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THE AAV MISHAP INVESTIGATION: HOW TO BUILD A CULTURE OF SAFETY TO AVOID PREVENTABLE TRAINING ACCIDENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON READINESS

OF THE

COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES

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THE AAV MISHAP INVESTIGATION: HOW TO BUILD A CULTURE OF SAFETY TO AVOID PREVENTABLE TRAINING ACCIDENTS

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON READINESS,
Washington, DC, Monday, May 3, 2021.

The subcommittee met, pursuant to call, at 11:02 a.m., via Webex, Hon. John Garamendi (chairman of the subcommittee) presiding.

OPENING STATEMENT OF HON. JOHN GARAMENDI, A REPRESENTATIVE FROM CALIFORNIA, CHAIRMAN, SUBCOMMITTEE ON READINESS

Mr. GARAMENDI. Good morning, ladies and gentlemen. I call to order this hearing of the Readiness Subcommittee of the House Armed Services Committee. First, some administrative and technical notes.

I ask unanimous consent that nonsubcommittee members be allowed to participate in today's briefing after all subcommittee members have had the opportunity to ask questions. Is there any objection?

Without objection, nonsubcommittee members will be recognized at the appropriate time for 5 minutes.

I also ask unanimous consent that noncommittee members, if any, be allowed to participate in today's hearing after all committee members have had an opportunity to ask questions. Is there any objection?

Hearing none, without objection, noncommittee members will be recognized at the appropriate time for 5 minutes. And that will be Mr. Levin in the second and Seth Moulton in the first.

Members are reminded that they must be visible on screen within the software platform for the purposes of identity verification. Members must continue to use the software platform's video function while attending the hearing unless they experience connectivity issues or other technical problems that render the members unable to fully participate on camera. If you experience technical difficulties, please contact the committee staff.

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Finally, there is a 5-minute countdown clock on the software platform's display, usually in the upper right-hand corner. I will remind you, if necessary, when your time is up.

Now, with these administrative tasks out of the way, I would like to focus our attention on the hearing at hand. I will reserve the majority of my opening remarks for the second panel.

In our first panel, we will hear from the parents of two of the nine young Americans who died on July 30. Those nine young men volunteered to serve their country. They died because of a fully preventable training accident and a total disregard for their safety.

This tragedy should never have happened. It resulted from a cascading series of failures, all of which were preventable.

I can think of no better way to begin this hearing than to take a moment to honor their memory.

I am going to read the names of the eight Marines and one sailor that we lost, and then I would ask for a moment of silence.

First, Private First Class Bryan J. Baltierra, Lance Corporal Marco A. Barranco, Private First Class Evan A. Bath, Navy Hospital Corpsman Third Class Christopher Gnem, Lance Corporal Jack-Ryan Ostrovsky, Lance Corporal Guillermo S. Perez, Corporal Wesley A. Rodd, Lance Corporal Chase D. Sweetwood, and Corporal Cesar A. Villanueva.

And now, in their memory and in their honor, a moment of silence.

[Moment of silence.]

Mr. GARAMENDI. Thank you.

I will now turn to Mr. Lamborn for any opening remarks he may have.

STATEMENT OF HON. DOUG LAMBORN, A REPRESENTATIVE FROM COLORADO, RANKING MEMBER, SUBCOMMITTEE ON READINESS

Mr. LAMBORN. Mr. Chairman, thank you for honoring the memory of these nine exemplary young men who wanted to serve our country. Thank you for doing that.

It is sad that we have to be here today and to have the parents of these young men appear before us. And I am hopeful, and I am working hard with you, Mr. Chairman, to make sure that this doesn't have to happen again and we have to have a similar kind of hearing in the future.

So these young men just wanted to serve our country. It is fitting that we honor their memory. It is also fitting that we get to the bottom of whatever the causes were behind this, including holding accountable anyone who needs to be held accountable.

And with that, Mr. Chairman, I yield back to you.

Mr. GARAMENDI. Thank you, Mr. Lamborn.

I would like now to welcome and thank our witnesses. First, Mr. Peter Vienna, the father of Navy Hospital Corpsman Third Class Christopher Gnem. And secondly, Mr. Peter Ostrovsky, the father of [Lance Corporal] Jack Ostrovsky, United States Marine Corps.

Mr. Vienna, if you would like to start.

Hit your mute button, please.

You are good to go.

STATEMENT OF PETER VIENNA, FATHER OF NAVY CORPSMAN CHRISTOPHER "BOBBY" GNEM

Mr. VIENNA. Good morning, esteemed members of the House subcommittee. Thank you for the opportunity to speak about our son, Christopher "Doc" Gnem. His family and friends called him Bobby.

I wish you could also see and hear from my wife today. She has chosen to allow me to speak on her behalf because she would be unable to do so without breaking down. I can tell you this: Her raw emotion and the effect she would have on this panel would be deeply moving.

I believe all nine mothers should be heard, because today we are not only mourning our son, but also we mourn the eight other families that are navigating through this pain.

Nancy became a single mother when Bob was still an infant. She struggled to give him and his two sisters the best possible life she could. I came into their lives when Bobby was 14 years old. What I witnessed was the most incredible mother-son relationship. The two of them literally lived for each other.

Bobby was a natural athlete, excelling in judo and jujitsu, never once losing a match. As a high school student athlete, he played football and basketball, voted team captain as well as most inspirational on his varsity basketball team. In both basketball and jujitsu, he volunteered his free time to mentor the younger boys. He was truly a sensei and coach's dream.

He was the best of us, the favorite of his grandparents, aunts, uncles, and all of his cousins who looked up to him as a role model. I can say without prejudice that Bobby touched more lives positively in his 22 years than most people do in a lifetime.

Bobby, along with eight others are dead now, and here is just a short list of some of the reasons given in the investigation.

Forty-year-old AAVs [assault amphibious vehicles] designed without safety in mind that came off the "dead-line," end of life, deemed "not seaworthy," should never even have been put back in the water.

No real safety boat for this training exercise. Both Marine and Navy's own policy states two safety boats for every six AAVs in the water. There were 13 that day.

No emergency egress training. They knew they were sinking for quite some time, yet they were found with their full body armor

still on, some even with their helmets and rifles still strapped to their body. They obviously had no idea what to do.

No radio contact or eyes on the AAVs. Our boy's boat was sinking for 45 minutes while chasing the *Somerset* that was traveling away and conducting helicopter exercises.

All 23 gallons of transmission fluid were lost on the trip to the island. Only 6 gallons were available to replace it, yet that AAV was sent back into the water to try and reach the *Somerset.*

An AAV crew that did not follow its own emergency SOPs [standard operating procedures]. Had they done so, the AAV still would have sunk but not with our boys in it. I point that back at leadership's failed duty to properly train and certify that crew, just another result of a terrible lack of readiness.

His mother, his surviving sisters, Jasmine and Jade, and his fiancee Savannah, who received her surprise engagement ring in a box 7 months after he was killed, have not been able to accept this loss, especially now knowing how incredibly preventable it was.

Losing her only son has broken my wife. She is suffering both mentally and physically. For me, well, frankly, for the last 9 months I have been on suicide watch. I had no control over losing my son, but I refuse to lose my wife.

I also refuse to call what happened on July 30 a "mishap," the definition of which is an "unlucky accident." We have all seen that nightmare of an investigation, so we know that what actually occurred was a predictable outcome resulting from the reckless disregard for human life by a command that ignored its own safety standards and operational procedures, putting mission above the young lives they were supposed to protect.

Not a combat mission, this was just training. And if I hear one more time, "We have to train like we fight," I think my head will explode, because for decades now it has been true that every year the military loses more lives in training than they do in combat.

Before I go any further, I wish to say for the record that even after all the recklessness and gross negligence that took our only son, my wife and I are still not anti-military. On the contrary, we believe we owe it to our son to do what we can to effect the change that leads to a better, stronger, and safer military. We actually want to help.

I repeat, what happened on July 30 was no "mishap." It was yet another example of what should be expected under any institution that is allowed to self-police and self-punish, allowed to deflect blame away from those at the top, all while hiding behind an antiquated law that protects it from the accountability of answering legally to those that it recklessly harms.

No possibility for a day in court, resulting in our troops becoming second-class citizens the moment they swear in. Yes, I am speaking of the Feres Doctrine. And I would argue that its existence is what will continue to foster this culture across all the military branches where medical malpractice, sexual assault, and training deaths that far outpace combat deaths will continue to plague our precious troops and the civilian families that love them.

To the Marine and Navy command [inaudible] our sons down, as well as the subcommittee members questioning them today, my

wife wants me to ask this: What if your son or daughter was on that AAV?

Our son will never come home. Look, how do we keep other families from suffering this unbearable pain? Please don't allow our nine sons to die in vain.

Thank you.

[The prepared statement of Mr. Vienna can be found in the Appendix on page 47.]

Mr. GARAMENDI. Mr. Vienna, thank you very much for your testimony, and we certainly attempt to understand the depth of your sorrow.

I would like now to turn to Peter Ostrovsky.

Peter.

STATEMENT OF PETER OSTROVSKY, FATHER OF MARINE LCPL JACK–RYAN OSTROVSKY

Mr. OSTROVSKY. Chairman Garamendi, Ranking Member Lamborn, and distinguished members of the Subcommittee on Readiness and noncommittee members, on behalf of my entire family, thank you for the opportunity to speak with you about our fallen son, Jack-Ryan Ostrovsky, who was a lance corporal and 20 years old when he drowned with eight other Marines and a Navy corpsman during a preventable AAV incident off of San Clemente Island, California.

Our son, Jack-Ryan, and his fraternal twin brother, Samuel, were born prematurely at 26 weeks and were hospitalized for 2½ months in the neonatal intensive care unit, along with another month in a local hospital nursery, before they came home to us. They were both fighters from the get-go.

My wife, Lynn Ostrovsky, gave up her career as a flight attendant with a major airline to be a stay-at-home mom. I am a retired Federal law enforcement officer who dedicated 31 years of my professional life to service with the Treasury Department and the Department of Homeland Security.

As a teenager, Jack-Ryan was a very loving boy. He loved swimming, mountain biking, hiking, snowboarding, marksmanship training, and military history.

A year after graduating from high school, and after we moved as a family to Bend, Oregon, Jack-Ryan decided to enlist in the Marine Corps. He told us that he wanted to serve his country and do things that he could not do in the civilian world. He wanted to start at the bottom as a grunt and become a Marine Corps rifleman.

Jack-Ryan loved being a Marine, and we loved that he loved being a Marine. With only 13 months of service, he was already talking about reenlisting and his dream of pursuing a billet in special operations and making the military his lifelong career.

We will always be proud of Jack-Ryan. He followed in the footsteps of his great-grandfather, Bill Fischman, who served in the Navy, and his grandfather, Jack Fischman, who served in the Army, along with becoming the first Ostrovsky to serve in the U.S. military.

His commanding officer described Jack-Ryan as a future leader and a standout who would seek out fellow Marines that were struggling and offer them a kind word and a smile.

A week before the AAV incident, Jack-Ryan told me about his concerns with the AAVs and that, "They sink all the time." It was hard for me to believe that statement, but now I know there was more to the story that was the basis for his concern.

The loss of Jack-Ryan has destroyed our family's future plans. Jack-Ryan was supposed to be the next leader of our family, who was going to create his own legacy of success through his military career. We were looking forward to watching Jack-Ryan build a family of his own and blessing us with grandchildren. Jack-Ryan was also supposed to look after his brother Samuel, who has suffered from a life-long educational disability.

When the Marine Corps briefed Lynn and I on the results of the investigation, we were shocked and disappointed by the top-down recklessness, gross negligence, and lack of duty of care for our son and all of the Marines and sailors in his AAV company.

While reviewing the investigation report, many issues stood out to me that are a cause for concern and questions, namely:

Why were dead-lined AAVs, deemed to be in poor condition and not seaworthy, assigned to a unit that would be deployed as America's maritime response force?

Why did my son's AAV company not initiate any of the relevant prerequisite egress training which would have better prepared him and the others for such an emergency?

Why did the pre-exercise confirmation briefing and its sections of risk to mission and risk to force not mention any of the waterborne risks associated with utilizing AAVs that were in poor condition and embarking Marines that were not adequately trained?

But yet, the only identified risk was assessed to be "unlikely to occur" and was that there could be "a casualty to the assault force during embarkation/debarkation operations" on San Clemente Island and onboard the USS *Somerset.*

As an experienced Federal investigator who has planned, conducted, and approved many high-risk law enforcement operations, the lack of detail in the briefing tells me one of two things: Either it was intentional as an alleged cover-up for the lack of readiness, or the exercise planners were not qualified to appropriately assess risk, or perhaps both.

In my opinion, the entire AAV company was placed at extreme risk due to poor equipment, inadequate training, and a poorly coordinated and monitored unsafe training exercise.

We expect that the Marine Corps and Navy hold accountable, from top down, all those who are responsible for this preventable catastrophic incident, through all of the means that are available at their disposal, and with transparency.

We also expect that U.S. military systems of accountability and liability be modernized as a way to ensure that every day, moving forward, military officers fully appreciate and know the realities of their burden of command, so that there is no place for recklessness and gross negligence in the U.S. Marine Corps and the U.S. Navy.

Thank you.

[The prepared statement of Mr. Ostrovsky can be found in the Appendix on page 54.]

Mr. GARAMENDI. Thank you very much.

I want to express my deep appreciation and sympathy to our two presenters. In your presentation, you not only spoke to the loss that you have had, but you also spoke to the challenge that the Marine Corps has to create a culture of safety.

I am going to forgo my own questions and would ask my colleagues to keep their questions short. And really, I want to get as quickly as possible to the issues that our two witnesses have presented—the problems that the Marine Corps and the Navy exhibited in this tragedy.

However, the gavel sheet is as follows. I am going to withhold my questions. Mr. Lamborn, Mr. Courtney, Mr. Wilson, and then back to Ms. Speier, in that order.

So, Mr. Lamborn, I turn to you.

Mr. LAMBORN. Thank you, Mr. Chairman.

And to the two fathers and any of the other parents who are also in this hearing, obviously, your two sons were among our Nation's finest. There is no question about that.

And we owe it to you to get to the bottom of this so that you could take solace in the fact that the end result of this will be that these kinds of accidents will be more prevented in the future than would have otherwise been the case. And there is some solace in that.

I will just ask one very brief question per what you just said, Mr. Chairman.

Do either of you have a comment on the lines of communication that you had with the Marine Corps after the incident up until today, any comments that would be helpful to us to know about? And you will have to unmute your computer.

Mr. VIENNA. Speaking to that direct question, I can tell you that we have filed some complaints about some of the things that we experienced working with the Casualty Office, through our Navy Casualty Office.

I would just suggest that in the future they take a look at what kind of aptitude a person would have that is going to be assigned to walking a family through this type of madness. I have expressed those concerns, and I believe they are starting to be handled. I won't go into detail.

But also, with an investigation like this, we are talking about finding out that your son has passed away, starting to get—and not hearing anything back other than, "Yeah, we don't know what to tell you. The water was [inaudible] that day and it just started taking on water and it sunk very rapidly." That is basically the story we got.

And then bits and pieces started to come out where there are questions, but there are 9 months of silence from the other side. It is maddening for a family.

And then to have them show up at your home 9 months later and drop a 2,000-page report in your lap and tell you that they are sorry and then leave you to navigate that and these nine families to navigate that after the fact was very difficult.

And I can tell you that we pretty much relived it. It is as if, going through being notified, that your son was killed twice. But now, with the second time, there is the confusion and anger and this drive to try to fix it.

So that is kind of where we are left. This investigation took quite some time.

And I don't doubt that the gentlemen that came, the colonel and the lieutenant colonel that came to our house, were sincere and wanted to help. In fact, the colonel that came and presented to us told us that one of the reasons he was chosen was he was going to be leading [inaudible] and he needed to learn. That is great.

They proceeded to tell us about what they were going to do to fix these specific problems. And my answer was this: Thank you. I am glad you are going to try to fix these specific problems. But what about all the other mishaps? What about all the shoddy equipment? What about all the other nontraining that is received and terrible decisions that are made? How are you going to fix that?

