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02 July 1996

From: Chairman, Incident Specific Preparedness Review Team  
To: Commandant (G-M)

Subj: INCIDENT SPECIFIC PREPAREDNESS REVIEW (ISPR) OF THE  
RESPONSE TO THE OIL SPILL RESULTING FROM THE GROUNDING  
OF THE TANK BARGE NORTH CAPE IN BLOCK ISLAND SOUND OFF  
POINT JUDITH, RHODE ISLAND ON 19 JANUARY 1996

Ref: (a) COMDT (G-M) ltr 16465 of 09 FEB 96

1. As required by reference (a), an Incident Specific Preparedness Review (ISPR) was conducted on the subject oil spill incident response. The ISPR Team members included LCDR JosephPancotti, Commandant (G-RER); LCDR Walter M. Hunt, Commandant (GMRO); Mr. John Morhman, Delaware Department of Natural Resources Emergency Management; Mr. John Joeckel, Ashland Petroleum; LTJG Lauren V. Kabler, Commandant (G-MRO) as recorder; and myself as Chairman.
2. We were tasked with comparing the response in this case against current federal, state, and local oil spill response contingency plans with the purpose of evaluating the effectiveness of the post-Oil Pollution Act of 1990 planning and preparedness process. The goal of the ISPR was to identify strengths and weaknesses in this process which could yield effective improvements in the planning efforts of all those involved in marine environmental response.
3. After meeting with program manager staff and an initial review of background material and "lessons learned" identified by the Spill Management Team, we developed a number of areas of emphasis. These were consolidated into the following five broad Focus Areas:
  - a. Response Management System: What type of system was used? What were its strengths and weaknesses? Was it planned?
  - b. Planning and Preparedness: How was the Area Contingency Plan helpful? Where was it deficient? How could it be improved? How did the Spill Management Team benefit from preparedness activities?
  - c. Information Management System: What were the strengths and weaknesses of the information management system? How can the Area Contingency Plan be improved to overcome deficiencies?
  - d. Support System: Was adequate support planned for this type of response? What improvements are needed?

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e. Resource Management System: What lessons can be learned to help others in better managing resources for future spills?

4. Enclosure (1) is the ISPR Report for this incident. It is divided into three parts: an Executive Summary, Lessons Learned, and a report on the ISPR process.

5. There were many lessons learned as a result of this significant response. We have tried to identify and discuss those most important to response planners. Unfortunately, the critical nature of the review and the reporting format do not easily reflect the overall performance of this response. There are two very important points that we would like to stress at the outset of this report:

a. The Spill Management Team in this case performed in a commendable fashion. Battling severe and dangerous weather conditions, dealing with a situation that was extremely tenuous, and having to perform under unbelievable political, media, and public scrutiny, the Unified Command mounted an extremely effective response.. It is widely believed that this response was a "success."

b. The response in this case validates the post-OPA 90 planning and preparedness process. The success of this response was due in large part to the smooth integration of the Federal and State agencies involved. The Spill Management Team clearly benefited from previous Area Committee planning efforts. The ease at which Federal and State personnel were able to work together toward a common goal is a testament to the Area Committee concept.

DENNIS A. SANDE Captain, U.S. Coast Guard

End: (1) Incident Specific Preparedness Review

Copy: Commandant (G-MRO)  
Commander, First Coast Guard District (m) Commanding Officer, CG Marine Safety Office  
Providence

**T/B NORTH CAPE SPILL**

**INCIDENT SPECIFIC  
PREPAREDNESS REVIEW  
(ISPR)**

Submitted: 02 July 1996

## EXECUTIVE SUMMARY

### The Incident

Disaster struck the Rhode Island coast on the evening of January 19, 1996. The Tug SCANDIA was towing the single-hulled tank barge NORTH CAPE loaded with four million gallons of no. 2 fuel oil bound from Newark, New Jersey to Providence, Rhode Island. Suddenly, a fire broke out onboard the SCANDIA and the crew was forced to abandon their vessel. The tow drifted until both the tug and the barge grounded in heavy surf in Block Island Sound off Point Judith, Rhode Island. The barge began leaking and eventually spilled approximately 828,000 gallons of oil. This devastating event became the worst spill in Rhode Island history and the second largest recorded in New England.

### The Response

Following a dramatic Coast Guard rescue, the Federal On-Scene Coordinator (FOSC) swung into action to mitigate the effects of the spill. Coast Guard Marine Safety Office Providence personnel formed the nucleus of a Spill Management Team and established a forward command post near the site of the grounding. Their numbers quickly grew when help arrived from numerous First Coast Guard District units, the National Strike Force, Rhode Island State emergency management and environmental agencies, and various other Federal agencies.

These personnel quickly organized themselves into an Incident Command System Spill Management Team. The FOSC, the Rhode Island Department of Environmental Management representing the Governor, and the owner of the T/B NORTH CAPE quickly established a Unified Command to direct the response.

Skimming operations using both commercial resources and two Coast Guard buoy tenders equipped with the Vessel of Opportunity Skimming System (VOSS) began on January 20. The first attempts at salvaging the barge were made the next day. In the meantime, plans were being formulated to protect the environmentally sensitive areas predominant in this region. Lightering operations progressed through the 23rd of January when severe weather dictated the curtailment of these efforts. Lightering was renewed on the 25th and the TIB NORTH CAPE was finally refloated on January 26. It was subsequently emptied and towed to New York.

In addition to coping with the severe weather that plagued salvage attempts, the Spill Management Team faced challenges protecting natural resources. An estimated 80% of the no. 2 oil quickly mixed through the water column and worked its way through breachways that were near impossible to protect. Nevertheless, the team did manage to recover all visible oil from the surface of the water, offload approximately 3.2 million gallons of oil from the barge without further discharge, and additionally remove approximately 70,000 gallons of diesel fuel from the Tug SCANDIA. Despite often hazardous conditions, there were no serious injuries resulting from the response efforts.

The strengths of the response were the strategic functioning of the Unified Command, the smooth integration between Federal and State agencies, and the effective public affairs efforts of the Spill Management Team. The success of this response can be directly attributed to the planning and preparedness efforts of the Rhode Island/Southeastern Massachusetts Area Committee.

