed lessons learned from DWH because it did not track and document the outcome of each individual recommendation. Seven independent groups published reports following the DWH response. These seven reports yielded a collective 549 recommendations including: redundant themes, corrective actions outside of USCG purview, and unfeasible suggestions. To focus on the highest priorities, the USCG employed a strategic process, which enabled the service to prioritize and execute significant improvements in the spill response program. By focusing on the need to individually track all 549 recommendations from cradle to grave, the OIG report overlooked the solution-oriented process the USCG employed to 1) validate feasibility and eliminate duplication, and 2) prioritize, assign, and track the most viable recommendations to closure.
4. The OIG report infers that all 549 recommendations from the seven after action reports are valid and justified action by the USCG; the USCG does not concur with that supposition. The audit does not recognize the USCG's authority, obligation and expertise to determine the validity, applicability, and feasibility of each recommendation. Using a tiered analysis, the USCG reviewed all 549 recommendations and produced the Deepwater Horizon Strategic Lessons Learned After Action Report, which narrowed the list of recommendations to 250 USCG-specific action items. The Vice Commandant and Deputy Commandant for Operations then charted a senior-level workgroup to further prioritize the recommendation list and ultimately identify the 50 most viable for targeted action. Simultaneously, the USCG prioritized the Marine Environmental Response (MER) mission-specific recommendations from the seven DWH studies into three initiatives that highlighted "People, Policy and

ENCLOSURE (1)



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Equipment” improvements within the MER program. These three focus areas became the framework of the MER Mission Performance Plan Report to Congress issued by the Commandant.

5. The USCG’s effort to address DWH lessons learned far surpassed any previous Service analysis and engagement to date in pursuing post-incident corrective actions. The overall process significantly enhanced nationwide MER preparedness and set a benchmark for future information and knowledge management during a complex contingency in the maritime domain. The USCG agrees that there is room for improvement in the administrative tracking of individual lessons learned following a response incident. However, it is critical to acknowledge the strategic process followed by the USCG to consolidate, prioritize and implement the most valuable lessons from the DWH response into meaningful results.

RECOMMENDATIONS AND USCG RESPONSES

We recommend that the Assistant Commandant for Response Policy (CG-5R):

Recommendation #1: *Identify or develop a process to ensure that USCG initiatives and subsequent corrective actions, especially those developed as a result of recommendations from DWH after action reports, can be tracked back to individual recommendations.*

USCG response: Concur. The USCG has the potential to receive a variety of reports from governmental and non-governmental entities following response operations across the full range of USCG statutory missions. These reports may contain a multitude of suggested recommendations, and it is the USCG’s prerogative to determine which of these reports and suggested recommendations will or will not be considered, selected, prioritized, and tracked.

To clarify this position in USCG policy, the following wording is being prepared for inclusion in an upcoming revision to COMDTINST 3010.19C, Coast Guard After Action Program:

“In addition to the development and processing of Coast Guard After Action Reports described in this instruction, the Coast Guard may charter or receive other post-incident reports, such as Incident Specific Preparedness Reviews (ISPR), Federal On-Scene Coordinator Reports (FOSC), National Incident Commander (NIC) Reports, reports from other agencies, and/or industry group reports. The Coast Guard Headquarters office with policy oversight responsibility for the contingency that generated these reports will have responsibility to determine and prioritize which of the report(s) recommendations the Coast Guard will act on, and to track the accomplishment of the selected recommendations using the Contingency Preparedness System (CPS). The Office of Contingency Preparedness and Exercise Policy (CG-CPE) can advise the office with policy oversight responsibility on methodologies for prioritization of recommendations and for tracking within CPS the resolution of recommendations selected for pursuit.”

This policy change will be implemented by December 31, 2014.



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Recommendation #2: Evaluate the use of CPS or other USCG systems of record for tracking recommendations and corrective actions from oil spill response after action reports. Consider expanding the use of the identified system of record to all USCG after action reports.

USCG response: The USCG is already considering how its Contingency Preparedness System (CPS) can be used to capture lessons learned information beyond that generally captured in contingency preparedness exercises and response operations. The Office of Contingency Preparedness and Exercise Policy (CG-CPE) is fully engaged with the USCG Strategic Management Directorate (CG-095) as a member of the USCG Knowledge Management Work Group (KMWG). A key element of the KMWG's work is to explore the broader nature of lessons learned as an element of overall USCG knowledge management.