The reality is this issue is a cultural issue. It is a nonsafety cultural issue within the Marines and, obviously, partly in the Navy as well. I think it goes across all military branches.

Mr. GARAMENDI. Mr. Vienna, that is precisely what this hearing is going to try to accomplish.

Mr. VIENNA. Thank you.

Mr. LAMBORN. Mr. Ostrovsky, I don't know if you have anything to add.

Mr. GARAMENDI. You may answer the question.

Mr. OSTROVSKY. Yes, I do.

Our experience was different. Our casualty assistance calls officer, who is a Marine first sergeant from the Reserve Center in Springfield, Oregon, did a great job. I think he is a highly seasoned and qualified Marine, very empathetic, very sensitive to our needs. So we did have a positive experience with him. So we do appreciate that.

But we do recognize that that job is hard. I am sure it is. For the first sergeant that we worked with, it was the first time that he had to do a casualty assistance call, and he did a great job. So we very much appreciate him and everything that he has done for us.

Thank you.

Mr. LAMBORN. Thank you.

Mr. Chairman, I yield back the balance of my time.

Mr. GARAMENDI. Thank you.

Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman. And I just want to join you and Doug in thanking our two witnesses this morning.

And I just want to share how much I appreciate the powerful testimony that you presented this morning and I think challenged all of us on this subcommittee and full Committee of Armed Services to do more, in terms of action.

I would just want to share with you that, unfortunately, this has not been the first time that this subcommittee has experienced a hearing like this. And I chair the Seapower Subcommittee. We jointly did the investigation and followup in the wake of the *Mc-*

Cain and *Fitzgerald* collisions that took place in [2017]. There were at least a half dozen hearings which occurred in the wake of that.

And I want you to know that as a result of that, there actually were structural statutory changes that were made in terms of the surface fleet deployment system. We put safety measures, safety brakes into the law.

Again, Senator John McCain, it was actually one of his final milestone moments when he chaired the Senate Armed Services Committee, and we worked together on the conference committee. We put 17—excuse me, it was almost 50—statutory changes in terms of just the way decisions were handled, in terms of deploying ships for sailors that were not certified and fully trained up, and equipment that was not ready. It did not extend to the type of deployments that we are discussing here today.

But I want you to know that we actually have the ability to make real change in terms of the National Defense Authorization Act [NDAA]. And I know Chairman Garamendi and Doug and certainly in Seapower [Subcommittee], we are going to do everything in our power to make sure that these hearings and your testimony actually is going to result in real action, tangible action, in the wake.

And I just want to just finally note that, Mr. Vienna, pointing to the Feres Doctrine, thank you for raising that issue. I think that is an antiquated part of the law that goes back to a Supreme Court decision in the 1950s, which really needs to be updated and modernized, as Mr. Ostrovsky said.

I mean, we need to really as lawmakers make some real modifications and changes to the system to reflect the complexity of the technology and, frankly, some of the overuse of outdated equipment.

So thank you to both of you.

And with that, Mr. Chairman, I would yield back.

Mr. GARAMENDI. Thank you, Mr. Courtney.

Mr. Wilson.

Mr. WILSON. Thank you, Chairman John Garamendi and Ranking Member Doug Lamborn, for convening this extraordinarily important hearing. And I am just so grateful that we have the witnesses before us today.

I want to thank you, both of you, Mr. Vienna and Mr. Ostrovsky. Your testimony is heartfelt, and what a tribute to your sons, and your families should be so proud. I am grateful for both of you being here today and with your families. And no service member should have a similar example of loss of life as we have heard today.

As the father of four sons who have served in the Armed Forces—one is still in the Navy right now—I particularly identify with what has occurred. And then I want to assure you that I look forward to working with Chairman Garamendi, with the ranking member, Doug Lamborn, on whatever we can do to assist you.

In fact, sadly, I have had personal loss in the military. A former congressional staff member of mine, Marine Lieutenant Colonel Trane McCloud, tragically was killed in an accident in Iraq in 2006. And then, in 1978—it still has affected our family—my late

brother-in-law, Marine Captain Tim Dusenbury, was killed in a helicopter accident in Greece.

And with that, a question for Mr. Vienna and then Mr. Ostrovsky. And it really is parallel to what Ranking Member Lamborn has asked.

But were there shortfalls in the information provided to you? And I know, Mr. Ostrovsky, that you indicated that there should have been more transparency.

But on the notification to you, the backup for the arrangements for the funerals, the notification to every family person possible, were there shortfalls?

And then is there anything—again, this is so bipartisan—whatever we can do to address it.

Beginning with Mr. Vienna.

Mr. GARAMENDI. Mr. Vienna, you have to unmute. You are still muted, sir.

Mr. VIENNA. Hello?

Mr. GARAMENDI. Good to go.

Mr. VIENNA. Okay, thank you. I apologize. I am pressing over and over again the mute button/unmute button, and it is just not working well for me.

I am trying to understand the question in regards to our notification and funeral arrangements and those kind of things. They go directly to some of the issues that we did have with our CACO [casualty assistance calls officer] situation.

For example, we had planned the funeral for Saturday. We were told his body would arrive 4 days prior to that from Dover. It didn't come until that day, so we had at the last minute, had to change our funeral plans, move them back a day. And we had 650 people at the ceremony. It was extremely difficult.

Also, they could not seem to coordinate flights to try to make the memorial in San Diego, and we were, in the end, we were going to miss it. There was just no way, because it was also the same day that our son's body was supposed to be arriving now from Dover that evening, and the funeral was the next morning. It was chaotic.

And we ended up having a—there was someone with money here in our community that heard about it and ended up flying us there on his private jet in order to get to San Diego, attend the memorial of all nine boys, which I am so glad we didn't miss, and fly us back in time to then go to San Francisco Airport with our son and have that procession ceremony.

We didn't get him into the funeral home until midnight, and the very next morning we had to do the funeral. So it was very rushed, and it was due to ineptitude in being able to get these schedules squared away for us.

So I believe that is what the question was. I don't want to go on a tangent about these issues. I wanted to—fixing what happened so that other——

Mr. GARAMENDI. If I might, Mr. Vienna, thank you very much.

Mr. Wilson, your time has expired.

Mr. WILSON. As I conclude, I would like to thank Mr. Vienna. That was specific, and we need to address those.

Thank you. And I yield back.

Mr. GARAMENDI. These questions that we have received from the members and the responses indicate that there is a series of issues that need to be dealt with, with regard to family notification, and we will get into those in detail.

I am going to now turn to Ms. Speier, who actually heads up the [Military] Personnel Subcommittee. And this particular problem is an issue that I know she wants to deal with.

So, Ms. Speier, if you would.

Ms. SPEIER. Thank you, Mr. Chairman, and to Ranking Member Lamborn.

Let me just say to you, Mr. Vienna and Mr. Ostrovsky, we have had extensive conversations. Your testimony today shows the palpable pain that you have endured.

And I agree with you, we can no longer use the term "mishap." I don't care if it has been the term used historically. It is offensive to the families who lose their children because of either dereliction of duty or gross negligence or because it is an accident. It is, in fact, not a mishap.

And to your point, Mr. Vienna, you know that we have made some changes. The Feres Doctrine is not law. It is a Supreme Court decision on which we have relied on. We should do more than we have done, although we have provided, over the course of 10 years, $400 million to deal with claims by service members who are victims of medical malpractice at medical facilities.

I think we need to expand that to deal with gross negligence in situations like this. And we will have to discuss this as part of the NDAA. There is a hefty price tag that comes with it, of course, but the lives that are lost are real lives.

So I want to thank you both for your extraordinary testimony. We are not going to rest until people are held accountable and that we can make sure that this kind of conduct is not tolerated, because it was conduct at the highest levels that allowed these AAVs to be deployed.

Mr. Ostrovsky, I would just like to give you the floor to add any other recommendations that you would like to make sure that we deal with as it relates to these casualty officers and their interactions with the families.

Mr. OSTROVSKY. My comment with regard to transparency relates to the fact that when the press release came out that the MEU [Marine Expeditionary Unit] commander was relieved, which was the day before we received our briefing on the results of the investigation, that press release mentioned that administrative and other action was taken against 10 others that were found to have some kind of responsibility, yet it didn't tell us what kind of action was taken.

So when you use that term "administrative action" without any detail, it makes you wonder what is the real action. And I understand that you can't name names, the Privacy Act. I was a Federal employee myself for quite some time, so I am familiar with that.

But at least I think it would be helpful to the families to know the type of administrative action that was taken, because it could be anywhere from a day off without pay to months off without pay or reduction of rank or whatever. So I think it would be helpful in

the future to have some more detail as to the type of action without naming names.

Ms. SPEIER. Thank you, Mr. Ostrovsky.

I think it is also important for us to appreciate that when persons are ostensibly fired, they are not really fired as we think of it in civilian society. They are transferred. And I think we have to take a hard look at whether or not we want people in leadership in some other unit who have made the decisions they made in circumstances like this.

Mr. Chairman, I yield back.

Mr. GARAMENDI. Thank you very much, Ms. Speier.

The gavel order is as follows: Mr. Bergman, Ms. Slotkin, Mr. Johnson, and then it would be Mr. Levin.

Mr. Bergman.

Mr. BERGMAN. Good morning, everyone. You notice I am flying the Marine colors behind me here. It is a small way to express my feelings of your loss.

There are no good casualty officer calls. In my time in command, we did too many of them. But I can just say to you, I don't care what side of the aisle our members are on on this committee, we will take an attitude of holding everyone accountable, including ourselves. There are no free passes here. And there is no excuse for bypassing safety when it is in a training environment.

And I will just end it with that, because that is what I believe. And I know many of my colleagues here on the committee believe the same thing. We will do everything that we can to ensure that this does not happen again.

With that, I yield back.

Mr. GARAMENDI. Thank you, Mr. Bergman. You always remind me not to mention your past service in the military, so I won't do that. But you certainly understand.

Ms. Slotkin.

Ms. SLOTKIN. Good morning, everyone.

You know, unlike some of my peers, this is the first time I have actually been in a hearing where we have heard from parents of folks who have been lost. And I have a stepdaughter in the Army, so your testimony was extremely relatable and powerful. And I am so, so sorry for your loss.

I guess my question is, on the accountability side, maybe starting with Mr. Ostrovsky, what was the official reason the Navy—I am sorry, the Marines, said to you in this large report that you both received for the reason why the craft was allowed out when not being certified for seaworthiness? What was the official answer to that?

Mr. OSTROVSKY. I think, as I recall, if I recall the details of the report, is just that it was a matter of assignment of the equipment. There was assignment of equipment in poor condition, equipment that was dead-lined.

You know, the other side of it is the lack of training. Not even initiating the appropriate relevant training is the cause.

And I would say that one thing to say is that when you look at gross negligence and recklessness by a military officer, there is nowhere in a military manual or training that conducts recklessness or gross negligence. And I would say that when somebody behaves

in that fashion, they are outside of the scope of their duties, and they should bear that responsibility or that liability for being outside of the scope of their duties.

Now, whether the U.S. military wants to somehow indemnify them or take that liability on, but that liability exists. They are outside of the scope of their duties. There is no way that it can be said, especially in a training environment, that that kind of behavior is acceptable.

And I am sure there are many military officers that would echo what I am saying in saying that it is not to be tolerated. It is substandard.

Ms. SLOTKIN. Yes. Mr. Chairman, I would just say that is something I know I personally don't know enough about, but I think might be worthwhile looking at is sort of the responsibilities of someone when they are acting outside the scope of their responsibilities. I know it is a topic we talk about on other issues, but I certainly would be interested.

And, Mr. Vienna, you said that you were here because you wanted to make sure this didn't happen to other families, and I appreciate that.

Can you tell me what the Marines said to you about what they were going to do to make sure such mistakes don't happen in the future? Did they give any sort of positive action they were going to take?

And just remember to unmute.

Mr. GARAMENDI. Mr. Vienna, you are still muted.

[Problems with mic.]

Mr. VIENNA. So in talking about some of the exact issues, one thing that they had pointed out was they were no longer going to have the AAV commanders making decisions to splash, that that should come from a platoon commander or an AAV platoon commander higher up. You know, some very specific things that were going to change. Safety boats would now be absolutely in the water. Things like that.

But what is disheartening to me is there was an article that came out by a retired colonel, Walt Yates. He just retired about a year ago. And I spoke with him for about an hour and a half yesterday. And he alerted us that on August 15, 2017, there was a similar mishap—well, not a similar mishap. It was a helicopter accident, where it crashed off the side of one of the ships, fell into the water. And the reasons given for the three deaths in that investigation was lack of training, lack of egress training.

That is in 2017. Those parents went through the same thing we are going through. They were told that their sons or daughters would have survived had they only gotten the proper training. We are now at 3 years, 4 years later, and we are still in the exact same position that we were before.

And what it boils down to and the reason why this really goes all the way up to the top is that where that comes from is really money. It is budget acquisitions. It is the people up at the very top, and I am talking about the assistant commandant level, that decides what does and doesn't make the budget.

What ends up happening is lethality gets chosen over safety.

Mr. GARAMENDI. Mr. Vienna.

Mr. VIENNA. Yes.

Mr. GARAMENDI. Mr. Vienna, excuse me.

I am going to have to take a little bit of control of this. We are now nearly 50 minutes into the 2 hours that we have available for our hearing. And I know that there are at least five more members of the committee that would like to ask questions.

I would ask my committee members and others to not seek the same answer again. The questions that Ms. Slotkin, you asked, we want to specifically ask, as Mr. Vienna just said, the assistant commandant that question: Why, after all of these years, after all of these accidents, the Marine Corps is still not properly training its men and women.

So, Ms. Slotkin, your time has expired.

Mr. Vienna, thank you very much for your comments.

I am instructed that all members have the opportunity to ask questions. If the question has already been asked, then please move on to another question.

The gavel order is Mr. Golden, Mr. Moore, Ms. Strickland, Mr. Moulton, Mr. Levin. And I will assiduously follow the 5-minute clock and interrupt as necessary. So thank you very much.

Mr. GOLDEN. Mr. Golden, you are on. Mr. Golden. We will come back to you, Mr. Golden.

Mr. MOORE. Mr. Moore, you are up. Hello, Mr. Moore.

We will return to Mr. Golden and Mr. Moore should they come back on.

Ms. Strickland, it is your 5 minutes.

Ms. STRICKLAND. Thank you, Mr. Chair.

To Mr. Vienna and Mr. Ostrovsky, I just want to express my deepest sympathies. And there is nothing like losing a child, especially when they have signed up to serve our country. So I am very sorry for your loss.

There was something that Ms. Speier said earlier that really struck me, and it is the way we use the term "mishap." And as we talk about moving forward, I want to make sure that we take a look at the term "mishap," because to me it trivializes what has happened to these young people.

With that said, very briefly, I have a question for each of the gentlemen who just testified.

There are a lot of things that we need to do better—accountability, investing in equipment, keeping it up to date. But if there was one thing that we could do as far as legislation goes or making an investment, what would you like to see us do to help give you some solace and rectify this issue so that other families don't suffer?

Mr. Vienna.

Mr. VIENNA. Am I unmuted?

Ms. STRICKLAND. I can hear you.

Mr. VIENNA. Okay, great.

I would say carve out something within the Feres Doctrine that doesn't allow gross negligence.

In a situation like this, where there were as many issues as there were, we can't call it anything other than gross negligence.

And when it reaches that level, you don't want to have these little lawsuits here and there for frivolous things. I understand that. But in a situation like this, there needs to be accountability.

And without accountability, this is just going to continue, and we will be watching in 3 or 4 years another hearing about lack of training and shoddy equipment and all these things. It is just going to recycle itself.

Ms. STRICKLAND. Thank you, sir.

Mr. Ostrovsky.

Mr. OSTROVSKY. Yes, I would seem to agree with Mr. Vienna.

I think the importance of modernizing the system of accountability and liability is that on the front end, military officers will comport themselves appropriately if they know on the back end, if they do something outside of their scope, they will be held liable.

So it is really all about the front end, so that this never happens again, we don't find ourself in these situations.

