



DEPARTMENT OF THE NAVY
COMMANDER EXPEDITIONARY STRIKE GROUP SEVEN
UNIT 25093
FPO AP 96601-6006

5800
Ser N00/026
23 Feb 12

SECOND ENDORSEMENT on .

ltr of 13 Jan 12

From: Commander, Expeditionary Strike Group SEVEN
To: File

Subj: COMMAND INVESTIGATION INTO THE DEATH OF PS1 REGAN YOUNG
ONBOARD USS ESSEX (LHD 2) ON 23 NOVEMBER 2011

Encl: (115) CO, USS ESSEX, memo of 7 Feb 12

1. Per reference (a), I have reviewed subject investigation.
2. I approve the findings of fact, opinions, and recommendations of the Investigating Officer as modified by the Commanding Officer, USS ESSEX (LHD 2) with the following exceptions:

a. Findings of Fact (FoF)

(1) Add:

(a) FoF 200. Based on ESSEX underway schedule for the year prior to 23 November 2011, the W-2R SOT check should have been completed 26 times for the forward NSSM launcher and 50 times for the aft NSSM launcher. [Encls. (56), (57), (58), and (115)]

(b) FoF 201. Of the 26 times the W-2R SOT should have been conducted for the forward NSSM launcher prior to 23 November 2011, a review ESSEX's records reveal that the system was tagged out four times. [Encl. (115)]

(c) FoF 202. Of the 50 times the W-2R SOT should have been conducted for the aft NSSM launcher prior to 23 November 2011, a review of ESSEX's records reveal that the system was tagged out six times. [Encl. (115)]

b. Opinions (Op)

(1) Disapprove:

(a) Op 14. Per FoF (84), the W-2R SOT is required weekly and 24 hours prior to getting underway. Therefore, the W-2R SOT performed was required on 23 November 2011, which was 24 hours prior to ESSEX's underway. The W-2R SOT performed on 21 November met only the weekly requirement. Additionally since the NSSMS system was not tagged out in accordance with the W-2R Maintenance Requirement Card the check conducted on 21 November was invalid and therefore not accomplished.

Subj: COMMAND INVESTIGATION INTO THE DEATH OF PS1 REGAN YOUNG
ONBOARD USS ESSEX (LHD 2) ON 23 NOVEMBER 2011

(b) Op 15. As described in FoFs (92)-(133), (140)-(148), and (200)-(202), ESSEX leadership did not effectively foster a culture of procedural compliance and accountability, specifically within the CSF4 work center.

(2) Add:

(a) Op 17. On numerous occasions prior to and including 23 November 2011, CSF4 work center failed to properly complete required maintenance on the forward and aft NSSM launchers in accordance with established maintenance and safety standards. [FoFs. (200) through (202)]

(b) Op 18. The Combat System department leadership failed to establish and foster an atmosphere of compliance with established maintenance and safety standards and to provide meaningful oversight of the individuals conducting these procedures. [FoFs. (25), (36) through (47), (50), (51), (68), (70), (74), (79), (80), (95)-(97), (99), (100), (128), (129), (131), (132), (143), (144), and (146) through (148)]

3. I specifically approve the opinion that the death of PS1 Young occurred in the line of duty not due to his own misconduct. I have directed that the line of duty determination be recorded in PS1 Young's medical and personnel records.

4. As a result of this investigation, I have directed the following additional actions:

a. The development of a Combat System Assessment Team in order to conduct a thorough review of practices and procedures of the ESSEX's Combat Systems Training Team.

b. The Commanding Officer, ESSEX will provide a monthly report of all remedial actions directed by this investigation.

5. As a result of this incident, I have issued the Commanding Officer, ESSEX, an administrative counseling.

Copy to:
OPNAV N85
OPNAV N86
COMSEVENTHFLT
COMPHIBRON ELEVEN
CO, USS ESSEX