## **The Review**

Despite the resounding success of this response, there were indeed aspects that would have benefited from better planning and preparedness. That is the purpose of the Incident Specific Preparedness Review - to examine the response against existing plans in an attempt to identify those areas that could be improved through future planning and preparedness efforts.

The ISPR Team identified 108 specific areas that deserve comment. Admittedly, like other lessons learned, most of these were areas for improvement. There were, however, several significant aspects of the response that were extremely effective and these too are included so that others might learn from these positive lessons. The 108 areas were consolidated into 32 formal lessons learned. These were grouped together into the five Areas of Focus identified by the ISPR Team at the outset of this review. A brief summary of the ISPR conclusions relating to each of these five areas follows.

## **Areas of Focus**

### 1. Response Management System

The Spill Management Team (SMT) organized loosely around the National Interagency Incident Management System (NIIMS) Incident Command System (ICS). While the basic fundamentals of ICS were followed, the Area Contingency Plan lacked the functional specificity and the SMT lacked the training and experience to establish an effective ICS organization. While the State and the Federal agencies involved clearly benefited from their work together during the Area Committee planning process, the Responsible Party did not integrate smoothly into the Incident Command System. The Responsible Party, State, and FOSC did perform effectively as Unified Commanders, and this was one of the clear strengths of this response.

## 2. Planning and Preparedness

While the process of developing the Area Contingency Plan certainly benefitted members of the Spill Management Team, the plan itself still requires much work in the area of ICS organization, functions, responsibilities, and assignments. The organization employed during this response worked for this response, but there is cause for concern that a similar organization would be ill-equipped to handle a larger, more complex response. It was also noted that a lack of training and participation in exercises adversely affected the performance of the Spill Management Team.

## 3. Information Management Team

The effectiveness of the information management system is best summed up as follows: external information management was superb; internal communication could have benefitted from better developed plans. Much can be learned from the effectiveness of both the public affairs efforts and the practices instituted to provide information to higher authority. Better internal communication and display of available incident and resource status would have improved the efficiency of the response.

## 4. Support System

The support networks employed to handle public affairs and personnel safety were extremely effective. Less effective was the utilization of special forces and assistance available to the Unified Command, such as the Scientific Support Coordinator, the Regional Response Team, and the Navy Supervisor of Salvage.

## 5. Resource Management System

While difficult to draw conclusions about resource management without doing some amount of second guessing, it appears that all available salvage resources may not have been used. An important lesson learned in this area of focus was that the Oil Spill Response Organization (OSRO) employed by the Responsible Party in this response may not have been capable of performing in accordance with its classification. This raises some serious concerns about the OSRO classification process that existed at the time of the spill.

**NATIONAL PREPAREDNESS FOR RESPONSE EXERCISE PROGRAM  
LESSONS LEARNED SYSTEM (PLLS) LONG REPORTS**

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## PLLS LONG REPORT

1. FOCUS AREA: ISPR #1.1 - Response Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESPONSE MANAGEMENT SYSTEM, UNIFIED COMMAND
4. TITLE: Unified Command
5. OBSERVATION: The Federal On-Scene Coordinator, State On-Scene Coordinator, and Responsible Party functioned effectively as a Unified Command.
6. DISCUSSION: The Area Contingency Plan specified a Unified Command consisting of the Federal On-Scene Coordinator (FOSC), State On-Scene Coordinator (SOSC), and the Responsible Party (RP). It was envisioned that overall strategic decision-making would be performed and the response would be directed by this Unified Command. In fact, during this response, that is exactly what occurred. From the outset of the response, the FOSC, the SOSC representing the Governor, and the RP behaved as one unified commander. All strategic decisions were made jointly and communicated down through the organization with no misalignment between agencies or the responsible party.

The success of this response was due in large part to the performance of the Unified Command. Three aspects of this performance stand out and deserve comment:

- (1) First, all decision-making was jointly made. This type of decision-making benefits from the perspectives and expertise of the three primary stakeholders in the response: the Federal government, State government, and the responsible party. There was much evidence available during this incident review to conclude that throughout the response, the three entities shared information, expressed concerns and expectations to each other, and reached their strategic decisions via consensus. This consensus decision-making provided the response organization with confidence that decisions were well-conceived and that they would stand. There was little misalignment in directing the response as would occur when three sets of directions are being handed down.
- (2) Second, the Unified Command performed at the strategic level. Specifically, tactical and support considerations were left to others in the organization. There was no evidence of "micro management." This type of empowerment boosted the confidence and morale of the organization.
- (3) Most importantly, the entire response organization spoke with one voice. This had a significant impact on how the performance of the organization was perceived by the public. Clearly, separate agendas were never suspected by the public. By hearing a consistent, unified position emanating from the Unified Commanders, the public detected a well-organized and efficiently-functioning spill management team.



7. LESSONS LEARNED: The public will perceive an efficient and effective response organization when the FOSC, SOSC, and RP behave as a well-functioning unified command. The members of the response organization will have high confidence in the response strategies when they perceive them to be jointly made. These personnel will have high confidence and high morale when the Unified Command limits its functioning to strategic issues.

8. RECOMMENDED ACTION: The role of the Unified Command should be spelled out in the Area Contingency Plan. Area Committees should ensure the FOSC, SOSC, and when possible - the potential RPs, discuss and agree to this type of unified behavior and consensus decision-making. When it is not possible to discuss this performance ahead of time with RPs, this agreement should be sought at the very outset of the spill response.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #1.2 - Response Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESPONSE MANAGEMENT SYSTEM, INCIDENT COMMAND SYSTEM, AREA CONTINGENCY PLAN, PLANNING, OPERATIONS, LOGISTICS, FINANCE
4. TITLE: Incident Command System
5. OBSERVATION: The entire response organization did not function as planned in the Area Contingency Plan.
6. DISCUSSION: A basic Incident Command System (ICS) was outlined in the Area Contingency Plan (ACP). The organization consisted of the standard Unified Command with sections for Planning, Operations, Logistics, and Finance. Additionally, the ACP contained basic functional descriptions of these sections. The organization used during the response was Operations-heavy and Planning-weak. In fact, virtually all aspects of the response were controlled by the Operations Section, with the Chief of the Operations Section performing akin to a Chief of Staff or Deputy On-Scene Coordinator. A discussion of the actual functioning of each of the four sections follows:

Once up and running, the Finance Section did perform in accordance with the description in the ACP. While there may not have been ideal integration between the Responsible Party's and the Federal and State On-Scene Coordinator's staffs, a fairly accurate accounting of resources was maintained. Additionally, procedures were established and maintained to process and document claims.