Thank you.

Ms. STRICKLAND. Thank you, gentlemen. And, again, my deepest sympathies.

Mr. Chair, I yield back.

Mr. GARAMENDI. Thank you, Ms. Strickland.

The gavel order has been modified a little bit here. So if the members would—here is the new order: Mr. Johnson, Mr. Kahele, Mr. Moulton, Mr. Levin.

Mr. Johnson, you are up. My apologies for skipping over you a moment ago. Mr. Johnson.

Mr. JOHNSON. It is fine, Mr. Chairman. I am going to yield to allow more time so we move on. Thank you.

Mr. GARAMENDI. Thank you, Mr. Johnson.

Mr. KAHELE. Please unmute, Mr. Kahele. You are up.

Mr. KAHELE. Same here, Mr. Chair. Thank you so much. Aloha from Hawaii——

Mr. GARAMENDI. I am afraid you just remuted yourself. You are good.

Mr. KAHELE. Thank you, Mr. Chair. Aloha from Hawaii.

And I just want to thank both of you testifying today for your cooperation.

But I will yield my time to the others that I know have questions that they have. Thank you, Chairman.

Mr. GARAMENDI. Thank you, Mr. Kahele.

Mr. Moulton.

Mr. MOULTON. Thank you, Mr. Chairman.

Gentlemen, I can't imagine your loss. And I am deeply affected by your testimony here this morning. I know it is not easy, so thank you very much for coming and sharing it with the committee.

As a Marine veteran of 1st Battalion, 4th Marines, this is a situation that I know well. I spent a lot of time in an AAV, including in waterborne operations. That is how we got into Baghdad in 2003. I can tell you we sat on the roof, because we were afraid it would sink.

So there is a lot of work here to do. And as a Marine veteran, as a veteran of AAV operations and of MEU operations, I can

promise you that I will do everything I can to get to the bottom of it.

Thank you.

Mr. Chairman, I yield back.

Mr. GARAMENDI. Thank you, Mr. Moulton. Indeed, we will lean on you for your expertise and experience as we deal with these issues.

Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman, thank you, members of the subcommittee, for allowing me to waive on.

I also wanted to say thank you to Mr. Vienna and Mr. Ostrovsky just for being here today under these incredibly difficult circumstances. Thanks for being here on behalf of your sons, your families, and the other families who are suffering in the aftermath of this tragedy.

It is incredible to see your strength on behalf of your sons as you tell their story and as you work to effect change so that no parent has to go through your experience in the future.

I am here today because I proudly represent the service members and their families at Camp Pendleton. If you have ever been to our region, to North County, San Diego, or to South Orange County, you know how much the base and the men and the women who serve there mean to our region.

Our Marines and sailors define us. They define our communities. They come from all across our country to answer the call of service and to protect our Nation, our values, and our way of life. And the fact that they do it right down the street, that makes us incredibly proud.

Many service members, as you also know, stay in our area when they transition back to civilian life and they make our communities stronger. And it makes me incredibly sad hearing about your sons and reading about the other Marines we lost to think about the pillars of the community that they would have been. And I know our communities would have wanted to have them stay here in San Diego.

So I am so sorry for your losses. Your sons were inspirations. Their legacies continue to be. And, with that in mind, I know that my colleagues, and myself included, we are going to do all we can to uncover the facts of this tragedy to ensure it is not repeated.

Thank you, Mr. Chairman. I yield back.

Mr. GARAMENDI. Thank you, Mr. Levin.

I want to give a very special thank you to our two witnesses today. These are two of the nine families that have lost their sons in this accident. And so for the Baltierra family, the Barranco family, the Bath family, the Perez family, the Rodd family, the Sweetwood family, and the Villanueva family, our sympathy goes out to you. Our prayers go out to all of the families who have suffered so much.

The testimony we receive today gives us the direction and the desire to get at this problem. There is clearly a safety culture issue within the Marine Corps—and, unfortunately, we also find it in other services.

This committee will work diligently with the other subcommittees to address the issues that have been raised here, the issues

of notification when there is a loss, the issues of responsibility, as has been highlighted here several times.

And we are now going to recess this panel, and we will take a 5-minute break. And we will bring the Marine Corps Assistant Commandant to join us and the Navy C—and the Navy admirals to join us in the second.

So with that, this panel is recessed. We will return in about 5 minutes. And so if the membership would stand by as we change out here.

Thank you very much once again to our two witnesses, Peter and Mr. Vienna. Thank you so very much for joining us.

With that, we are in recess.

[Recess.]

Mr. GARAMENDI. We are back on the record with panel two of today's hearing. I understand that we have been able to get an extra half-hour here, so we will go until 1:30.

As I have stated before and it bears repeating, the tragic events of 30 July 2020 were preventable. As I reread the investigation in preparation for this hearing, I was once again gripped by the sense of dread associated with reading the details of the multiple systemic failures that led to the loss of nine service members in the prime of their life.

The Marine Corps failed—failed to adequately maintain the material readiness of the AAV fleet. The Navy and the Marine Corps totally failed to ensure that personnel were adequately trained to ensure that this exercise could be performed safely.

The Navy and the Marine Corps failed to effectively integrate with each other to ensure that roles and responsibilities were adequately or even minimally understood, and that there was someone—someone with sufficient seniority who was paying attention, monitoring the changing events, and constantly conducting and updating the risk management, the safety or the lack of safety.

The Navy and the Marine Corps totally failed to understand and to flag that after two decades of focusing on land-based combat the proficiency for amphibious operations may have been lost, may have atrophied, and that personnel needed additional training to conduct the exercise safely.

The leadership of the Navy and Marine Corps totally failed to account for the potential problems that COVID–19 would have on readiness of these units. They were so desperate, as they showed us, as they said in hearings, formal hearings, that not to worry, we have overcome the impacts of COVID and our readiness is not diminished. Gentlemen, that was not true, as tragically shown in this incident.

What is most upsetting to me is the failure of the Surface Navy and the Marine Corps to develop a culture of safety that would empower junior service members to alert the chain of command when there is a breach of safety protocols, to be heard, to not be ignored. We don't have to invent that culture. It does exist. It does exist in Naval Aviation and the Naval Reactors community. That culture needs to be in every part of both the Navy and the Marine Corps, and indeed the other services as well.

The Navy and Marine Corps leadership must make a decision. They must decide to not allow the status quo to continue. The 9

members of the Marine Corps—the 8 members in the Marine Corps and 1 member of the Navy that were lost were not the first; indeed, the Marine Corps has lost 60 Marines in training accidents in just the last 5 years, 60 in 5 years, and more than 130 in the previous 10 years.

There is an eerie echo here of the Marine Corps hymn. These losses have been in the air, on the land and sea. As Mr. Courtney said in his earlier statement, the Surface Navy is still struggling to adopt sustained cultural changes in the wake of the loss of 17 sailors on the USS *McCain* and *Fitzgerald.* We have passed laws, we have provided money, and these tragedies continue.

We have honored these nine members of our military with appropriate funerals and services. But I will say this, the only way to really honor their loss is that the Marine Corps and the Navy develop a culture of safety. This is not war; this is training. This subcommittee, and indeed the full committee, demands better.

I know that there are additional investigations underway, command investigations, and we will get to those with a subsequent hearing, and we will be focusing on the events specific to this tragedy and to what the Navy and the Marine Corps are doing to prevent it from happening again.

With that, I turn to my colleague and ranking member, Mr. Lamborn, for his opening statement.

Mr. LAMBORN. Thank you, Mr. Chairman, for having this hearing. Thank you for our witnesses for being here.

I am going to keep this short so we can get into your testimony and the give-and-take with questions afterwards in the limited time that we have, but I want to know in a broad sense, what is the Marine Corps doing to foster a better safety environment. Obviously, there were a number of issues of things that went wrong in this particular incident.

And, more specifically, I want to know what is happening with the proficiency for amphibious landings. Amphibious landings obviously were not a priority in our Iraq and Afghanistan conflicts in recent years, but with a pivot toward the Pacific it absolutely becomes a priority.

So I want to know about that in particular and with AAVs. You know, why are AAVs so decrepit and so poorly maintained? Do we need to buy new ones? Are they not being maintained in a good state of readiness? What is the issue there? So those are the things I want to hear about when we go through our testimony.

With that, Mr. Chairman, I yield back.

Mr. GARAMENDI. I will introduce our witnesses, and following their testimony, we will go through the normal gavel order of questions.

Joining us today is General Gary Thomas, Assistant Commandant of the Marine Corps; Vice Admiral Roy Kitchener, Commander of Naval Surface Forces; and Major General Gregg Olson, Assistant Deputy Commandant, Plans, Policies, and Operations, Headquarters United States Marine Corps. Gentlemen, your formal testimony will be put in the hearing record.

Mr. Thomas, General Thomas, would you please proceed.

STATEMENT OF GEN GARY L. THOMAS, USMC, ASSISTANT COMMANDANT OF THE MARINE CORPS

General THOMAS. Chairman Garamendi, Ranking Member Lamborn, and distinguished members of this subcommittee, thank you for the opportunity to appear before you today to discuss the sinking of an assault amphibious vehicle on July 30, 2020, and how the Marine Corps can improve its safety culture. Today, Vice Admiral Kitchener, Major General Olson, and I are prepared to answer questions about what happened, what we have learned, and what we are doing to enact change.

First and foremost, the sinking of this AAV and the deaths of eight Marines and one sailor were preventable, preventable in so many ways, but we failed. We failed these brave young men. The testimony that we just heard from the families represented here today is heartbreaking. We also mourn their loss and extend our deepest sympathy to their loved ones. Though it is little comfort to the families, we will honor their memory by taking the necessary actions to prevent a tragedy like this from ever happening again. We owe this to these service members and their families.

The command investigation provided sufficient detail about the direct causes of the AAV's sinking. However, I believe there is more that we can learn about how this incident occurred and how to prevent similar tragedies in the future. I have directed a general officer to conduct a follow-on investigation into the forming of the Marine Expeditionary Unit, including training and readiness oversight up to the Marine Expeditionary Force level. This investigation is in progress, and we will provide the findings to this subcommittee after Headquarters Marine Corps review.

We will also seek the counsel of a blue-ribbon panel of outside experts so that we can capitalize on the generations of amphibious experience that resides outside of our ranks. It is a Navy-Marine Corps imperative to train to standard for amphibious operations. Future operating concepts and the lives of our Marines and sailors demand that we increase our common understanding of the requirements for operations from the sea.

To date, 11 Marines have been or will be held accountable for their respective roles in this tragedy in accordance with applicable law and regulations. Some of these accountability actions are ongoing, including boards to consider separation from the service. We make decisions regarding accountability based on an individual's responsibilities and their performance of duties. An individual's rank neither obligates nor excuses them from accountability. As we learn more about this tragedy, we will take additional measures as appropriate.

More broadly, the Marine Corps recognizes that our historic ground and aviation accident trends must change course. Over the past few years, we have improved our safety reporting mechanisms, our information sharing and safety management practices.

As a result of these and other efforts, we are seeing a reduction in vehicle rollovers, and from 2019 to 2021, we saw our lowest aviation flight mishap rate on record. However, the 2020 sinking of this AAV and other recent accidents make it clear that the Marine Corps safety culture must improve and that Marines at all levels must make better risk decisions.

Every Marine must be empowered to assess risk and speak up when they see something unsafe. Commanders must provide the necessary oversight to mitigate risk and stop operations when the risk is too high. Commanders must also develop command climates that value and reward hazard reporting.

At an institutional level, we must provide the guidance and resources that support good decision-making. We also have to manage operational tempo so that our Marines and sailors have the opportunity to complete necessary training in a safe and productive manner.

We are committed to providing the leadership and resources to make these changes. We appreciate your oversight and continued support as we learn from our past and make lasting changes to our safety culture. We look forward to answering your questions.

[The prepared statement of General Thomas can be found in the Appendix on page 61.]

Mr. GARAMENDI. General, thank you very much.

I now turn to Vice Admiral Kitchener, Commander of Naval Surface Forces.

STATEMENT OF VADM ROY I. KITCHENER, USN, COMMANDER, NAVAL SURFACE FORCES

Admiral KITCHENER. Good morning, Chairman Garamendi, Ranking Member Lamborn, and distinguished members of the Readiness Subcommittee. I appreciate the opportunity to testify today.

I too want to begin by expressing my personal condolences to the families of our fallen Marines and sailor who served their country with pride and honor. This devastating loss underscores the very dangerous work our sailors and Marines perform each day in our All-Volunteer Force, and it once again reminds us of our solemn obligation to provide each service member an environment where risk is being properly managed. We are committed as a Navy-Marine Corps team to ensure that events such as this does not happen again.

I just listened to the testimony of Mr. Vienna and Mr. Ostrovsky about their personal loss and poor experience with the casualty assistant calls officer, or CACO, process. I spoke with Mr. and Mrs. Vienna before. Incredibly grateful that they were willing to share their experience with me. I am deeply saddened that the Navy CACO process did not work as it should have for this grieving family. I have reached out to my counterparts who oversee the CACO process, and they are reviewing what happened with the Viennas as well as any improvements that may result.

The Navy is committed to understanding not only how our actions may have contributed to this tragedy but also how we can better support families in the future. And I say that not only as a commander but also as a father of four, three of whom are serving in the military, including one enlisted Marine at Camp Pendleton.

Immediately following the tragic events on 30 July, the Navy and Marine Corps implemented a safety pause of AAV operations. The Navy has not resumed waterborne AAV operations and will not do so until we are satisfied that all necessary policies, procedures, and

risk mitigation measures are in place. Additionally, all commanding officers and well-deck teams will be trained to these new requirements and will have reviewed the specific lessons learned before AAVs embark a Navy ship.

The Marine Corps investigation discovered inconsistencies in the Navy and Marine Corps operating procedures and policies for waterborne AAV operations. I am working deliberately and urgently with my Marine Corps counterpart to look across the full range of Navy-Marine Corps integrated operations to ensure that our operating procedures are aligned, including a joint policy on the use of safety boats and clear lines of authorities during training evolutions. We are committed as a Navy-Marine Corps team to put sailors and Marines—to not put sailors and Marines at risk while we examine our integrated policies and procedures.

While the Navy fully supports the finding and recommendations of the Marine Corps investigation, the Marine Corps investigation did not fully address Navy actions on this fatal day. We are accountable as an organization and must fully address whether Navy action or inaction contributed to the incident and what changes to practice and policy we must make to recommencing waterborne AAV operations.

Accordingly, we initiated our own command investigation with a team of 16 Navy, Marine Corps, and civilian subject matter experts in areas such as planning, Navy and Marine Corps integration and training, and operational safety. Our investigation is expected to be completed within 30 days.

Professional seamanship is the standard with no exception. We owe that to the Marines and sailors in our care. It is in our culture to critically evaluate, then make and effectively implement necessary changes. Although we operate in a dangerous and demanding environment and will never be able to eliminate all risk, you have my word that we will, with great speed, provide you, the American people, and our Navy-Marine Corps team, with our critical assessment of our current procedures and our plan to best mitigate risk as we move forward with integrated amphibious operations to ensure this never happens again.

On behalf of all sailors, their families, and our Navy civilians, I thank you for your continued support and look forward to your questions.

[The prepared statement of Admiral Kitchener can be found in the Appendix on page 73.]

Mr. GARAMENDI. Thank you, Admiral.

I now turn to Major General Gregg Olson, Assistant Deputy Commandant, Plans, Policies, Operations.

STATEMENT OF MAJGEN GREGG P. OLSON, USMC, ASSISTANT DEPUTY COMMANDANT FOR PLANS, POLICIES, OPERATIONS, UNITED STATES MARINE CORPS

General OLSON. Thank you, Mr. Chairman. Thank you, Ranking Member, and other distinguished members of the subcommittee. As I make ready to answer your questions, let me note my deep sadness regarding this preventable tragedy. I have years of experience with amphibious assault vehicles, including my first tour as a 20-

something lieutenant. I can put myself in the place of these young men who were counting on others to keep them safe.