USCG policy was strengthened in the November 2012 release of COMDTINST 3010.19C, Coast Guard After Action Program, to specify the development of USCG action reports for any response operation bearing the characteristics of a Type 1 or Type 2 event as described in Incident Command System publications, or for Type 3 incidents where there are significant lessons learned.

Additionally, recognizing the USCG may receive a variety of reports from other governmental and non-governmental entities following a major event, the following wording is being prepared for inclusion in an upcoming revision to COMDTINST 3010.19C, Coast Guard After Action Program:

"In addition to the development and processing of Coast Guard After Action Reports described in this instruction, the Coast Guard may charter or receive other post-incident reports, such as Incident Specific Preparedness Reviews (ISPR), Federal On-Scene Coordinator Reports (FOSC), National Incident Commander (NIC) Reports, reports from other agencies, and/or industry group reports. The Coast Guard Headquarters office with policy oversight responsibility for the contingency that generated these reports will have responsibility to determine and prioritize which of the report(s) recommendations the Coast Guard will act on, and to track the accomplishment of the selected recommendations using the Contingency Preparedness System (CPS). The Office of Contingency Preparedness and Exercise Policy (CG-CPE) can advise the office with policy oversight responsibility on methodologies for prioritization of recommendations and for tracking within CPS the resolution of recommendations selected for pursuit."

This policy change will be implemented by December 31, 2014.



Appendix C

Summary of Deepwater Horizon After Action Reports

Report Title	Report Summary
<i>BP Deepwater Horizon Oil Spill Incident Specific Preparedness Review (ISPR)</i> January 2011	ISPRs are directed by USCG headquarters following the completion of the initial response phase of a specifically selected incident. This USCG-mandated report examined the effectiveness of preparedness and implementation of the response to the DWH incident in relation to the National Contingency Plan, area contingency plans, and other oil spill response plans.
<i>Deepwater Horizon Strategic Lessons Learned After Action Report</i> May 2011	This report was an effort by the USCG to leverage its lessons learned process to identify challenges and remedial actions. The report focused on overarching strategic issues that have a significant and enduring effect on the USCG and its ability to perform its mission.
<i>Joint Industry Oil Spill Preparedness and Response Task Force: Draft Industry Recommendations to Improve Oil Spill Preparedness and Response</i> September 2010 <i>Progress Report on Industry Recommendations to Improve Oil Spill Preparedness and Response</i> November 2011 <i>Second Progress Report on Industry Recommendations to Improve Oil Spill Preparedness and Response</i> November 2012	Experts in the oil industry convened this task force to work cooperatively to address DWH issues. The task force examined the industry's ability to respond to a Spill of National Significance and the actual response to the DWH incident.

Source: DHS OIG



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Report Title	Report Summary
<i>National Incident Commander's Report: MC252 Deepwater Horizon</i> October 2010	This report reflects the National Incident Commander's observations and recommendations related to the DWH oil spill response. This oil spill was the first time both a Spill of National Significance was declared and a National Incident Commander was designated. According to this report, these designations tested, under extreme conditions, the existing laws, regulations, policies, and procedures that govern oil spill response and fundamental principles regarding the respective roles of responsible parties and Federal, State, local, and tribal governments in oil spill response.
<i>On Scene Coordinator Report Deepwater Horizon Oil Spill</i> September 2011	The National Contingency Plan requires an On Scene Coordinator report that records the situation as it developed, the actions taken, the resources committed, and the challenges encountered. The Federal On Scene Coordinator is responsible for directing and coordinating oil removal actions.
<i>Report of Investigation into the Circumstances Surrounding the Explosion, Fire, Sinking and Loss of Eleven Crew Members Aboard the MOBILE OFFSHORE DRILLING UNIT DEEPWATER HORIZON In the GULF OF MEXICO April 20 – 22, 2010</i> September 2011	DHS and the Department of the Interior determined that a joint investigation of the Deepwater Horizon explosion, sinking, and the associated loss of life was the best strategy for determining the events, decisions, actions, and consequences of this marine casualty. The USCG and the Bureau of Ocean Energy Management, Regulation and Enforcement conducted a joint investigation, resulting in two separate reports. This report contains the results of the USCG's investigation of the DWH incident.
<i>DEEP WATER: The Gulf Oil Disaster and the Future of Offshore Drilling Report to the President National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling</i> January 2011	President Obama created the National Commission on the BP Deepwater Horizon Oil Spill and Offshore Drilling and directed it to determine the causes of the disaster, to improve the country's ability to respond to spills, and to recommend reforms to make offshore energy production safer.

Source: DHS OIG



Appendix D

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Appendix E
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