The Logistics Section was established almost immediately. This section was headed up by a representative of the State Emergency Management Agency and this appears to have been an ideal choice. All needs of the internal response organization, i.e. supporting the command center and its personnel as well as support for field personnel, were handled efficiently and effectively. Functionally, however, the role of providing logistics for the response itself, i.e. locating response equipment, etc., was not performed by this section. Rather, the Operations Section took on this responsibility.

The Operations Section did accomplish most, if not all, of the functions planned in the ACP. Unfortunately, the Operations Section took on many of the responsibilities of other sections. Specifically, strategy planning was performed almost exclusively by the Operations Section. Since a true "Information Center" was not established, the Operations Section was burdened with providing information to agencies and others requesting information. This function required the attention of personnel that might have been better used attending to the actual directing and monitoring of the response. In addition to planning the response, directing and monitoring it, and providing information about it, the Operations Section also located and supported equipment, personnel, and resources for it.

The Planning Section clearly did not perform as intended by the ACP. Short-term planning was performed by the Operations Section; there was virtually no long-term planning (a written Incident Action Plan was not produced until the fifth day of the response). Incident and resource status was not maintained until well

into the response. An important function that this section did perform, and in which it was well-disciplined, was establishing and controlling the cycle of meetings of the response organization.

While the response organization may not have functioned as planned in the ACP, it did perform, collectively, most of the functions outlined in the ACP. The two glaring deficiencies were long-term planning for strategy and resources, and maintaining status of the incident. Therefore, it can be concluded that the organization used during the response was adequate to direct and monitor the response. It can be argued, however, that the nature of the response, i.e. the type and behavior of the oil discharged, did not tax the organization to the point where the organization became inefficient and ineffective. The functional organization described in the ACP is a valid model for significant discharges and incidents. In this case, if the barge were to have lost its entire contents, 4 million gallons of oil, the response organization may have found themselves ill-equipped to handle the increased demands of such a discharge.

7. LESSONS LEARNED: When staffed with dedicated, motivated individuals, almost any organization that performs required functions will succeed to a point. When the demands of the response exceed the capabilities of any one group within the organization, the response will become inefficient and possibly ineffective.

8. RECOMMENDED ACTION:

a. Area Committees should fully develop the organization to be used during significant responses. Functional descriptions of the elements in the organization should be explained in detail. Area Spill Management Teams (SMTs) should become skilled at performing the functions outlined through training, practice, and exercises.

b. SMTs should strive for adhering to the planned organization as soon as the SMT is assembled for a response. Of course, each response will require a tailor-made organization. One of the attributes of the Incident Command System is that it is flexible. FOSCs and Unified Commands need to take advantage of that flexibility, while adhering to the basic tenets of the Incident Command System.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #1.3 - Response Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESPONSE MANAGEMENT SYSTEM, INCIDENT COMMAND SYSTEM, SPILL MANAGEMENT TEAM, INTEGRATION, FEDERAL, STATE, CONTINGENCY PLAN, AREA COMMITTEE
4. TITLE: Federal and State Integration in the Incident Command System
5. OBSERVATION: Federal and State agencies integrated well into the Incident Command System.
6. DISCUSSION: COMDTNOTE 16471, Establishment of Area Committees and Development of Area Contingency Plans, states that the primary role of the Area Committee is to act as a planning and preparedness body comprised of experienced response representatives from Federal, State, and local government agencies. Each member of the Area Committee is empowered by their agency to contribute to the development of the Area Contingency Plan and to carry out its provisions during a response. Those members of the Area Committee that take on a response role during an actual incident comprise the Area Spill Management Team. There was much evidence during this incident review to conclude that the Area Spill Management Team benefited from their work together as members of the Area Committee. Representatives of Federal and State agencies were placed in key roles in the Incident Command System. They functioned well together, exhibiting a high degree of trust and confidence in each other's abilities and performance.
7. LESSONS LEARNED: The Area Spill Management Team will perform more effectively when members of the team have participated together during the Area Committee contingency planning and preparedness process.
8. RECOMMENDED ACTION: This response validates the value of the Area Committee concept and its contingency planning process. Area Committees should continue their efforts to prepare the response community as much as possible. Working together, Federal, State, and local government agency representatives will gain trust and confidence in respective agency capabilities. This will facilitate the effectiveness of the Spill Management Team.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #1.4 - Response Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESPONSE MANAGEMENT SYSTEM, INCIDENT COMMAND SYSTEM, SPILL MANAGEMENT TEAM, INTEGRATION, RESPONSIBLE PARTY, VESSEL RESPONSE PLAN, AREA CONTINGENCY PLAN
4. TITLE: Responsible Party Integration in the Incident Command System
5. OBSERVATION: The Responsible Party's Spill Management Team did not integrate well into the Incident Command System.

6. DISCUSSION: The Vessel Response Plan (VRP) did not contain an organization chart of the Responsible Party's (RP) Spill Management Team (SMT), nor did it contain clear descriptions of functional responsibilities for members of the SMT. This undoubtedly led to almost complete lack of integration of the RP SMT into the Incident Command System employed by the response organization. The notable exception was at the Unified Command level, where the RP was ever-present and fully integrated with the Federal and State On-Scene Coordinators. Elsewhere in the organization, however, the RP chose to remain separate and distinct from the rest of the integrated organization. The most glaring example of this was in the Operations Section. There was no RP presence in this Coast Guard-dominated section, resulting in the appearance that the Coast Guard was controlling the operation while the RP concerned himself with salvage issues apart from the rest of the operation. Likewise, while the Finance Section maintained cost documentation for the entire response, the RP set up a separate RP finance element. Although the RP did perform logistics functions to support the response, this was done outside and separate from the Logistics Section established by the response organization.