I have done my underwater egress training, and I know the fear and disorientation that results when you are rapidly submerged. I also know the value of the training in saving lives. Every time I review the details of this tragedy, I am struck by its senselessness. My heart goes out to the families of the young men who died, and I especially appreciate the bravery of the two witnesses who testified in the previous panel.

As I answer your questions, please do not mistake my matter-of-fact tone for any lack of empathy. I am simply trying to keep my emotions in check. I look forward to your questions.

Mr. GARAMENDI. Thank you, General.

I have a document dated March 26, 2021, and it is signed by General Thomas. It speaks to the issues at hand and to what the Marine Corps is specifically doing to address the tragedy and the failures that occurred in this incident.

Point number eight, General Thomas, you said the loss of these eight Marines and one sailor was a preventable tragedy. You went on to say, we mourn the loss of their lives and share their families' enduring grief. The Marines and sailors who died made the ultimate sacrifice while serving their fellow Marines and the Nation will never be forgotten.

General Thomas, those words need to be followed up by action. You have laid out seven specific actions that the Marine Corps intends to take. In our communication prior to this hearing, I told you that the construction industry in the United States has instituted a safety officer always on site, always there to review and with a whistle to stop the construction activity if something is not safe.

I recommended to you that the Navy should consider such a safety officer on all risky operations. As I look at the seven recommendations that you have made, I don't see an opportunity in any of those for someone to blow the whistle and call timeout. Clearly, that could and should have happened in this tragedy, but it didn't.

I want to hear from you how you can assure us that the issues of safety will be paramount in exercises. General Thomas, what assurances can you give us that your seven recommendations will lead to someone having the power to blow the whistle and stopping the exercise until safety can be assured?

General THOMAS. Thank you, Chairman. The first thing that I would say is that—and you have alluded to this, this is, our safety culture has got to improve. All Marines need to understand that a safety culture or a culture of excellence is integral to mission success.

I share your view on making sure we have adequate oversight, and we are looking at adding additional safety specialists at the right place to ensure that our exercises are as safe as they possibly can be. That, in addition to safety protocols, are the types of things that are required to get our safety culture where it needs to be.

I would point out that no one person is able to see all the intricacies of an exercise, and so equally as important as to having the right people with oversight is to, as you alluded to, Chairman, em-

powering Marines to stand up or speak up when they see something that is unsafe and for them to be heard, and then for leaders at all levels to provide necessary oversight to mitigate risk and then to stop operations when that risk is too high.

I would tell you, Chairman, that in all the exercises that we do across the Marine Corps every day, every exercise at some point Marines are standing up and pausing operations, and that is exactly what we need to do in this case, which is where we failed in this particular exercise. But we are taking a hard look at that, Chairman, and we will keep this committee informed as we go forward.

Mr. GARAMENDI. I am going to forgo additional questions. I suspect most of the questions will be asked by my colleagues that I would have asked, so I am going to turn it over to Mr. Lamborn. But before I do, I think the number is 137 Marines that died in various accidents, training accidents over the last decade, 60 in the last 5 years.

Mr. Lamborn, it is your turn, 5 minutes.

Mr. LAMBORN. Okay. Thank you, Mr. Chairman.

Mr. GARAMENDI. Excuse me, Mr. Lamborn, you are now recognized for 5 minutes.

Mr. LAMBORN. Okay. Can you hear me okay?

Mr. GARAMENDI. Yes, please, go ahead.

Mr. LAMBORN. And, Mike Johnson, you may want to mute, Mike Johnson.

Okay. General or Admiral, whoever wants to take this question, obviously there were some real deficiencies with the training regime that was in place that were not followed or should have been followed, shouldn't have been in place. But also when it comes to the equipment and the AAVs in particular, it seemed like it was a disaster waiting to happen.

These AAVs were taking on water, the bilge pumps weren't able to keep up, the batteries weren't sufficient. There were a lot of specific things that were wrong with these AAVs, and a subsequent inspection found that many of them failed. I believe the majority, once they were inspected, failed inspection and should not be used.

So what will the Marine Corps do with the need for better AAVs in the future? This is something our subcommittee, besides the training aspect, is going to want to look at. So what is the best insight you can give us on how to get to a better state where we have AAVs that are good for training and actually good in actual conflict? Thank you.

General THOMAS. Congressman, I will start and then I will turn it over to General Olson. But let me be clear, the AAV platoon should have received vehicles in a higher state of material readiness than they did. These are old vehicles, but they are broadly well understood of what is required to keep them up, although we have learned some things since the mishap that General Olson will describe. But we will—I assure you, we will fully resource any requirement to keep this vehicle in a high state of material readiness until its sundown in 2026.

Let me turn it over to General Olson for any additional fill-in.

General OLSON. Ranking Member Lamborn, you are 100 percent correct, sir. These vehicles were delivered in, as the investigating

officer notes, horrible condition. Twelve of the thirteen were inoperable on the 20th of April. All should have been ready for both land and water operations.

The AAV platoon mechanics, augmented by three mechanics from the parent battalion, did return them to condition code for land operations in time for a land-only mechanized rate course. By the time they got onboard ship, they had been returned to what we thought was waterborne capable.

What we found in our subsequent inspections, after safety review's message came out on the 31st of July, was that we had a problem across the fleet with our watertight integrity. Some 54 percent of the vehicles that were inspected had failures in the watertight integrity of their plenum doors. That is the large intakes on the front that permit air to come in and out of an engine that is underwater. Eighteen percent had cargo hatches that were leaking in excess of what they should have been, and fully 50 percent had inoperable emergency escape lighting systems. There were other discrepancies as well.

None of those vehicles are permitted back into the water until they are returned to operable condition. The watertight integrity testing regime has been instantiated into our technical manuals and into our technical instructions. We had not been inspecting to the level of detail necessary to determine these discrepancies.

As Chairman Garamendi noted, it may have been that 20 years of land-road operations have caused us to lose some of our amphibious edge. To that end, we are moving out on a detailed watertight integrity regime that will ensure that no vehicle goes in the water without being watertight and integral.

You are correct about the bilge pumps. There are bilge pumps on every AAV that can expel water at a rate far greater than typically enters. AAVs leak, but the 400-some-odd gallons per minute that they can pump over the side should have been sufficient in this case; in this case, it was not. The vehicle had far greater mechanical degradation than we knew of.

And when the transmission failed, the hydraulic bilge pumps failed. When the transmission failed, the engine went to idle and ceased charging the batteries. And then when the engine compartment itself filled with water, the generator failed, and effectively, the vehicle was without power.

We know we have things to fix, and we know we have a glide slope to 2026 when the amphibious combat vehicle [ACV] will be fully operationally capable. In the meantime, we will continue to sustain and fund the AAV fleet, to include finishing off the return to condition code alpha [RCCA], to think about sending a vehicle back for depot-level maintenance and its return to you in like-new condition.

While even though inspections of the RCCA vehicles learned that we have a watertight integrity issue that must be addressed, we will make these vehicles watertight, and we will not put them in the water unless they are so.

Mr. LAMBORN. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. GARAMENDI. The gavel order is Courtney and Wilson and then we will have additional. I note Representative Moulton, when

he spoke earlier and talked of his own experience with the AAV and their rocky situations, that he and his colleagues sat on top fearing being unable to get out if they had to, if they were inside. We will come to you, Mr. Moulton, a little later, and I suspect you will want to talk about that.

Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman, and thank you to the witnesses.

Admiral Kitchener, in 2017, we had the two collisions in the Indo-Pacific region, *Fitzgerald* and *McCain.* And after that, CNO [Chief of Naval Operations] Richardson ordered a complete comprehensive review, and that was in addition to all the normal investigations which we have already heard about this morning for this incident.

And, but the point of the comprehensive review was really to look at structural changes in terms of the whole decision-making for sending large surface ships out in the Pacific region where, again, the operations commander was kind of overruling or, you know, just overriding any concerns regarding training certifications, ship readiness. And clearly, there was this string of completely unacceptable accidents and loss of life that was identified as flowing from it.

Again, the CR, the comprehensive review, ended up with a large number of recommendations. You described a command-level report that is in the works right now that we are going to get back within the next 30 days or so. Is that what that is looking at? Is that looking, again, not just at the specifics of who is responsible but really the structural system that is in place in terms of sending AAVs out that really are not safe?

Admiral KITCHENER. Representative Courtney, thank you for the question. The Navy cooperated fully with the Marine Corps and the investigation and provided access to, you know, records, logs, and many witnesses. And when we reviewed the investigation we agreed with the fundamental conclusion that is there were no causal factors attributable to the Navy. However, what we did find left a few questions unanswered. And what we are—so we decided to open our own investigation to understand, you know, what actions and decisions that Navy personnel made that day could have contributed to the tragedy and then what policies and practices may be required and must be improved.

So we stood up a team of 16 people that is made up of Navy, Marine Corps, and civilian personnel, and we specifically asked them to look at the actions of the personnel that day and the planning and the approval and the execution of the operation. Additionally, we asked them to look at the communications between Navy and Marine Corps personnel prior to, during, and in the aftermath of the incident.

We also asked them to look at a number of—assess the impact of a number of conditions that day that may have been contributing factors. You know, for example, the sea state in the morning and the sea state in the afternoon; the operation, the use—the policies and use of safety boats and who was making those decisions; and, finally, we asked them to look at the command-and-control structure, and was there a rigid one in place that clearly delineated

authorities. Was it [inaudible] geared to [inaudible] during the operation.

You know, as from the *McCain* and *Fitzgerald* incidents, we have worked very hard at our safety culture, and we expect and encourage all sailors to have a questioning attitude, to expect to find conditions that require and to also make sure that they act on unsafe conditions and not ignore them. And it is up to us as leaders to create that environment that facilitates that action.

Mr. COURTNEY. Well, thank you, Admiral. You know, I would just note though that the CR did come back and identify real weaknesses in the existing system after *McCain* and ways that we could structurally and by law actually prevent that. And as I mentioned earlier today, I mean, Congress actually adopted that and now that is actually in law.

And I think we have actually seen some progress in terms of not having, you know, sailors untrained and uncertified, again, on large surface fleet ships. And hopefully that is what I think—I am speaking for myself at Seapower and I am sure other members, that is what we want in terms of getting specific problems here.

Because as the chairman said, this is just happening too frequently, and that says that there is something more than just, you know, kind of, you know, trust us, we will take care of this. We have really got to look at the structure of command and control and decision-making. And Congress needs to step in and, like we did with *McCain* and *Fitzgerald,* make real changes.

With that, Mr. Chairman, I yield back.

Mr. GARAMENDI. Thank you, Mr. Courtney.

The gavel order is as follows: Mr. Johnson and Ms. Speier in that order. Mr. Wilson will return, and I will come back to him when he returns.

Mr. Johnson, you are up.

Mr. JOHNSON. Thank you, Mr. Chairman. I appreciate it very much and thank the generals for their time. And this is an important hearing. We did hear that heart-wrenching testimony earlier, and it is so disturbing to all of us.

Let me just get right to a couple of questions. I apologize if some of this has been answered already in previous statements or questions. My internet has been a little intermittent today.

But we know that we had multiple mishap—I know the term we are having concerns with as well, but mishap investigations have revealed that unit leadership properly reported on training and material deficiencies, but we have these reports that they were ignored or even later relieved.

How are you remedying this? Let me ask this, General Thomas, I guess, how are you remedying this and empowering commanders to highlight deficiencies and escalate concerns without facing punitive action? And then, secondly, how should a leader that raises these types of issues within their chain of command proceed when that chain of command is not responsive enough to ensure mission success and safety?

General THOMAS. Thank you, Congressman. I think you are getting right to the culture, you know, issue. Again, I would just start by, you know, some of the things we are—we have got to instantiate with our leaders is the importance that they have in terms of

oversight, identifying risk, and stopping operations, and then actually rewarding that. We are now, you know, incorporating some of that into our commander training, new commander training.

But we also have to create the environment where if someone raises the alarm within the chain of command or even just a junior Marine, that is exactly what we want them to do, and we have to figure out ways to reward those Marines who are taking—we would say, again, that is part of mission success.

I mean, obviously, you know, when you have a tragedy like this, it is a failure from beginning to end. If we can, you know, with our education system, our reporting systems create an environment where people are comfortable, I think we will make a lot of headway towards the safety culture that we need.

Mr. JOHNSON. I appreciate that response. One of the questions we have is, would there perhaps be value in developing an independent safety process inside DOD for leaders to raise those issues, and is that something you all have considered so far?

General THOMAS. You know, I am a fan of, you know, independent, you know, views just because of the ability to provide eyes-on that perhaps an organization may be missing. That is something that came out of one of the commission's safety reports. We do have a mechanism within DOD, a joint that has been probably more dormant than it had—should have been over the past few years. That may be something that we could use going forward to instantiate some of the things that you just described, Congressman.

Mr. JOHNSON. It makes sense. I mean, from a layperson's viewpoint, that is just, to us it seems kind of commonsense. But let me ask you one more question. Mishap investigations, as we know, often produce lengthy lists of recommendations for actions.

So what is your process for ensuring that those changes are actually incorporated in the service's policy and doctrine?

General THOMAS. We have an oversight panel led by a flag officer looking at all the recommendations and then having individuals, you know, come back and brief on the progress it has made until that progress is—until, you know, that action is actually complete.

Part of that process, by the way, includes coming back to the subcommittee and describing, here is the action plan and here is the progress that we are making until action complete.

Mr. JOHNSON. I appreciate that. We take that responsibility seriously, and I am grateful for that cooperation and your acknowledgment of that.

So with that, Mr. Chairman, I will yield back.

Mr. GARAMENDI. Thank you, Mr. Johnson.

General Thomas, you correctly said that, in your March 26 memo, the eight things and then the subsets. And indeed we will come back to you in due course, probably 6 months or so, and say, is it actually happening? Are you actually doing these things? The other part of this, and this has been mentioned in your opening testimony, General Thomas, and that is the issue of accountability. We will probably hear more about that.

I am now going to turn to Ms. Speier for your questions.

Ms. SPEIER. Thank you, Mr. Chairman.

Thank you, all, for your presentations this afternoon.

General Thomas, you used the word "preventable," that this was a preventable set of circumstances. Major General Olson, you said it was "senseless." General Thomas and General Olson, do you both recognize that this was also reckless? General Thomas.

General THOMAS. Congresswoman, I think that some of the actions taken were reckless, yes.

Ms. SPEIER. Major General Olson.

General OLSON. Ma'am, I was surprised at how cavalier some of the actions were. I would say that some of them rose to recklessness.

Ms. SPEIER. Would you support us providing compensation to the families for reckless or gross negligence? General Thomas.

General THOMAS. Ma'am, I will have to take that one for the record, because it is a policy issue. This is something that we would come back to you with based on response from the—along with our leaders at Office of Secretary of Defense.

[The information referred to was not available at the time of printing.]

Ms. SPEIER. All right. Major General Olson, yes or no?

General OLSON. Ma'am, I would have to associate myself with the assistant commandant's remarks. I don't know enough about the issue to speak authoritatively.

Ms. SPEIER. All right. Vice Admiral Kitchener. Actually, you are muted. I am going to move on. I think you are probably going to say the same thing as your colleagues.

Who made the decision—who was responsible for the readiness of the MEU?

General THOMAS. Congresswoman, I will, you know, give you a broader view and let General Olson fill in. But the Marine Expeditionary Unit is a composite unit, and before it forms, comes together—normally 6 months prior to deployment—those are separate units, and there is an individual that has responsibility for the readiness of those individual units, nominally the division. Once the MEU comes together, the MEU has—the commander has responsibility for the readiness and the MEF [Marine Expeditionary Force] has oversight responsibility.

General Olson, would you like to add something to that?

Ms. SPEIER. I want a name.

General OLSON. Elaborating briefly, ma'am, the commander of 1st Marine Division at the time would have been responsible for the initial readiness of the division units forming the ground combat element, as would the wing commander be responsible for the aviation units, and the Marine Logistics Group commander be responsible for the logistics units that composited together to form the subordinate elements of the 15th Marine Expeditionary Unit.

Ms. SPEIER. So that was General Castellvi, correct?

General THOMAS. General Castellvi was the division commander at the time, yes, ma'am.