This lack of integration between the RP and the rest of the organization led to the appearance of the Coast Guard planning, directing, and supporting protection and recovery operations and the Responsible Party planning, directing, and supporting salvage operations. Further, virtually all support for the organization's infrastructure, i.e. supporting the command post and the spill management team, was arranged without the assistance of the RP.

7. LESSONS LEARNED: When the Responsible Party does not integrate RP spill management team members into the overall response organization, inefficiencies in managing the response may result. At a minimum, there will be the appearance of inefficiency. Further, having duplicate elements within the organization performing planning, operations, logistics, and finance functions will increase the information-sharing burdens of the spill management team.
8. RECOMMENDED ACTION:
  - a. Area Committees should design fully-integrated spill management team organizations in their Area Contingency Plans.
  - b. Responsible Parties should design fully-integrated, i.e. Federal, State, and RP, spill management team organizations in their Vessel and Facility Response Plans.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #1.5 - Response Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESPONSE MANAGEMENT SYSTEM, UNIFIED COMMAND, INCIDENT COMMAND SYSTEM, ORGANIZATIONAL CONSULTANT, COMMAND STAFF, STRIKE TEAM
4. TITLE: ORGANIZATIONAL CONSULTANT
5. OBSERVATION: There was insufficient attention given to the proper functioning of the organization during the response.
6. DISCUSSION: Even when a response management system has been extremely well planned, there is still a need to attend to that organization, especially during the beginning stages of the response. There may be significant differences between the way an organization is expected to behave and the way it actually does. It is extremely helpful for someone to be assigned the responsibility of detecting these differences, someone who will act in the capacity of organizational consultant to the Unified Command.
7. LESSONS LEARNED: Assigning someone to perform the role of "organizational consultant" to the Unified Command will help ensure the response organization behaves in accordance with the Area Contingency Plan.
8. RECOMMENDED ACTION: In developing the spill management team in the Area Contingency Plan, the Area Committee should assign the function of organization consultant. This function should include observing the organization to ensure the functions outlined in the plan are being performed in the manner envisioned by the plan. The individual assigned this function should either be empowered to make necessary changes to the organization or should have access to the Unified Command to recommend these changes. There are several logical choices for assigning this function. An actual staff element could be established with that individual reporting directly to the Unified Command. Sometimes the FOSC elects to assign a senior member of an assisting Coast Guard Strike Team to serve as an advisor to the Unified Command. In this type of arrangement, the senior Strike Team member could also advise the FOSC Unified Command on organizational efficiency and recommended changes. Perhaps, the best way to accomplish this task is to designate a knowledgeable and skilled Chief of the Command Staff. Since information responsibilities would be assigned to the command staff, the individual responsible for heading up these functions would be in a good position to detect deficiencies in the functioning of the organization, especially regarding lateral and vertical information gaps. If assigned, a Chief of the Command Staff would be an ideal choice for attending to the organization. Such an assignment would free up the FOSC, Unified Command, or other senior personnel from having to address organizational structure concerns.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.1 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, INCIDENT COMMAND SYSTEM, AREA CONTINGENCY PLAN, ORGANIZATIONAL RESPONSIBILITIES, PLANNING, OPERATIONS, LOGISTICS, FINANCE
4. TITLE: Functions of Organization Elements in the Incident Command System
5. OBSERVATION: The Area Contingency Plan did not contain sufficient information regarding the functions and duties of the elements in the response organization.
6. DISCUSSION: The Area Contingency Plan (ACP) contained a basic description of an Incident Command System (ICS). Basic functional descriptions of the four sections (Planning, Operations, Logistics, and Finance) were included in the form of "functional bullets." While helpful, this level of description is inadequate for two reasons: (1) General descriptions such as this are wide open to interpretation of response personnel. There is a risk of personnel interpreting the functions either too broadly or too narrowly. If viewed too narrowly, necessary functions may not be performed. If viewed too broadly, duplication of functions will result in inefficiency. (2) Simple "Section" functional descriptions do not provide assistance in setting up the type of organization that will emerge to handle a significant response. There will be several to many personnel assigned to each element in the organization. Branches, Divisions, or Groups will emerge out of necessity as the organization evolves. Without pre-planning as to what functions each of these branches, divisions, or groups will perform, much time will be devoted to making organizational structure decisions during the response. These decisions will be made by individuals and will not benefit from the varying perspectives available through the Area Committee.
7. LESSONS LEARNED: Simple functional descriptions of the four sections of the Incident Command System are inadequate for assisting the spill management team to organize efficiently and effectively during a response.
8. RECOMMENDED ACTION: Area Committees should fully develop in their Area Contingency Plans a complete functional description of the organization. This needs to be more than a line diagram with functional bullets. Branches, Groups, Divisions, and Teams should be established as part of the organization. Specific functions and duties of these elements should be included in the ACP.



## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.2 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, INCIDENT COMMAND SYSTEM, AREA CONTINGENCY PLAN, PERSONNEL ASSIGNMENT; WATCH, QUARTER, AND STATION BILL
4. TITLE: PERSONNEL WATCH, QUARTER, AND STATION BILL
5. OBSERVATION: There was no plan for assignment of personnel to the organizational positions defined in the Area Contingency Plan.
6. DISCUSSION: While an Incident Command System was specified in the ACP, there was no plan for assignment of personnel to the positions. Decisions regarding "who will do what" had to be made during the actual response. In some cases these decisions proved to be sound. Such was the case in assigning a representative of the State Emergency Management Agency to head up the Logistics Section. This agency was especially well suited to identifying sources of support and obtaining equipment for the response organization. This "good fit" could have and should have been identified prior to the response. Other decisions may not have been, as sound. But the importance is not in the soundness of the decisions on who to place where; the importance is that these decisions eat up critical time during the beginning stages of the response.
7. LESSONS LEARNED: If personnel assignment decisions are not made during the planning process before a spill, these decisions will have to be made during the response and this will occupy the time and energy of response management personnel during the critical first phase of the response.
8. RECOMMENDED ACTION: Area Committees should identify in the Area Contingency Plan which personnel will be assigned to the positions required by the organization defined in the plan. The best method of accomplishing this is through a "Watch, Quarter, and Station Bill." Such a document could clearly define who will be assigned to each position (e.g. Section Chief, Department Head, Team Leader, etc.) specified by the plan. Ideally, this Watch, Quarter, and Station Bill should include personnel from the entire spill management team, meaning representatives from the Coast Guard, other Federal agencies, and the State agencies. positions expected to be filled by the Responsible Party should also be identified. The Area Committee should decide if these RP positions will be primary or in addition to other assigned personnel, since the Area Committee should be prepared to respond to a spill where the RP is either unknown or unable or unwilling to field necessary personnel. The Area Committee should agree on the planned assignment of personnel and the individual agencies of the Area Committee should commit to filling those positions when the need arises.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.3 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, INCIDENT COMMAND SYSTEM, AREA CONTINGENCY PLAN, PERSONNEL ASSIGNMENT. PERSONNEL MOBILIZATION PLAN
4. TITLE: Personnel Mobilization Plan
5. OBSERVATION: There was no plan for identifying and assigning personnel not readily available to the immediately responding spill management team.
6. DISCUSSION: In this response, the cognizant Coast Guard District did a commendable job in locating and providing personnel resources that might be able to assist the spill management team. Some of the resources provided by the Coast Guard District proved to be absolutely essential to an effective response. Unfortunately, these assignments were left to the judgment of District staff at the beginning moments of the response. While this judgment proved to be extremely effective and certainly valuable, these decisions were made unilaterally by the Coast Guard District and not by the planning body, i.e. the Area Committee responsible for planning the spill management team. There was much evidence available in this incident review to conclude that the District sent to the scene whatever they thought might be helpful to the FOSC and the Unified Command. Unfortunately that left utilization decisions up to those already occupying positions in the Unified Command. There were more than a few examples of personnel showing up without a job to do, certainly some cases of mismatch, and in some cases personnel were sent back home. This reduces the efficiency of the spill response.
7. LESSONS LEARNED: Inefficiency will result when decisions regarding required personnel resources are made during the response rather than ahead of time.
8. RECOMMENDED ACTION: The Area Committee should identify in the planning process which personnel resources are needed that are not readily available to the local spill management team. There should be a plan for obtaining these resources. The result of this planning process should be the development of a "Personnel Mobilization Plan" that identifies the source of personnel who will be called upon to dispatch to the scene of a significant discharge. Sources of these personnel for the Coast Guard will certainly include the National Strike Force, but should also include the National Pollution Funds Center, the Maintenance and Logistics Command, the Marine Safety Center, Coast Guard Districts, Marine Safety Offices, Groups, and Air Stations. Beyond the Coast Guard, other agencies should identify through the contingency planning process, the identity and location of critical personnel. A Personnel Mobilization Plan, coupled with a well defined organization and a Watch, Quarte , and Station Bill, will enable the spill management team to quickly mobilize and attend to the response rather than having to attend to the organization.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.4 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, INCIDENT COMMAND SYSTEM, AREA CONTINGENCY PLAN, PERSONNEL CHECK-IN CENTER, PLANNING SECTION
4. TITLE: Personnel Check-in Center
5. OBSERVATION: There was no organizational element established to assist arriving personnel to integrate into the organization.
6. DISCUSSION: In this response, many people simply showed up at the command center. Some were sent by the cognizant Coast Guard District; others were called in by individuals within the organization. There were even some cases of agency personnel voluntarily showing up to assist. Typically, these arriving personnel were interviewed by members of the spill management team, most often the Operations Section, with the intent of deciding where best to use them. Of course, this interview process was necessary due to not having a personnel utilization plan, but even so, these arriving personnel were not adequately accounted for or supported. Ideally, the response organization should be waiting for personnel to arrive. When they do, they should be checked-in so that resource status can be accurately maintained and so logistical support can be arranged. Arriving personnel should be checked-in, given their assignment, and provided with support information. The best method of accomplishing this is through a "Personnel Check-in Center." In the standard Incident Command System, this function should be performed by the Planning Section. Regardless of where the function is assigned, it is nevertheless a very critical function that must be performed. Otherwise personnel may not be used effectively, their use may not be accurately documented, and they may find themselves unsupported regarding lodging, messing, etc.
7. LESSONS LEARNED: There is a risk of personnel being underutilized, unaccounted for, or unsupported, when the response organization does not include a "Personnel Check-in Center."
8. RECOMMENDED ACTION: Area Committees should ensure a Personnel Check-in Center is planned as part of the spill response organization. The center should be tasked with: (1) processing incoming personnel, (2) providing them with information regarding the organization and the response, (3) assigning them their role and responsibilities for the response, including the identification of their supervisor, (4) explaining logistics support, and (5) maintaining the status of these personnel

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.5 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, INCIDENT COMMAND SYSTEM, SPILL MANAGEMENT TEAM, TRAINING, EXERCISES, TABLETOP EXERCISE, AREA EXERCISE, NATIONAL PREPAREDNESS FOR RESPONSE EXERCISE PROGRAM
4. TITLE: Spill Management Team Training and Exercises
5. OBSERVATION: The Spill Management Team members were not adequately trained in implementing an Incident Command System for a major pollution incident.
6. DISCUSSION:
  - a. The Area Contingency Plan (ACP) contained a Plan Review Annex with an Exercises/Drill Appendix as required by COMDTNOTE 16471, Establishment of Area Committees and Development of Area Contingency Plans. The ACP set an ambitious goal for the Marine Safety Office to conduct quarterly exercises. The plan also contained a requirement to conduct a formal review of each quarterly exercise. Unfortunately, the Coast Guard Marine Safety Office was unable to conduct any exercises during the year preceding this incident.
  - b. The National Preparedness for Response Exercise Program (NPREP) requires a Spill Management Team Tabletop Exercise annually and an industry or government led full "Area Exercise"<sup>1</sup> for the entire Area response community triennially. The Spill Management Team in this case had not conducted a Spill Management Team Tabletop Exercise within the year preceding this spill. Regarding the full Area Exercise, in accordance with the triennial cycle, this response community was scheduled for an exercise in 1997.
  - c. Recognizing a need for Incident Command System (ICS) training at the Marine Safety Offices (MSOs), the cognizant Coast Guard District had embarked on a program to train all of its MSOs in the implementation and application of ICS. Unfortunately again, this Marine Safety Office was scheduled to receive this training four months after this spill occurred. During the response, many of the members of the Marine Safety Office filling key positions were unfamiliar with the provisions of the Incident Command System. This reduced their effectiveness. Fortunately, State representatives filling key positions were much more familiar with ICS and aided greatly in ensuring required functions were performed.
7. LESSONS LEARNED: The effectiveness of the Spill Management Team will be reduced if the members of the team have not received training in ICS and have not exercised their organization prior to an actual spill.

8. RECOMMENDED ACTION:

a. Area Committees should ensure Area Contingency Plans include a schedule of exercises. These exercises should be designed to provide practice for the Area Spill Management Team to perform required functions of the Incident Command System.

b. Area Committees and Coast Guard Districts should ensure Federal On-Scene Coordinators (FOSCs) comply with the exercise schedule developed by the Area Committee. At a minimum, the NPREP requirements should be followed, especially conducting the annual Spill Management Team Tabletop Exercise.

c. Commandant (G-MRO) and Coast Guard Districts should make every effort to fund and provide ICS training to ALL FOSCs and Coast Guard members of Area Spill Management Teams.

d. FOSCs should make every attempt to arrange for ICS training for all Area Committee members who will be part of the Area Spill Management Team.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.6 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, RESPONSE STRATEGIES, SENSITIVE AREAS, AREA CONTINGENCY PLAN
4. TITLE: Identification of Response Strategies for Sensitive Areas
5. OBSERVATION: The Area Contingency Plan did not adequately identify strategies for protecting sensitive areas. Fuel oil that had dispersed into the water column was carried by the storm tide through breachways and entered several coastal salt water ponds.
6. DISCUSSION:
  - a. Enclosure (1) to COMDNOTE 16471, Establishment of Area Committees and Development of Area Contingency Plans, requires that Area Contingency Plans (ACPs) include the identification and prioritization of sensitive areas and a strategy for their protection. Enclosure (1) to COMDTNOTE 16471 provides the following direction for developing Appendix V to Annex E of ACPs:

"When sensitive areas are identified, each shall be assigned a priority for protection. Response strategies intended specifically for protection of a particular sensitive area shall be identified, including the possibility of pre-staging response equipment in the vicinity of that sensitive area. All appropriate countermeasures, mechanical and others such as dispersants, chemical agents, and other spill mitigating substances or devices, including preapproval or disapproval, as documented in Annex G of this plan, shall be identified."

"The sensitive areas shall be mapped out, and any natural collection sites, boom sites and specific response strategies for spills in or near those areas and specific response strategies for spills in or near these areas shall be detailed in this appendix. This is probably the most important and critical appendix in your plan. [bold added for emphasis] Delineating sensitive areas and outlining strategies should be done with as much detail as possible by outlining and explaining the sensitive areas through chartlets and/or other visible descriptions.
  - b. The ACP did contain Sensitive Area Maps for Massachusetts, prioritizing sensitive areas. It did not, however, prioritize sensitive areas for protection in Rhode Island.
  - c. The ACP did have an extensive description of general response strategies in which many response techniques were described, including types of shoreline protection, construction and use of expedient booms, and construction of dikes, ditches, and dams. Further, the ACP identified Trustom Pond in Kingston, Rhode Island as a National Wildlife Refuge supporting many hundreds of waterfowl during the migration season. The plan did not, however, provide specific strategies on how the coastal salt water ponds in Rhode Island were to be protected.
  - d. Area Committee planners were in the process of developing necessary strategies at the time of this incident. One month prior to this spill, Coast Guard and other members of the Area Committee actually

examined the breachways and discussed how difficult it would be to control a spill in this area. During the response to this incident, there was simply not enough time to devise a strategy and obtain necessary equipment to overcome the racing currents of the breachways.

e. It would be unfair to imply that time was the only factor preventing an effective protection strategy in this response. The currents of the breachways present a particularly difficult challenge to response planners. The Coast Guard, the State, and the scientific community have been working and will continue to work to Ward a solution, if possible, to this vexing problem.

7. **LESSONS LEARNED:** Generally, there is insufficient time in responding to a major oil spill to devise specific protection strategies for sensitive areas and to obtain necessary protection equipment. Strategies to protect sensitive areas must be designed before an actual spill.

8. **RECOMMENDED ACTION:** Area Committees should ensure Area Contingency Plans include:

- a. the identification of all sensitive areas
- b. prioritization of these sensitive areas
- c. protection strategies for these sensitive areas
- d. identification of necessary equipment to employ the strategy

9. **COMMENTS:** The task of accomplishing the recommended action is easier said than done. This is truly a monumental task for most Area Committees, one that takes the commitment of a great deal of time, money, and knowledgeable personnel resources. This Area Committee is a case in point: they knew what had to be done and were doing it; they simply had not completed their work in time. Such is the case with most Area Committees. This process of identifying, prioritizing, and developing strategies to protect sensitive areas is a continual and never-ending process. Absent a significant influx of money and experienced staff at the Federal Trustee, State, and local level, earmarked to accomplish this task on a continual basis, there is little expectation that all sensitive areas within all Areas will be protected.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.7 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, CHEMICAL COUNTERMEASURES, DISPERSANTS, PRE-AUTHORIZATION, REGIONAL RESPONSE TEAM, AREA CONTINGENCY PLAN, REGIONAL CONTINGENCY PLAN
4. TITLE: Chemical Countermeasures Pre-authorization Process
5. OBSERVATION: A chemical countermeasures pre-authorization process was in place prior to the spill. This process expedited the approval for the Federal On-Scene Coordinator to apply dispersants as part of the response strategy.
6. DISCUSSION: The Regional Response Team and the Area Committee had completed the necessary groundwork to ensure that requests from Federal On-Scene Coordinators (FOSCs) to use dispersants during a spill would be expedited. Further, this process was included in the Area Contingency Plan. In this case, the FOSC did request authorization to use dispersants. The pre-approval process worked out in advance of the spill seemed to satisfy all stakeholder concerns during the spill. In this instance, the use of dispersants was approved in an amazingly short period of time - nine hours after the Coast Guard first learned of the incident.
7. LESSONS LEARNED: Procedures for obtaining authorization to use chemical countermeasures which are agreed to by all stakeholders ahead of a spill and which are included in the Area Contingency Plan will greatly facilitate the authorization to use such chemical countermeasures.
8. RECOMMENDED ACTION: All Regional Response Teams and Area Committees should work out and agree to the process by which FOSCs may be given authorization expeditiously to use chemical countermeasures. This process should be detailed in both Area Contingency Plans and Regional Contingency Plans.



## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.8 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, CHEMICAL COUNTERMEASURES, DISPERSANTS, STRIKE TEAMS, AREA CONTINGENCY PLAN
4. TITLE: Identification of Resources for Chemical Countermeasures.
5. OBSERVATION: The Area Contingency Plan and the Vessel Response Plan did not have a listing of public/private resources for chemical countermeasure (dispersant) supply and application materials.
6. DISCUSSION:
  - a. The Area Contingency Plan (ACP), while containing detailed procedures for obtaining authorization to use dispersants, did not contain a listing of the location of dispersants and necessary application equipment.
  - b. Enclosure (1) to COMDNOTE 16471, Establishment of Area Committees and Development of Area Contingency Plans, requires a description of applicable chemical countermeasures preauthorization plans. In part, this guidance states:

"preauthorization plans should address factors such as ... available product and storage locations, available equipment and adequately trained operators, and the available means to monitor product application and effectiveness."
  - c. During this response, it took several days for the Responsible Party (RP) to locate dispersants and application equipment. In conducting this incident review, decision makers stated that they would not have applied dispersants (after receiving prompt approval) had they been immediately available because the nature of the spill precluded their effective use. That may have been the case, nevertheless, they were unavailable for use had the decision-makers agreed to use them. It should be noted while the oil that had already spilled in this case may not have been suitable for dispersant use, there were still 3.2 million gallons of oil onboard a barge that was in a precarious situation. With approval out of the way, it would have been extremely valuable for the Unified Command to have necessary dispersants and application equipment at their disposal in the event the 3.2 million gallons of oil were to have been lost.
7. LESSONS LEARNED: Effective use of chemical countermeasures depends on two things: (1) rapid approval to use them, and (2) rapid acquisition of necessary supplies and equipment to apply them. Both of these may be, and should be, pre-planned and included in the Area Contingency Plan.

8. RECOMMENDED ACTION:

a. Area Committees should ensure that in addition to procedures to gain preauthorization for chemical countermeasures use, Area Contingency Plans should include identification of the location of necessary chemical countermeasures supplies and application equipment.

b. Because this listing of supplies and equipment will be common to many different Area Contingency Plans, and because the National Strike Force Strike Teams already have the identity of much of this equipment, it is recommended that the National Strike Force Coordination Center task cognizant Strike Teams to provide this information to Area Committees.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #2.9 Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, INCIDENTAL OIL DISCHARGES, DECANTING, REGIONAL CONTINGENCY PLAN, AREA CONTINGENCY PLAN
4. TITLE: Incidental Discharges of Oily Water Associated with Response Operations
5. OBSERVATION: The Area Contingency Plan did not contain a pre-approval process nor a pre-determined agreement worked out among stakeholders regarding incidental oil discharges.
6. DISCUSSION: Decanting is a vital part of the recovery process. The inability to decant water from recovered oil/water mixtures and return the excess water into the recovery area significantly reduces the volume of available temporary storage capacity, thus reducing the effectiveness of the on-water skimming and recovery operations. The inability to return the excess water containing some amount of oil will delay recovery operations and possibly lead to a complete cessation of recovery operations until additional temporary storage can be arranged. It is essential that.. the return of oil and oily water associated with the mechanical recovery process be clearly authorized so that responders are not placed at significant legal risk when carrying out mechanical recovery operations.

The National Contingency Plan states in Section 300.310(c):

"Oil and contaminated materials recovered in cleanup operations shall be disposed of in accordance with the regional Contingency Plan and the OSC Contingency Plan and any applicable laws, regulations, or requirements."

In this case, there was no pre-approved decanting process, however acceptable procedures were agreed to by the Federal and State On-Scene Coordinators. It appears that in this case, prompt agreement by the stakeholders during the response overcame the risk associated with not having the procedures approved ahead of time.

7. LESSONS LEARNED: Lack of pre-approval to decant oily water mixtures recovered from oil removal operations may delay or postpone skimming and recovery operations.