Ms. SPEIER. All right. And he was found responsible for a lack of training. No action was taken against him, and up until last week he was, in fact, the inspector general for the Marine Corps, correct?

General THOMAS. That is correct.

Ms. SPEIER. And he is now on administrative leave, I believe?

General THOMAS. He has been suspended from his duties, that is correct.

Ms. SPEIER. Okay. Who made the decision to deploy the AAVs that were in a lot designated as too broken to operate?

General THOMAS. General Olson.

General OLSON. That would have been the former commander, lieutenant colonel board-slated commander of the 3rd Assault Amphibian Battalion.

Ms. SPEIER. And who was that?

General OLSON. Ma'am, I don't have his name at my fingertips.

Ms. SPEIER. Okay. Would you provide that to the committee?

General OLSON. Yes, ma'am.

[The information referred to was not available at the time of printing.]

Ms. SPEIER. And you said—you have said to us a number of times that eight people were fired in that chain of command, but as we all know, firing in the military is not the same term as it is in civilian status. So they were all transferred, but they are still in the military. Is that correct?

General THOMAS. Ma'am, I will take that one. So it is actually 11, and the majority of those 11 are being considered for separation from the service and some have had lesser discipline taken against them.

I would just point out that one of those being held accountable suffered drowning injuries. One of those being held accountable, you know, dove into the water to rescue one of the Marines that came to the surface. All of those Marines have suffered traumatic stress injuries, and, of course, as you know, they have to live with the decisions that they made that led to this incident.

Ms. SPEIER. I understand that. But if you go through the list of problems with these AAVs, they make your head spin. It was egregious behavior, and maybe we should be talking to some of those who have been, quote, fired to find out where the pressure was coming from that required them to move forward with this exercise.

Four of the AAVs were inoperable once they were on the island. I mean, this was a deathtrap in which we put these service members, nine of whom are now dead.

With that, I yield back.

Mr. GARAMENDI. Thank you, Ms. Speier. We will probably have a second round of questions and so for the—for my colleagues, you should prepare for that.

The gavel order is as follows: Mr. Golden, Mr. Moulton, and Mr. Levin. Our Republican colleagues are welcome to come back on to the screen if they would like to, and we will intersperse them.

Mr. Golden.

Mr. GOLDEN. Thank you, Mr. Chair. You got me all right here?

Mr. GARAMENDI. Yes. Please proceed.

Mr. GOLDEN. Very good.

A couple of questions for our Marines on the panel. I think one of the—I think the ranking member really started down this line of questioning. One of the biggest concerns was the inoperability and just general unpreparedness of the AAVs. The Marine Corps job is to be ready to fight, fight today really.

This committee often has a conversation with the Marine Corps ongoing about what you need for the future, but what about readiness today? And, in particular, as the Marine Corps is pivoting back to a real focus on amphibious operations, I am very concerned about the status of these AAVs for the next 5 years.

Would you say with confidence, either one of you, that this committee is fully aware of what the Marine Corps needs to ensure the operability and general readiness of the AAV fleet in the United States Marine Corps?

General THOMAS. Congressman, I will begin. I am not sure if the committee is fully aware of what we are doing to ensure that the AAV is fully ready until it is sundowned in 2026, and we look forward to working with the committee on those things.

I would tell you that one of the things that we are learning about this mishap is how we are actually reporting readiness. You know, the metrics that we are using, I think, in some cases, indicated a higher state of readiness across the fleet than was actually warranted, and I think General Olson can speak to that.

I think the other thing that we have learned is—based on this tragedy is that the—there were things as the AAV aged that made the previous inspection regime no longer, you know, appropriate, and that is something that we are going to have to pay attention to going forward. But I would say, broadly——

Mr. GOLDEN. Let me just—if I could just jump in, I just want to really stress the importance that this committee knows what is necessary to make sure that you are in a state of readiness for amphibious operations as an organization.

Don't let it be for lack of communicating. It is always admirable—you know, I was a Marine, sir. We always say with pride that we make do with less, which is a great culture to have on the battlefield, but in terms of this communication and congressional oversight, I think it can be a real danger and an impediment.

The Marine Corps I know is interested in accountability in this instance, and I have full, you know, faith that that is going to move forward with these investigations and that we will get answers and the right steps will be taken. But what I want to know is that the Marine Corps is prepared to communicate to Congress what it needs and not think that it is limited in making the hard ask for what is necessary from the Nation to ensure that our Marines are safe, that our sailors are safe, but just as importantly, this is a readiness issue. Are you ready for the fight, and is the equipment in place that you need?

One thing that really jumps out at me is what looks like a lack of communications operability. The fact that one thing pointed out is that no one noticed safety boats in the water—not in the water, failed to notice the distress flag. Why wasn't there comms? You know, is there a lack of communications readiness between the Marine Corps and the Navy, between our AAVs and the ships that carry them? I am very concerned about that. Have we given you the equipment that you need to carry out this mission successfully is what I am trying to ask.

General OLSON. I will take that, if I might.

General THOMAS. Go ahead.

General OLSON. One of the upgrades that is being done to the remaining fleet of the AAVs that will carry it through to 2026 is an upgrade to the radio suite, both for operability reasons and also for compatibility reasons with the cryptologic requirements moving forward.

Another place where communications failed in this tragedy was inside the AAV itself. All of our AAVs that will remain in service to 2026 will be getting an internal communications modification as well. A third modification is to a backup battery power system for the emergency egress lighting system. And then a fourth is to put an up-gunned weapon station on it that is the same remote weapon station as will be on the amphibious combat vehicle.

We are confident the funding profile for the AAV line and our ability to both cannibalize AAVs that are being taken out of service for usable parts or selectively interchange between AAVs that remain in service for usable parts will carry this vehicle—in combination with the return to condition code alpha depot-level effort—carry this vehicle to 2026 when the ACV is fully operational.

Mr. GOLDEN. I see that I am out of time. Thank you, Mr. Chairman.

Mr. GARAMENDI. Thank you, Mr. Golden. We are going to follow up on what Mr. General Olson just said about reconditioning and the maintenance of this. I would point out to my committee members that it is going to come down to where is the money going to be spent.

And the Readiness Subcommittee has had serious concerns throughout all of the departments about money being spent on new, bright, shiny equipment and while not maintaining the existing equipment. So we will be following up on all of the equipment that is being used throughout, certainly in the Marine Corps and also the other services.

With that, I will turn to—I don't see our Republican colleagues returning at this moment, so, Mr. Moulton followed by Mr. Gallego and then Mr. Levin. Mr. Moulton, you are on.

Mr. MOULTON. Thank you, Mr. Chairman. Can you hear me okay?

Mr. GARAMENDI. Yes.

Mr. MOULTON. And let me just begin by reaffirming or seconding your last remark. I remember sitting on the deck of an amphibious ship off the coast of Kuwait before the Iraq invasion and loading ammunition into our rifles that was dated 1967 and 1968 for the Vietnam war.

So we can find countless examples across the services of places where we have not invested in the basic requirements for front-line troops, those men and women in the infantry, while we have no problem spending hundreds of millions of dollars on lots of F–35s that can't even reach China. So there is a lot to be discussed there in the broader committee.

Gentlemen, the mech [mechanized] raid, of course, is one of several ways that you can get Marines to shore and, operationally, it is only approved for low-threat environments.

General Thomas, in your written testimony, you state that amphibious operations is one of our core capabilities and future oper-

ational concepts demand we increase our common understanding of the requirements of operations from the sea.

But, General, as you know, the last major amphibious invasion, my company's invasion of Baghdad aside, took place at Inchon during the Korean war. Seventy years later, on 30 July 2020, what future operational concept were these Marines training for? Were these Marines risking their lives for something that, realistically, we aren't going to ever do?

General THOMAS. Congressman, I would just offer, you know, this: If you look at our new concepts, Expeditionary Advanced Base Operations [EABO], particularly in the Indo-Pacific, and the requirement to seize key maritime terrain, I would argue that movement of forces over the surface will continue to be an enduring mission. Not the only one. Some by air, of course, as you well know and you have experienced during your time with the Marine Corps. But it continues to be an important mechanism that we will have to use, you know, to execute Expeditionary Advanced Base Operations.

Now, the conditions are going to have to be set differently, because of the threats, et cetera. But just because of the size of forces and the equipment that we would need to move, you know, move ashore, that is going to still be an important function for us.

Mr. MOULTON. Well, I just hope we are carefully considering that. And I can certainly imagine myself as a commander, given the reputation for AAVs in the Marine Corps for at least the last 20 years that I have known, I would certainly be reluctant to put Marines in them if I had other options available, literally almost any other option available. So I think we need to carefully consider that as we look at our capital requirements going forward.

Vice Admiral Kitchener, a similar question to you. You articulated concerns in your written testimony that have led you to curtail waterborne operations. Are you also investigating whether or not AAV operations are relevant in future operating environments, and when can we expect to hear the results of those findings?

Admiral KITCHENER. Congressman, thank you for the question. First, we are looking, with our Marine Corps colleagues, at the planning documents that we have and our documents that oversee AAV operations, and we are making sure we are aligned there.

I would echo General Thomas' answers to the question, where, on an EABO concept and in the fighting scheme of maneuver in the Western Pacific, there is still a need for that capability to move large pieces of equipment and seizing that terrain and controlling SLOCs [sea lines of communication] on some of the—within the first island chain out there. So I do see value as we move ahead and incorporate the new ACVs into the fleet.

And additionally, we will continue to work as one team in making sure we are, you know, aligned on those policies and how we are going to employ those assets.

Mr. MOULTON. My next question is about accountability. Historically, the Marine Corps has a culture of instinctively relieving everyone after a mishap or a disaster without parsing individual command responsibilities. And I think there was an attempt to do this in the report. I read it thoroughly.

But I have to say, I am heartened to know that the Marine Corps is looking at division responsibilities, because there clearly was some oversight there that should have happened. Whether in regards to COVID training timelines or basic oversight of this AAV battalion, clearly some things were missed.

Mr. Chairman, with that, I yield back. And I have further questions if we come back around.

Mr. GARAMENDI. Thank you, Mr. Moulton. Your question goes to the larger policy issues, Mr. Moulton. I know that Commandant Berger looks forward to an opportunity to explain to the full committee the Marine Corps strategies for the future.

And embedded in your question—or embedded in his testimony should be answers to the questions that you raised, which are fundamental to our work overseeing and providing the necessary programs and money to carry out that mission.

I am now going to turn to—here is the gavel order that we have: Mr. Gallego and then Mr. Levin.

Mr. Gallego, you are on.

Mr. GALLEGO. Thank you, Chairman.

You know, I actually spent 7 months living on AAVs. In the great scheme of things, somehow the Marine Corps thought the best way to transport men around Iraq was to shove us into AAVs. They were deathtraps. We knew they were deathtraps. Because of that, I think, in total, we lost 18 Marines to IED [improvised explosive device] strikes in Iraq.

And, you know, the joke in the Marine Corps, especially among leadership, is, "How many Marines can you fit into an AAV? Always one more." And that certainly was the situation why so many of my brothers died, because there was always one more we could fit in there. We were jammed. We were packed, packed with ammo, and certainly, you know, set in a very dangerous, precarious situation.

What disturbs me, is that with this report, was that there was warning signs, and warning signs were missed. One of the things that I remember when I was enlisted in the Marine Corps, I was told if I ever saw something that was endangering, especially in terms of any exercises, that I could call for an immediate stop and there would be no, you know, ramifications for that, even though I was just a lance corporal. Well, clearly that is not true. And I think that is what happened here.

So, General Thomas, one of the things I want to get an assurance from you on is that you are going to work to change that culture, right? Things happen in war. People die. I have seen it, been there. But the worst thing that can ever happen, especially to our family members, is that when our men and women die because of recklessness, because of a Marine Corps attitude that we have to be tough and we have to be rough during training, because that is the culture, when we should be focusing on the actual training exercises, not on establishing this culture of, you know, of just cruelty, Spartan-like cruelty, which does not in the end create, in my opinion, deterrence or readiness.

So, General Thomas, do you see that people actually understand what happened and how this is actually going to—because we can update the AAV all we want, but it is, you know, really, you know,

dumb muscle usage instead of actually, you know, brainpower and management that will end up getting more men and women killed in these types of training exercises.

General THOMAS. Congressman, I would agree with you in terms of your points regarding the safety culture. That is exactly what we are trying to get after.

And then your experience of, you know, when you were serving and how you felt like you could, you know, raise a concern and be listened to, that is something that we have got to inculcate across the entire Marine Corps. I would argue, sir, that in many of our exercises that occurs every day, but clearly it didn't happen in this case. So it shows that we have got a lot of work to do.

The other thing that I would say is that when we talk about culture and, you know, Marine Corps culture—and many of the members are familiar with that—is that a safety culture and a culture of mission accomplishment are not mutually exclusive. As a matter of fact, a safety culture is integral to mission success.

And that is what leaders—that is what we are sharing with our leaders in leaders courses now, and that is what we have got to get all the way down to the deck-plate level.

Mr. GALLEGO. Thank you, General.

And, Vice Admiral, when I was I think a young PFC [private first class], I actually did a helo dump training, where they would put us in a helo and throw us underwater, you know, with gear, to train us to get out in case we ever, you know, had a helo operation that, you know, hit water.

I couldn't find that in the report. Maybe I just missed it. Was there, you know, that type of training for these men on the AAV prior to actually even entering, you know, water that is moving around in not a very controlled environment, like a dump tank so they know how to get out, what to do, how not to panic, things of that nature?

General THOMAS. Congressman, if I may.

Mr. GALLEGO. Yes.

General THOMAS. I will take that one if I can. That training does exist. That is part of the underwater egress training. However, the embark troops on this particular vehicle——

Mr. GALLEGO. Did not do it.

General THOMAS [continuing]. Were only partially trained and did not do that. They should have done that, and they should have never participated in the exercise, having not completed that training.

General Olson, would you add anything to that?

General OLSON. Sir, I would not. I would say that we can put 240 people through underwater egress training a week at Camp Pendleton, and that is almost 10,000 a year if we use the device to its full capabilities. The capability was there. These Marines were not trained in it.

Mr. GALLEGO. Well, I think that, you know, for future, if we are going to keep the AAV platform, then we also need to invest in the training side of it and maybe add more dunk tanks in order for them to do this, or else we are going to have this situation. Because in there and, you know, trying to get out of the hatch in an emergent situation—and I have had to do that—with all your gear on

is a horrifying experience on men. And I can't imagine what happens when water is coming in. And God bless those men and their families.

Thank you, Mr. Chairman. I yield back my time.

Mr. GARAMENDI. Thank you, Mr. Gallego.

I now turn to Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

General Thomas, I have some questions similar to those explored earlier. Given the conclusions of the initial Marine Corps investigation and the decision last year to suspend all AAV waterborne operations, pending a review that included equipment, and the concerns with these vehicles being pretty obvious, are AAVs currently in use at this time to train or support the mission?

And I ask because your written testimony describes AAV operations at Camp Pendleton last month, but it wasn't entirely clear to me in your earlier response.

General THOMAS. Congressman, the resumption of AAV waterborne operations had resumed, with strict limits. There are no ship-to-shore or shore-to-ship, and they are only AAV crews for proficiency training.

I think General Olson can provide some additional detail.

General OLSON. The assistant commandant is correct. We have more gates to cross before we are prepared to return. As was noted previously, we need to make sure that our doctrine, techniques, and procedures are 100 percent aligned between the Navy and Marine Corps team before we can safely return to water operations.

Right now, we are training crews to regain proficiency that they have lost over the last year, but they are not training with passengers in the back.

Mr. LEVIN. Thank you. In your testimony, you write that additional inspections with new criteria for hull watertight integrity, bilge pump function, and emergency egress lighting systems have been ordered.

Have the new inspection criteria had an impact on AAV use? For example, were the vehicles that Major General Olson described as no longer allowed in the water because they leak in use prior to the new inspections criteria?

General OLSON. ACMC [Assistant Commandant of the Marine Corps], I will take that.

Sir, they were up until the 31st of July. Then none were being allowed in the water until such time as we understood what the overall material condition of the fleet was. What we found is that we had excessive leakage. We want to get that leakage down to about 18 gallons an hour, which is the standard that we believe is safe for operations.

The pumps onboard the vehicles can expel 400 gallons an hour, so there is a great margin of safety that can be achieved. We know that the through-hull penetrations for the suspension and some other places in the AAV, some water is going to come in, but we expect it to be a minimal amount of water and that the pumps will able to expel it at a far greater rate than it could come in.

Just on a note from a previous question, the amphibious combat vehicle is a different hull form and does not share many of the

through-hull penetrations that the AAV itself does. It also has no plenums, which is the greatest source of our leakage.

Mr. LEVIN. General Thomas, I understand the Marine Corps canceled the AAV survivability upgrade in 2018, instead opting to go all-in on replacing the AAV with the ACV. That program involved upgrading AAVs with a new engine and transmission.

The investigation into this incident found transmissions failure impacted the bilge pumps. So how would you reconcile the July 2020 disaster with the decision to cancel the program to replace AAV transmissions; and were any steps taken to ensure the vehicles would remain safe, given the awareness that they were in need of upgrades?

General THOMAS. Congressman, the mechanism that was to keep the vehicles safe or up to speed was through depot repair, the so-called RCCA vehicles, returned to code condition alpha.

Regarding the transmission, and I would defer to General Olson on this, but, you know, there have been no significant problems identified with the transmission. It is true that this particular vehicle had a loose, you know, drain line, which allowed the oil to leak out of the transmission and eventually cause the engine, you know, to—or the system to stop working. I do not believe that that is a systemic issue that has been identified.

General Olson, can you clarify?

General OLSON. ACMC, I recommend we take the remainder of that for the record and have PM [Program Manager] AAV explain in detail.

My understanding, it was the mechanical failure of this individual transmission due to the loose drain line that permitted the transmission oil to leak out, not the failure of the transmission itself but the fact that there was no oil in the transmission. But may we please take that for the record and come back with additional detail.

[The information referred to was not available at the time of printing.]

Mr. LEVIN. Sure. And I am running short of time and I have one final question. I understand the Marine Corps has contracted BAE Systems for production of the ACV and that 18 of those vehicles were delivered in November of 2020, with the intent of fully replacing the AAV by 2028.

General Thomas, what training is currently happening across the fleet to allow Marines to familiarize themselves with this new equipment?

General THOMAS. Congressman, as you know, the ACV has been introduced there in Camp Pendleton, with an appropriate training program and certainly incorporating all the lessons learned from this tragedy.

Mr. LEVIN. Thank you, General.

I am out of time, so I yield back, Mr. Chairman.

Mr. GARAMENDI. Thank you very much, Mr. Levin.

We now have a second round. We have very, very little time.

On the gavel order, Garamendi, Lamborn, Golden, Johnson, in that order. I am going to just make a quick statement and then not ask a question.

This goes to Vice Admiral Kitchener. The Navy's role in this is very significant and definitely led to the tragedy. You have a command investigation underway. When that is completed, I am certain you will pass it over to us. I would anticipate a followup hearing on all of this sometime this year, probably in the late summer or into the fall. That will depend upon two investigations that are now in process, a command investigation in the Marine Corps and similarly in the Navy.

So, with that, I simply note the Navy's dereliction in this process. My words. We will see what the investigation comes forward.

Mr. Lamborn.

Mr. LAMBORN. Mr. Chairman, I am going to follow your example. I don't have any more questions. The committee has done an excellent job of probing into all the details. I think our work is cut out for us to monitor how this goes forward.

The equipment and the training failures that we saw, that those have to all be rectified. And we are going to be dogging this very closely.

I also want to say, the Marines on our subcommittee and full committee are amazing contributors to this overall understanding and getting to the bottom of this. Jack Bergman, Ruben Gallego, Jared Golden, and Seth Moulton, I think are all wonderful additions who help us get to the bottom of this.

So I just want to note that for the record. And I yield back to you, Mr. Chairman.

Mr. GARAMENDI. Point very, very well made. We are definitely enhanced by the experience of our members.

Mr. Golden, speaking of experience, have at it.

Mr. GOLDEN. Thank you. I just had a point I wanted to make, and I guess also it would be a question as well for General Thomas and Major General Olson.

When I was serving, I was in the 3rd Battalion 6th Marines and in the infantry unit, and there were times when we made decisions as a team, as a unit, to forgo certain equipment requirements.

You know, I guess I would describe in Afghanistan, being a small unit operating remotely in the mountains, we often made a decision to run patrol slick without our SAPI [Small Arms Protective Insert] plates, confident that speed was a safety measure in and of itself. Some Marines perhaps lost their lives as a result of a lack of SAPI plates, but I think we also felt quite confident as a unit that we were making the right decision.

There have been other experiences in training where I saw at the unit level, the squad level, or the platoon level, decisions made about what type of equipment to go with or not go with, which may have been contrary to what the book may have said.

One thing that I noted in this investigation was discussion about Marines being found having gotten out of the AAV successfully, still sadly losing their lives, being found in their battle gear, which prevented the flotation devices from being able to rescue them. Some discussion that had they been deployed at the surface it might have worked, but they were not in that situation.

I am just curious. Has there been any discussion in the investigation about what type of changes might need to be made in the culture to ensure that decisions could be made about what type of

gear to deploy in? I know I personally would not have been confident in an AAV taking on water to leave my SAPI plate and gear on and, you know, would have been looking for the flexibility to remove that.

So what lessons has the Marine Corps learned? Certainly, the idea is that if you are going to be doing an amphibious assault, you want the very best gear, but sometimes there are, you know, tradeoffs that need to be made.

So what can you tell me about what the Marine Corps is learning as a result of the information you have gathered from the investigation?

General THOMAS. Congressman, we continue to review what specific gear would be the most efficient to aid in the, you know, safe egress of troops leaving an AAV. And I will let General Olson, you know, go into more detail.

What I would also say is that, as has already been discussed, this vehicle slowly took on water for 45 minutes. If the crew had only had the embarked troops egress in a more timely fashion, whether they had everything on, their flotation device was more than sufficient to keep them afloat. That doesn't address your question, which is a good one, is that sometimes less is more, and we are taking a hard look at that.

General Olson.

General OLSON. Sir, I have got very little to add to that. The body armor is provided with a quick release. One of the things that we will examine is the interaction between the body armor and the life preserver unit, just to make sure that nothing is impeded. But we are going forward in a deliberate egress working group regarding how we get out of our armored vehicles, depending on what kit we are wearing.

What I would note is that over the years we have gone to a standard of you wear your protective gear inside vehicles because of things like rollovers, where that body armor actually shields you and prevents torso injuries, much as your helmet does. So everything is a compromise. But water and flak jackets may not be a good mix, and we need to take a very close look at that.

Mr. GOLDEN. Thank you.

Gentlemen, I appreciate your time today and the thoroughness of the investigation.

And I yield back, Mr. Chairman. Thanks for the hearing.

Mr. GARAMENDI. Thank you, Mr. Golden.

I will note that because two of the AAVs, maybe three, were found to be inoperable, they were left on the beach and the personnel that was in those were added to the other AAVs. Some of those personnel did not have life jackets as they returned to the ship. So once again, fundamental safety was ignored.

I am going to now turn to Mr. Johnson.

Mr. Johnson, are you still with us?

Mr. Moulton for a quick third round.

Mr. MOULTON. Just a second round for me, Mr. Chairman, but thank you very much.

Just a few quick points. First of all, gentlemen, I obviously have some serious concerns here about how this all happened. I also understand the importance of hard training.

And a story that this brings to mind is my own experience of training in Kuwait in anticipation of our second deployment to Iraq, when we were brought to a shoot house and I was the only platoon commander who brought his Marines through that shoot house completely on NVGs [night vision goggles]. It was considered a very risky thing to do. I felt we were prepared for it. But I have no doubt that there would be a hearing like this or at least a significant investigation if one of my Marines had been killed in that training. Many people would be inclined to say Lieutenant Moulton was taking risks with training that were not necessary because this wasn't Iraq, it was Kuwait.

But just a few weeks later, we found ourselves in the situation where enemy RPG [rocket-propelled grenade] gunners were shooting at Marines inside of a building because they had white-light flashlights on. And I was very proud that my platoon, at least, was safe from that threat, because we were confident using our NVGs in an actual combat environment.

So it is critical to me that we get to the bottom of this investigation to understand what happened here. It is also critical that we don't become a Marine Corps that is afraid of hard training, that is afraid of taking risks in training. It is a constant balancing act.

We have to ask questions like is this operation even realistic to justify the risk that we are going to take? And that is the leading question I had, the leadoff question I had for all of you. I am not sure in this case, a waterborne mechanized raid, that it is. But we do need to do hard training and it will entail risk.

The second thing I want to say is that we need to improve the culture of being able to question authority. And this is something that my colleague Mr. Gallego focused on. I am not sure that that culture exists in the Marine Corps today. And a recent trip that I made to IOC [Infantry Officer Course]—which might appropriately be renamed OCS [Officer Candidate School] part two, based on what I saw—confirmed to me that this is not the style of leadership that is being inculcated in our junior infantry officers. I think that is something that we need to look at very carefully.

The commandant himself is questioning assumptions, and I have praised him publicly all the time for doing that. We need to ensure that that same culture is encouraged among our junior leaders. That when we do that and when we talk about how to have accountability at the end of the day, we also have to be wary of having a zero defect mentality.

This is another thing I have seen in the Marine Corps, where whatever happens, a ton of people get relieved. We don't actually get to the bottom of what really happened and we are not thoughtful about where that accountability lies. If you take that approach, then you are not going to have thoughtful leaders, thoughtful leaders who know how to take risks in training that are appropriate, who know how to balance risks with the realism of the operation that they are training for, and ultimately who are going to be willing to question authority themselves.

So this is tough. This is hard. And I recognize that you are the ones in the fight. You are the ones who have to do this hard work going forward. It is going to be our job to ensure accountability, not

just for these families, although I cannot imagine their loss, but also for every Marine who will come after them.

The Marine Corps must be the Nation's premier fighting force. We can't become a Marine Corps that only cares about safety. But we also have to be smart about how we get there.

So, gentlemen, thank you very much for all your work. And, Mr. Chairman, thank you for your indulgence of my questions today.

Mr. GARAMENDI. Mr. Moulton, you could not have said it better. And I will not repeat it, but I will certainly take your testimony. We will write it up and we will put it on a placard for all to see.

Mr. Levin, your final.

Mr. LEVIN. No further questions at this time, Mr. Chairman. I appreciate our witnesses being here with us today.

Mr. GARAMENDI. Thank you very much. Mr. Lamborn, if you would like to make some closing remarks, I will make mine following yours and we will adjourn.

Mr. LAMBORN. I will just briefly say, Mr. Chairman, I am glad we had this hearing. There have been some really penetrating questions asked by each of the members of the subcommittee and others who joined us.

And I think that we are on a good path to at least get to the bottom of what happened with the training failures and the equipment failures and, even broader, the accountability issues that are raised in an incident like this.

So we have our work cut out for us to track this in the next months ahead, and we are going to do that, because we owe it to our men and women in uniform and those who were lost in this horrific accident 9 months ago that they have the best training and equipment possible. And I will work with you, Mr. Chairman, and other members of the committee to make sure we get that done.

And with those who are serving us in the Marines and Navy, I thank you for your service, but we are going to have to work hard to overcome this.

Thank you so much. I yield back.

Mr. GARAMENDI. Thank you, Mr. Lamborn.

I am going to close with where we started, and that is the tragedy itself, the loss of life, the effect on the families, their losses, and the sadness that exists. And it is obvious that is not just with the families, it is with the Marines themselves and the units who lost their partners in this accident.

Unfortunately, we do far too many hearings on accidents and tragedies. Mr. Courtney spoke to those. We have also done our own hearings with regard to land-based accidents. And I suspect that we will do this again. But I would hope that when we have an accident in the future that we will not find the kind of derelictions and problems that occurred in this tragedy.

So, with that, General Thomas and General Olson, I will circle back on this in several months and review the work that has been done, not only with this accident but with the issues of maintenance, with the issues of accountability, and with the very difficult balance that Mr. Moulton has brought to our attention in his closing comments: Safety and the necessity to have realistic exercises. So we will go back through all that again.

Admiral Kitchener, you have been mostly on the side here. We will review your report when it is available. And I suspect that we will find that there are also very serious derelictions in the U.S. Navy part of this participation in this accident and the accountability going forward.

We will continue to review these. I want to assure the military, in this case the Navy and the Marine Corps, that this subcommittee is profoundly concerned about the readiness, the maintenance of equipment, whether that is a ship at sea or it is an AAV or any other piece of equipment.

We do understand the need to bring on new equipment, but it is the responsibility of this committee that the existing equipment of all types be properly maintained and be available when needed and be in full working order, along with the training that goes with that particular piece of equipment.

And so, with that, this hearing is adjourned. I thank you all for your participation. We are adjourned.

[Whereupon, at 1:34 p.m., the subcommittee was adjourned.]

A P P E N D I X

MAY 3, 2021

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MAY 3, 2021

Statement by Mr. Peter Vienna – May 3, 2021

Statement to the House Armed Services Subcommittee on Readiness, **"The AAV Mishap Investigation: How to Build a Culture of Safety to Avoid Preventable Training Accidents"**

Good morning esteemed members of the House Subcommittee as well as those here representing Marine Corps and Navy leadership. Thank you for the opportunity to be heard. I wish you could also see and hear from my wife today. She has chosen to allow me to speak on her behalf because she would be unable to do so without breaking down. I can tell you that her testimony and its effect on this panel would be visceral. I believe all 9 Mothers should be heard because today we are not only mourning our Son, but we also mourn for eight other families that are navigating this pain.

Nancy became a single Mother when Bobby was still an infant. She struggled to give him and his 2 sisters, the best possible life she could. I came into their lives when Bobby was 14 years old. What I witnessed was the most incredible of Mother-Son relationships. The 2 of them literally lived for each other.

Bobby was a natural athlete, excelling in Judo and Jujitsu, never once losing a match. As a Highschool student athlete, he played football and basketball...voted Team Captain as well as most inspirational on his varsity basketball team. In both basketball and Jujitsu, he volunteered his free time to mentor the younger kids. He was truly a sensei and coach's dream.

He was the best of us. The favorite of his Grandparents, Aunts, Uncles and all his cousins who looked up to him as a role model. I can say without prejudice that Bobby touched more lives positively in his 22 years than most people do in a lifetime.

Bobby along with 8 others are dead now and here is just a short list of the reasons given in the investigation:

- AAV's that came off the "Dead-Line" ...end of life...deemed "not sea-worthy", should never have been put back in the water.
- No real safety boat put in the water, (SOP states "2 safety boats for every 6 AAV's in the water")
- 8 of the 9 killed had no emergency egress training. Found with full body armor still on, some with their rifle still strapped on.
- No radio contact or eyes on the AAV's, Bobby's boat was sinking for 45 min while chasing the Somerset that was traveling away and conducting helicopter exercises.
- All 23 gallons of transmission fluid was lost on the trip to the island, only 6 gallons were available to replace yet that AAV was sent back into the water to try and reach the Somerset.
- AAV crew that did not follow its own emergency SOP's. Had they done so, the AAV would have still sunk, but not with our boys in it. I point that back at leadership. Just another result of a terrible lack in training readiness.

His Mother, his surviving siters, Jasmine and Jade, and his Fiancé Savannah, who received her surprise engagement ring in a box 7 months after he was killed, have not been able to accept his loss. Especially

now, knowing how incredibly preventable it was. Losing her only Son has broken my wife. She is suffering both mentally and physically. For me, well frankly for the last 9 months I have been on suicide watch. I had no control over losing my Son, but I refuse to lose my wife!

I also refuse to call what happened on July 30th a "mishap". Definition of which is, "an unlucky accident". We have all seen that nightmare of an investigation, and so we know that what actually occurred was a predictable outcome resulting from the reckless disregard for human life by a command that ignored its own safety standards and operational procedures, putting mission above the young lives they were supposed to protect. Not a combat mission...this was just training. And if I hear one more time, "We have to train like we fight", I think my head will explode. Because for decades now it's been true that every year the military loses more lives in training than they do in combat.

Before I go any further, I wish to say for the record that even after all the recklessness and ineptitude that took our only Son, my wife and I are not anti-military. On the contrary, we feel we owe it to our Son to do what we can to effect the change that leads to a better stronger but safer military. We actually want to help.

I repeat, what happened July 30th was no "mishap". It was yet another example of what should be expected under any institution that is allowed to self-police and self-punish, without strong checks and balances...AND, is allowed to hide behind by an antiquated law that protects it from the accountability of answering legally to those it recklessly harms. No possibility for a day in court, resulting in our troops becoming 2nd class citizens the moment they swear in. Yes, I am speaking of the Feres Doctrine. And I would argue that its existence, is what will continue to foster this culture across all military branches where medical malpractice, sexual assault, and training deaths, that far outpace combat deaths, will continue to plague our precious troops and the civilian families that love them.

Our Son will never come home, but how do we keep other families from suffering this unbearable pain. Please don't allow our 9 Sons to die in vain!

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Hearing Date: May 3, 2021

Hearing Subject:

The AAV Mishap Investigation: How to Build a Culture of Safety to Avoid Preventable Training Accidents

Witness name: Peter Vienna

Position/Title: Gold Star Family Survivor of Christopher "Doc" Gnem

Capacity in which appearing: (check one)

● Individual ○ Representative

If appearing in a representative capacity, name of the organization or entity represented:

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2020

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

2019

Federal grant/ contract	Federal agency	Dollar value	Subject of contract or grant

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Organization or entity	Brief description of the fiduciary relationship

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Mr. Peter Ostrovsky Opening Statement to HASC Readiness Subcommittee

03 May 2021

Chairman Garamendi, Ranking Member Lamborn, and distinguished Members of the Subcommittee on Readiness, on behalf of my entire family, thank you for the opportunity to speak with you about our fallen son Marine Corps Lance Corporal Jack-Ryan Ostrovsky, who was 20 years old, when he drowned with 8 other Marines and a Navy Corpsman during a preventable AAV incident off of San Clemente Island CA.

Our son Jack-Ryan and his fraternal twin brother Samuel were born prematurely at 26 weeks; and were hospitalized for two and a half months in a neo-natal intensive care unit before they came home with us. They were both fighters from the get-go.

My wife Lynn Ostrovsky gave up her career as a flight attendant with a major airline to be a stay-at-home Mom. I'm a retired federal law enforcement officer who dedicated 31 years of my professional life to service with the Treasury Department and Department of Homeland Security.

As a teenager, Jack-Ryan loved swimming, mountain biking, hiking, snowboarding, marksmanship training and military history.

A year after graduating from high school and after we moved as a family to Bend Oregon, Jack-Ryan decided to enlist in the US Marine Corps. He told us that he wanted to serve his country and do things that you could not do in the civilian world. He wanted to start at the bottom as a grunt and become a Marine Corps Rifleman.

Jack-Ryan loved being a Marine and we loved that he loved being a Marine. With only 13 months of service, he was already talking about re-enlisting and his dream of pursuing a billet in special operations and making the military his life long career.

We will always be proud of Jack-Ryan. He followed in the footsteps of his great grandfather Bill Fischman who served in the Navy and his grandfather Jack Fischman who served in the Army, along with becoming the first Ostrovsky to serve in the US military.

His commanding officer described Jack-Ryan, as a future leader and a stand out, who would seek out fellow Marines that were struggling and offer them a kind word and a smile.

A week before the AAV incident, Jack-Ryan told me about his concerns with the AAVs and that, "they sink all the time." It was hard for me to believe that statement, but now I know that there was more to the story that was the basis for his concerns.

The loss of Jack-Ryan has destroyed our family's future plans. Jack-Ryan was supposed to be the next leader of our family who was going to create his own legacy of success through his military career. We were looking forward to watching Jack-Ryan build a family of his own and blessing us with grandchildren. Jack-Ryan was also supposed to look after his brother Samuel, who has suffered from a life-long educational disability.

When the Marine Corps briefed Lynn and I on the results of the investigation; we were shocked and disappointed by the top-down recklessness, gross negligence and lack of duty of care for our son and all of the Marines and Sailors in his AAV Company.

While reviewing the investigation report many issues stood out to me that are a cause for concern and questions. Namely;

Why were dead lined AAVs deemed to be in poor condition and not seaworthy assigned to a unit that would be deployed as America's maritime response force?

Why did my son's AAV Company not initiate any of the relevant pre-requisite egress training, which would have better prepared him and the others for such an emergency?

Why did the pre-exercise Confirmation Briefing not mention any of the waterborne risks associated with utilizing AAVs that were in poor condition and embarking Marines that were not adequately trained? But yet, the only identified risk was assessed to be "unlikely to occur" and was that there could be a "casualty to the assault force during embarkation/debarkation operations" on San Clemente Island and onboard the USS Somerset.

As an experienced federal investigator who has planned, conducted and approved many high-risk law enforcement operations, the lack of detail in the Briefing tells me one of two things, either it was intentional, as an alleged cover up for the lack of readiness, or the exercise planners were not qualified to appropriately assess risk, or perhaps both.

In my opinion, the entire AAV Company was placed at extreme risk due to poor equipment, inadequate training, and a poorly coordinated and monitored unsafe training exercise.

We expect that the Marine Corps and Navy hold accountable, from top-down, all of those who were responsible for this preventable catastrophic incident, through all of the means that are at their disposal and with transparency.

We also expect that US military systems of accountability and liability be modernized, as a way to ensure that every day moving forward Military Officers fully appreciate and know the realities of their burden of command, so that there is no place for recklessness and gross negligence in the US Marine Corps and the US Navy.

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Hearing Date: May 3, 2021

Hearing Subject:

The AAV Mishap Investigation: How to Build a Culture of Safety to Avoid Preventable Training Accidents

Witness name: Peter Ostrovsky

Position/Title: Surviving Father of USMC LCpl Jack-Ryan Ostrovsky

Capacity in which appearing: (check one)

● Individual ○ Representative

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2021

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract, grant, or payment
N/A			

2020

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract, grant, or payment
N/A			

2019

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract, grant, or payment
N/A			

2018

Foreign contract/ payment	Foreign government	Dollar value	Subject of contract, grant, or payment
N/A			

Fiduciary Relationships: If you are a fiduciary of any organization or entity that has an interest in the subject matter of the hearing, please provide the following information:

Organization or entity	Brief description of the fiduciary relationship
N/A	

Organization or Entity Contract, Grant or Payment Information: If you or the entity you represent before the Committee on Armed Services has contracts or grants (including subcontracts or subgrants) or payments originating from an organization or entity, whether public or private, that has a material interest in the subject matter of the hearing, received during the past 36 months, please provide the following information:

2021

Contract/grant/ payment	Entity	Dollar value	Subject of contract, grant, or payment
N/A			

2020

Contract/grant/ payment	Entity	Dollar value	Subject of contract, grant, or payment
N/A			

2019

Contract/grant/ payment	Entity	Dollar value	Subject of contract, grant, or payment
N/A			

2018

Contract/grant/ payment	Entity	Dollar value	Subject of contract, grant, or payment
N/A			

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THE HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON READINESS

STATEMENT OF

GENERAL GARY L. THOMAS
ASSISTANT COMMANDANT OF THE U.S. MARINE CORPS

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON READINESS

ON

THE AAV MISHAP INVESTIGATION:
HOW TO BUILD A CULTURE OF SAFETY TO AVOID PREVENTABLE TRAINING ACCIDENTS

MAY 3, 2021

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THE HOUSE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON READINESS

Chairman Garamendi, Ranking Member Lamborn, and distinguished members of the Subcommittee, I appreciate the opportunity to testify on the circumstances surrounding the tragic sinking of an Assault Amphibious Vehicle (AAV) on July 30, 2020.

First and foremost, the sinking of this AAV and the deaths of eight Marines and one Sailor were preventable. We mourn the loss of Private First Class Bryan Baltierra, Lance Corporal Marco Barranco, Private First Class Evan Bath, Navy Hospital Corpsman Third Class Christopher Gnem, Private First Class Jack-Ryan Ostrovsky, Lance Corporal Guillermo Perez, Corporal Wesley Rodd, Lance Corporal Chase Sweetwood, and Corporal Cesar Villanueva and share the families' enduring grief. We will honor their memory and make the necessary changes to prevent a tragedy like this from ever happening again. We owe this to these servicemembers and their families.

The July 2020 AAV sinking is one of several fatal Marine Corps training mishaps in recent years. Although each mishap is unique, our safety reports and investigations often identify similar causal and contributing factors. In many cases, deviations from standard operating procedures, operating equipment outside of its specifications, or departures from confirmed plans are to blame. I am also concerned that one of the strongest aspects of Marine Corps culture—a "can-do" attitude—may lead to preventable accidents and loss of life. This attitude helps us win our Nation's battles, but the level of risk we may accept in combat is not necessary in a training environment. When Marine leaders indiscriminately accept that our profession is dangerous and fail to mitigate risk, they may put themselves and their fellow Marines and Sailors in unnecessarily perilous situations.

Our string of serious mishaps demonstrates that our safety culture must change and Marines at all levels must make better risk decisions. While we can never eliminate all risk, we

have to get better at recognizing and mitigating hazards before they cause loss of life or equipment. Marines must internalize that there is a right way to do things, what the right way is, and the importance of choosing to do things the right way every time. Every Marine must be empowered to assess risk and to speak up when they see something unsafe. Commanders must provide the necessary oversight and guidance to mitigate risk and stop operations when the risk is too high. Commanders must also develop command climates that value and reward hazard reporting because it makes our units better and safer. At an institutional level, we must provide the guidance and resources that support good decision-making. We must also manage operational tempo such that our Marines and Sailors have the opportunity to complete necessary training in a safe and productive manner. We are committed to providing the leadership and resources to makes these changes.

This statement discusses the 2020 AAV tragedy, completed and ongoing investigations, and the institutional actions we are taking to prevent a loss like this in the future. Additionally, this statement updates the subcommittee on broader Marine Corps initiatives to affect substantive change in our safety culture and performance across the entire Marine Corps.

July 2020 AAV Sinking

On the morning of July 30, 2020, thirteen AAVs with embarked personnel from 15th Marine Expeditionary Unit (15th MEU) conducted a mechanized raid from USS Somerset to an objective on San Clemente Island. This raid included a planned return to the ship once actions were completed ashore. Later in the afternoon, following a series of delays due to maintenance issues with AAVs, a portion of the AAV platoon and embarked infantry company remained ashore, while another element began the transit back to USS Somerset. This transit occurred much later than originally planned. During the return transit, water began to enter the mishap

AAV through multiple points of leakage. The transmission failed, bilge pumps were unable to expel water rapidly enough due to the transmission failure, and the AAV began to sink. The vehicle commander gave the distress signal, known as a "November flag," but no safety boats were in the water. The AAV was slowly sinking for approximately 45 minutes before another AAV with embarked personnel pulled alongside to assist. The mishap AAV crew prepared to evacuate embarked personnel by opening a hatch on the top of the vehicle. The AAVs collided, causing the mishap AAV to turn broadside to a swell. A large wave swept over the AAV and water entered the troop compartment through the open hatch, causing the AAV to sink rapidly with eleven personnel on board. Despite an extensive search and rescue effort, eight Marines and one Sailor perished at sea. In addition, two Marines suffered serious injuries. This was the deadliest AAV mishap in Marine Corps history.

Investigations and Accountability

The Marine Corps initiated a command investigation into the sinking of the AAV immediately after the incident occurred. The command investigation determined the cause of this tragedy was a combination of maintenance failures, delayed and improper evacuation procedures used by AAV crewmen, and improper egress training of embarked personnel. Additionally, endorsing officials highlighted unsafe conditions that may have contributed to the loss of life, including a lack of safety boats in the water. In addition to the command investigation, we have completed a safety investigation that details specific safety-related causal and contributing factors. Although we do not publicly release safety investigations, we have integrated the findings of this investigation into our actions moving forward.

While the command investigation provided sufficient detail about the direct causes of the AAV sinking, it did not thoroughly examine higher headquarters oversight of the forming of

15th MEU. On April 2, 2021, I appointed a general officer with MEU command experience to serve as board president for a command investigation into the facts and circumstances surrounding the forming of the 15th MEU, training and material readiness impacts during its forming, higher headquarters oversight up to the Marine Expeditionary Force-level, and COVID-19 impacts. This investigation is currently in progress; we will share the findings of the investigation with this subcommittee after HQMC review. The U.S. Navy has also directed a command investigation into the facts and circumstances surrounding the AAV sinking, which will include Marine Corps representation on the investigation team.

The findings of fact, opinions, and recommendations in the original investigation were sufficient to permit accountability actions for individuals involved in this incident. To date, eleven individuals have been held accountable or are in the process of being held accountable for their actions and inactions, in accordance with applicable law and regulations. Some of these accountability actions are ongoing, including boards to consider suitability for future service. We make decisions regarding accountability based on an individual's responsibilities and their performance of duties. An individual's rank neither obligates nor excuses them from accountability. As we learn more about this tragedy through our additional investigation, we will take accountability measures as appropriate.

Another area to highlight from the investigation is the impact of COVID-related risks on this mishap. While COVID is not to blame for what happened, COVID impacts influenced leadership decisions at every level. These impacts were particularly pronounced in decisions made during February, March, and April 2020 as the AAV platoon was forming for the first time and we were simultaneously learning how to safely and effectively operate in the COVID environment. While COVID-related schedule changes and training cancellations may have

affected the units involved in this mishap, leaders should have intervened and mitigated the resulting risk. Our investigations so far have touched on COVID impacts, and it is an area that deserves greater attention in our broader readiness discussions.

Institutional Actions to Prevent Future AAV Mishaps

The command investigation provided valuable information to drive Service-level modifications to our procedures for amphibious operations. Based on investigation findings, the Marine Corps developed 54 tasks to help prevent a tragedy like this from happening again. We immediately took the below Service-level actions:

- The Commandant of the Marine Corps ordered an immediate suspension of all AAV waterborne operations on July 31, 2020, pending a comprehensive review of equipment, procedures, and training pertaining to safety during AAV waterborne operations.
- Program Executive Office, Land Systems ordered all AAV units to conduct additional inspections of every AAV with new criteria for hull watertight integrity, bilge pump function, and emergency egress lighting systems.
- Commanding General, Training and Education Command (TECOM) conducted a comprehensive review of all AAV-related publications and associated technical manuals as well as a course curriculum review board for Assault Amphibian School. These reviews resulted in immediate updates to course material and the AAV Common Standard Operating Procedures (SOP) concerning waterborne operational procedures, emergency procedures, and pre-operation checklists.

The following actions, among others, have been or will be taken across the Fleet Marine Force and U.S. Marine Corps Forces Reserve:

- Review all safety practices and procedures associated with waterborne and ship-to-shore operations and ensure commanders are directly responsible for safety structure.
- Clarify guidance on the provision of ready equipment and trained personnel to Marine Expeditionary Units.
- Ensure AAV waterborne and ship-to-shore operations are trained and evaluated during pre-deployment workup periods.
- Ensure personnel receive appropriate rest prior to high-risk training and operations.

- Ensure positive communications between AAV leaders and ships' personnel during ship-to-shore operations. Additionally, ensure appropriate personnel grant permission, based on sea state and safety boat status, to launch AAVs from a ship or recover them from the shore.

Additionally, appropriate agencies at HQMC have or will:

- Review the utility and effectiveness of the LPU-41 flotation device and field additional safety equipment that provides supplemental air in the event of a sinking.

- Review the Marine Corps Water Survival Program, AAV and Amphibious Combat Vehicle (ACV) embarked personnel training standards, the Submerged Vehicle Egress Trainer syllabus, and other associated training and publications.

- In coordination with the U.S. Navy, review employment of safety boats during waterborne and ship-to-shore operations to ensure consistent policies and doctrine within the Naval services.

- In coordination with the U.S. Navy, review the Common SOP for Assault Amphibian Operations and associated Navy publications, and develop applicable directives.

- Review the ACV program to ensure lessons learned from AAV mishaps are incorporated into ACV training, operations, and maintenance and that current ACV safety features adequately support emergency egress.

- Continue sustained funding of the AAV program for as long as the vehicle is in service. Currently, the AAV program will be sustained until the ACV is fully fielded. The ACV personnel variant will be fully fielded in 2026, and the 30mm gun and recovery variants will be fully fielded in 2028.

- Standardize water integrity testing procedures.

I will track the progress and completion of these and other actions to ensure we fully implement these changes throughout the institution.

Marines are the Nation's ready response force, and amphibious operations is one of our core capabilities. It is a Navy-Marine Corps imperative to train to standard for amphibious operations, and future operational concepts demand we increase our common understanding of the requirements of operations from the sea. We will present the above actions to the Navy and Marine Corps Board for senior leader awareness of the continued requirement for naval

integration and to gain insight on how we can create a repository of expertise in amphibious operations. HQMC will also present these issues to and seek the counsel of a "Blue Ribbon Panel" comprised of outside experts so we can capitalize on the generations of amphibious experience that exist in our retired community.

On April 9, 2021, HQMC published a list of requirements for units to resume AAV and ACV waterborne operations. These 18 requirements include specific training and qualifications, safety equipment, maintenance inspections, use of safety boats, timely sea state assessments, and positive communications. The first general officer in an AAV or ACV unit's chain of command must certify that the unit has met all 18 requirements before commencing waterborne operations. Our first unit to meet all requirements conducted waterborne operations on April 14, 2021 at Del Mar Boat Basin, Camp Pendleton, California. This training did not include embarked personnel or ship-to-shore movement. We will publish requirements for embarked personnel and ship-to-shore movement at a later date. This first step in our deliberate and incremental return to AAV and ACV waterborne operations will help us ensure safe conditions and regain lost proficiency as we prepare our units for further training and deployments.

Institutional Safety Initiatives

Leadership remains the bedrock of Marine Corps initiatives to improve safety culture, reduce mishaps, and increase readiness. Through senior leader engagements at commanders courses, general officer courses, and other training and education venues, we are taking every opportunity to instill in our leaders the value of a strong safety culture and how emphasizing risk management and good decision-making saves lives and improves readiness. The Executive Safety Board, comprised of general officer leadership from across the Service, meets on a semiannual basis to provide the oversight, support, and resources that enable safety performance

and readiness. We are also committed to pursuing technological advancements, data analytics, and training improvements that will bolster our Marines' ability to mitigate risks and safely accomplish their missions. Active leadership, using lessons learned and the resources detailed in this statement, is the key to reducing mishaps.

We know that a vital part of a healthy safety culture is the ability and willingness of Marines to report hazards and mishaps. In April 2018, we fielded the Aviation Safety Awareness Program (ASAP) to all aviation units. ASAP allows individuals to anonymously report hazards directly to their safety officer and commanding officer, who can then take action and provide feedback on the reported hazard. Additionally, ASAP affords individuals the ability to submit comments on the command climate of the unit, providing valuable and timely information to the commander on problem areas without fear of retribution. Since its fielding, we have received over 6,600 ASAP reports that contained actionable information for safety improvements. Based on the successful use of ASAP in our aviation community, we are testing a ground-oriented version of ASAP—the Marine Corps Safety Awareness Program (MCSAP).

We have also made strides over the past year in safety management and information sharing. In October 2020, we completed a seven-year effort to create the Marine Corps Safety Management System (SMS), which consolidated 18 policy documents into a single systems-based approach to safety. The SMS, modeled on the Federal Aviation Administration's safety management system, focuses on operational excellence through risk management. We have also recently implemented the Department of the Navy's Streamlined Incident Reporting (SIR) system for air and ground mishap reporting. SIR replaces the outdated Web-Enabled Safety System and has improved mishap information sharing through easier inputs and better search functions. We are also in the process of fielding an online "mishap library," which will enable

Marines to easily access mishap lessons learned for individual and unit professional development. We will soon have this mishap library linked with our training and readiness manuals, which will enable Marines at all levels to quickly locate vignettes and lessons learned specific to the training event they are planning. The combination of ASAP, SMS, SIR, and the mishap library provides the structure for Marine leaders to encourage a healthy reporting culture and emphasize the importance of learning from our mistakes and near-misses.

Conclusion

The Marine Corps is committed to ensuring the safety of our Marines, Sailors, and civilians as we train to be the Nation's naval expeditionary force-in-readiness. We have consistently reduced vehicle rollovers over the past three years, and from 2019-2021, we achieved our lowest two-year aviation flight mishap rate on record. However, the July 2020 AAV mishap and other safety trends clearly demonstrate that Marine Corps safety culture is not where it needs to be. We must make significant cultural and institutional changes to ensure the Marine Corps prevents unnecessary loss of life and equipment and our Marines and Sailors can maximize their potential. We appreciate your support and oversight as we learn from our past, improve our adherence to safety standards, and create lasting institutional change.

General Gary L. Thomas

General Gary L. Thomas is currently serving as the Assistant Commandant of the Marine Corps.

A native of Austin, Texas, he graduated from the University of Texas and was commissioned in 1984. He previously served as the Deputy Commandant for Programs and Resources.

General Thomas is a Naval Aviator and has served in several F/A-18 squadrons. He commanded VMFA-323 during Operation IRAQI FREEDOM while embarked aboard the USS CONSTELLATION (CV-64). He also commanded Marine Aviation Weapons and Tactics Squadron One (MAWTS-1), and he served as the Commanding General, 2d Marine Aircraft Wing (Forward) in Afghanistan as well as the Commanding General, 2d Marine Aircraft Wing in Cherry Point, North Carolina.

He has also served as Assistant Wing Commander of 2d Marine Aircraft Wing, the Assistant Deputy Commandant for Aviation, and as the Marine Corps Deputy Director of Operations.

His joint assignments include service in the Joint Staff Strategic Plans Directorate (J-5) and in the Force Structure, Resources, Assessment Directorate (J-8).

General Thomas is a graduate of the Weapons and Tactics Instructor Course, the Navy Fighter Weapons School, Air Command and Staff College, and the National War College. He holds a M.S. in National Security Strategy from National Defense University.

Major General Gregg P. Olson
Assistant Deputy Commandant, Plans, Policies, Operations

Gregg P. Olson grew up in Cumberland, RI, Montreal, Quebec, and Westlake Village, CA. He graduated from the United States Naval Academy in 1985.

An infantry officer, MajGen Olson has an additional Military Occupational Specialty as an embarkation officer.

MajGen Olson commanded a rifle company in 2nd Battalion, 1st Marines, and both Headquarters & Service and Weapons Companies in 3d Battalion, 2nd Marines. He commanded 2nd Battalion, 1st Marines during combat in Fallujah in 2004, and the 11th Marine Expeditionary Unit during its 2010 deployment.

His Marine Corps staff assignments include S-3 Operations Officer for 3d Battalion, 3nd Marines during Operation SEA SIGNAL (1995), S-3 Operations Officer for 15th Marine Expeditionary Unit (Special Operations Capable) during combat operations in Afghanistan (2001) and Iraq (2003), and service as G-3 Operations Officer for 1st Marine Division.

MajGen Olson's supporting establishment assignments include staff and ceremonial duties at Marine Barracks, Washington, D.C., Faculty Advisor at Amphibious Warfare School, and Director for Senate Liaison, Office of Legislative Affairs, Headquarters, Marine Corps.

As a field grade officer, MajGen Olson was assigned as Assistant Deputy Director for Regional Operations (J-33), J-3, the Joint Staff. During that tour, he qualified as a Deputy Director for Operations (DDO) in the National Military Command Center.

As a general officer, MajGen Olson was assigned as Deputy Commander, U.S. Marine Corps Forces, Central Command/Commanding General, Marine Corps Forces, Central Command (Forward), Manama, Bahrain. During that tour, he was additionally assigned as Commander, Task Force 51/59, Fifth Fleet, U.S Naval Forces, Central Command. In 2016, he was assigned as the Director of the Marine Corps' 2016 Quadrennial Defense Review Office at Headquarters, Marine Corps.

His Joint service as a general officer includes assignment as the Joint Staff's J-5 Deputy Director for Political-Military Affairs, Middle East (DDME), and as the Director of Operations and Cyber, US Africa Command, Stuttgart, Germany.

Major General Olson is a graduate of the Amphibious Warfare School, Marine Aviation Weapons and Tactics Squadron One Weapons and Tactics Instructor Course, the College of Naval Command and Staff, and the National War College.

He is married to a former Navy Nurse Corps officer.

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STATEMENT OF

VICE ADMIRAL ROY I. KITCHENER

U.S. NAVY

COMMANDER, NAVAL SURFACE FORCES

BEFORE THE
HOUSE ARMED SERVICES COMMITTEE
ON
READINESS:

THE AAV MISHAP INVESTIGATION: HOW TO BUILD A CULTURE OF SAFETY TO AVOID PREVENTABLE TRAINING ACCIDENTS

MAY 3, 2021

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SERVICES COMMITTEE

Chairman Garamendi, Ranking Member Lamborn, and distinguished members of the Readiness Subcommittee, I appreciate the opportunity to testify today.

First and foremost, I want to express my personal condolences to the families of our fallen Marines and Sailor who served their country with pride and honor. This devastating loss underscores the very dangerous work our Sailors and Marines commit to each day in our all-volunteer force, and it once again reminded us of our solemn obligation to provide each service-member an environment where risk is being correctly managed. We are committed as a Navy-Marine Corps team to ensure an event such as this does not happen again.

I have first-hand experience with amphibious operations and Navy-Marine Corps integration as I commanded Expeditionary Strike Group 2. This is the Navy's east coast expeditionary Strike Group, with an integrated Navy-Marine Corps headquarters staff responsible for three amphibious squadrons, a naval beach group, 13 amphibious ships and two tactical air control squadrons, totaling more than 11,000 Sailors and Marines, with the capacity to embark an additional 14,000 Marines. In my current position as the Commander, Naval Surface Forces, I am responsible for the development of current and future readiness of surface forces – including policies and procedures to conduct wet-well operations in support of Marine Corps waterborne operations.

Immediately following the tragic mishap on 30 July, the Navy and Marine Corps discontinued AAV operations. To this point, the Navy has not resumed waterborne AAV operations and will not do so unless and until we are satisfied that all necessary policies, procedures and risk mitigation measures are in place.

Prior to resumption of operations, Marine Corps requirements have been identified to include establishment of positive communications between safety boats, amphibious assault units and the ships they intend to embark or debark; requirement for face-to-face briefings and attendance (live or virtual) at the ship's confirmation brief for all AAV leaders prior to operations; ensuring that safety boats are in the water and removing the ability for an AAV to serve as a safety boat; and, confirming sea states assessments immediately prior to launch from ship's well decks or from the shore. Any additional Navy requirements for our units and any embarked Marine Corps units will be assessed and established following the completion of our ongoing Navy investigation. All Commanding Officers and well deck teams will be trained to

these new requirements and will have reviewed the specific lessons learned from the Marine Corps' investigation into these tragic events.

As the Marine Corps investigation discovered, there are inconsistencies in the Navy and Marine Corps standing operating procedures and policies for waterborne AAV operations. The ambiguity in these policies manifested themselves in decisions made in the planning and execution of AAV operations on 30 July 2020, but we are looking broadly across the full range of Navy-Marine Corps integrated operations to ensure our operating procedures are aligned. LtGen Craporatta, my Marine Corps counterpart at Marine Corps Training & Education Command (TECOM), and I have met and outlined the framework on how we will reconcile our service policies and ensure they are consistent and provide clear direction to operational planners and Commanders at sea.

A specific example involved the policy on the use of safety boats when conducting AAV operations. Marine Corps standard operating procedures did not require the use of a safety boat. Navy policy required the use of two safety boats. Operational planners for this exercise defined a requirement for one safety boat. Both policies allowed for an AAV to serve as a safety boat. Before we recommence ship-based AAV operations, we need to reconcile these differences and identify what "right" looks like in both a training environment and in a warfighting or operational setting.

While the Navy fully supports this and other findings and recommendations of the Marine Corps investigation, the Marine Corps investigation did not fully address Navy actions on the day of this fatal mishap. We are accountable as an organization and must fully address whether Navy actions, or inaction, contributed to the incident and what changes to practice and policy we must make prior to re-commencing waterborne AAV operations. Accordingly, we have initiated our own command investigation with a team of 16 Navy, Marine Corps and civilian subject matter experts in areas such as well deck operations, operational planning, communications in a maritime environment, oceanography, well deck operations, AAV operations, USMC maritime aviation operations, and operational safety.

Specifically, the investigation has been directed to address (1) communications, decisions and actions of Navy personnel involved in the planning, approval and execution of the operation, (2) communications between in Navy and Marine Corps personnel before, during and after the mishap, and (3) whether a clear command and control relationship was established and executed

consistent with the concept of operations. Additionally, the investigation will assess the possible impact of (1) the sea state at the beginning of operations and at time of mishap, (2) the location, movement and other ongoing operations of SOMERSET, and (3) the number and type of safety boats involved as well as the approval process for the same. This investigation will make use of the expansive interviews and evidence previously collected by the Marine Corps, but not necessarily referenced in their narrative report. Our investigation is expected to be completed within 30 days.

Professional seamanship is the standard with no exceptions. We owe it to our Marines and Sailors in our care. As we have demonstrated since the tragedies involving USS FITZGERALD and JOHN S. MCCAIN, it is in our culture to critically evaluate and then make and effectively implement necessary changes. Although we operate in a dangerous and demanding environment and will never be able to eliminate all risk, you have my assurance that we will, with great speed, provide you, the American people, and our Navy-Marine Corps team with our critical assessment of how to best move forward with integrated amphibious operations. On behalf of all Sailors, their families, and our Navy Civilians, I thank you for your continued support, and look forward to your questions.

Vice Admiral Roy Kitchener
Commander, Naval Surface Forces/Commander, Naval Surface Force, U.S. Pacific Fleet

Vice Adm. Roy Kitchener is a native of Trumbull, Connecticut and a 1984 graduate of Unity College with a Bachelor of Arts in Political Science. He attended the Navy Officer Candidate School in Newport, Rhode Island, and received his commission in 1985. He also attended the Naval Post Graduate School where he specialized in Western Hemisphere studies and earned a Master of Arts in National Security Affairs.

As a surface warfare officer, he deployed around the world and commanded destroyers, cruisers, and an expeditionary strike group. At sea he served as a division officer aboard USS Dewey (DDG 45); operations and training officer for Special Boat Unit 26, Republic of Panama; combat systems and weapons officer aboard USS San Jacinto (CG 56); executive officer aboard USS Cowpens (CG 63); and operations officer and chief of staff for Commander, Carrier Strike Group 11. He commanded USS John Paul Jones (DDG 53) and USS Higgins (DDG 76), during the Navy's Sea Swap Initiative, and also commanded USS Princeton (CG59) and Expeditionary Strike Group 2.

Ashore, Kitchener served as the Surface Warfare Directorate's Naval Surface Fire Support program officer on the staff of the Chief of Naval Operations; combat systems instructor at Surface Warfare Officers School; ballistic missile defense operations chief at the Cheyenne Mountain directorate at Commander, U.S. Northern Command; and vice commander of Naval Mine and Anti-Submarine Warfare Command. He served as the chief of staff at numerous commands, to include Commander, U.S. 3rd Fleet; Commander, Naval Surface Forces; Naval Striking and Support Forces North Atlantic Treaty Organization (NATO); and U.S. deputy military representative to the NATO Military Committee. Most recently, he was commander, Naval Surface Force, U.S. Atlantic Fleet.

Kitchener assumed the duties as commander, Naval Surface Forces/Naval Surface Force U.S. Pacific Fleet on August 3, 2020.

His decorations include the Defense Superior Service Medal (three awards), Legion of Merit (five awards), Defense Meritorious Service Medal, and various service and campaign awards.

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