8. RECOMMENDED ACTION.

- a. Regional Response Teams and Area Committees should review the status of all applicable laws and regulations that could impact the ability to decant during oil spill response (the following states have clarified this issue through the legislative process: Maine, New York, New Jersey, Maryland, Virginia, North Carolina, Alabama, Texas, California, Oregon, Washington, and Hawaii).
- b. Regional Response Teams and Area Committees should reach agreement on acceptable decanting procedures and these should be included in Regional Contingency Plans and Area Contingency Plans.
- c. Commandant (G-MRO) should amend Enclosure (1) to COMDTNOTE 16471, Establishment of Area Committees and Development of Area Contingency Plans, to require the inclusion of acceptable decanting procedures in the Area Contingency Plan.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR 42.10 - Planning and Preparedness, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: PLANNING, PREPAREDNESS, COMMAND POST, AREA CONTINGENCY PLAN
4. TITLE: Command Post Location
5. OBSERVATION: The command post used during the response had been pre-identified.
6. DISCUSSION: In this response, a hotel located near the site of the discharge was chosen to be the site of the Unified Command Post. This facility was chosen because it had been pre-identified by response planners (although it had not yet been entered into the Area Contingency Plan). It proved to be quite capable of accommodating the needs of the Incident Command System organization, including adequate space for the command center, Joint Information Center, and additional communications equipment. Because this location was pre-identified, the Spill Management Team was able to set up the command center for this response in an extremely rapid manner.
7. LESSONS LEARNED.: Identification of potential command post sites will facilitate the rapid establishment of a command center to control response operations.
8. RECOMMENDED ACTION: Area Committees should ensure potential facilities capable of being used as Incident Command System Command Posts are pre-identified and listed in the Area Contingency Plan.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #3.1 - Information Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: INFORMATION MANAGEMENT SYSTEM, PUBLIC AFFAIRS, JOINT INFORMATION CENTER, UNIFIED COMMAND
4. TITLE: Public Affairs
5. OBSERVATION: Public Affairs efforts during the response were extremely effective; the Unified Command presented a "unified" position to the public via the news media.
6. DISCUSSION: One of the factors that helped to make this response a "success" in the eyes of the public was the effective public affairs efforts of the Unified Command. Almost immediately upon notification of the incident, public affairs specialists from the cognizant Coast Guard District and the National Strike Force Coordination Center Public Information Assist Team were dispatched to assist the Federal On-Scene Coordinator (FOSC). These personnel were joined by public affairs personnel from the State and the Responsible Party. A Joint Information Center (JIC) for the purpose of media affairs was established promptly.

The FOSC was extremely effective in ensuring that frequent, timely, and accurate information was provided to the news media. He was extremely accessible to the news media. To ensure the accuracy of information, meetings of the Incident Command System Spill Management Team supervisory personnel were scheduled just prior to news conferences; this ensured that the media had the latest and most accurate information.

During this response, there was never any misalignment of information presented by the Federal government, State government, and the Responsible Party. Acting in a true unified fashion, the Spill Management Team presented the impression of an effective and efficient response organization.
7. LESSONS LEARNED: The public will perceive an effective and efficient response through the news media when the Unified Command devotes attention to ensuring that frequent, timely, and accurate information is provided to the media. The effectiveness of the response will be enhanced when the FOSC, State, and Responsible Party present a unified position to the media.
8. RECOMMENDED ACTION: The public's perception of a response is based largely on the information provided by the news media. Area Committees and FOSCs should recognize that a great deal of attention to the media is necessary. An adequate public affairs organization should be planned as part of the Incident Command System and included in the Area Contingency Plan. Necessary resources should be acquired immediately upon notification of a significant discharge and a Joint Information Center should be established as soon as possible. Frequent, unified information should be provided to the media throughout the response.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #3.2 - Information Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: INFORMATION MANAGEMENT SYSTEM, PUBLIC AFFAIRS, JOINT INFORMATION CENTER, AGENCY INFORMATION
4. TITLE: Joint Information Center
5. OBSERVATION: A Joint Information Center was established as part of the Incident Command System for this response. While extremely effective performing media affairs responsibilities, this center was ineffective performing other information requirements.
6. DISCUSSION: The National Interagency Incident Management System (NIIMS) Incident Command System (ICS) requires the establishment of a Joint Information Center (JIC). The purposes of this center are to (1) accommodate all public information needs associated with the response and (2) meet all information needs of the response organization and its member agencies.

In this response the JIC did a remarkable and commendable job of ensuring that frequent, timely, and accurate information was provided to the news media. The Joint Information Center acted on behalf of the Federal On-Scene Coordinator (FOSC), the State, and the Responsible Party. The perceived success of this incident was due in large part to the public affairs efforts of the Unified Command and the Joint Information Center.

Regarding the responsibility to serve the information needs of the response organization, the agencies providing Spill Management Team members, and the general public at large, the JIC was ill-equipped to perform effectively. Ideally, the Joint Information Center should be capable of handling all incoming calls and inquiries. The JIC should be staffed with knowledgeable personnel who can provide accurate information to inquirers without having to rely on other members of the Spill Management Team to provide information. That is not what happened in this incident. Participating agencies, especially the Coast Guard, relied heavily upon the Operations Section for information. The Operations Section was the Coast Guard's first choice for information and they were called frequently. In fact, an actual system was established between the Operations Section and the cognizant Coast Guard District to provide formal briefing updates which could be passed on to higher authority. This certainly occupied some of the time available to Operations Section senior personnel.

Complicating matters further, the JIC was insufficiently staffed to handle all incoming calls. The telephone system was set up such that calls reaching busy lines rolled over to the Operations Section. In some cases, these ringing lines were answered directly by senior members of the Operations Section. Many of these calls could have been handled by members of the Spill Management Team who had less critical responsibilities.

7. LESSONS LEARNED:

a. Rapid establishment of a Joint Information Center, adequately staffed with professional public affairs personnel is one of the best ways to ensure the media receives frequent, timely, and accurate information. This will help the public perceive an effective and efficient response.

b. When the Joint Information Center is not tasked to handle agency requests for information, or is not staffed properly to handle agency requests for information, or does not have the capability to handle all incoming calls, other members of the Spill Management Team with critical responsibilities may find themselves spending a portion of their time providing information instead of attending to their critical responsibilities.

8. **RECOMMENDED ACTION:** Area Committees should ensure a Joint Information Center is included as part of the Incident Command System in their Area Contingency Plan. The Joint Information Center should be tasked with the responsibility of accommodating all information needs of the public, the media, response agencies, and the internal response organization. The Joint Information Center should be adequately staffed and internal mechanisms should be developed so that these personnel have accurate and timely information to pass on to others. Finally, satisfactory communications systems should be planned such that other sections of the Incident Command System are relieved of having to answer incoming telephone calls.



## PLLS LONG REPORT

1. FOCUS AREA: ISPR #3.3 - Information Management System, submitted by Incident Specific preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: INFORMATION MANAGEMENT SYSTEM, COMMUNICATIONS, COMMUNICATION PLAN
4. TITLE: Communication Plan
5. OBSERVATION: There was no plan for establishing a communication system for this response.
6. DISCUSSION: In most responses to significant incidents, a complex communications system will be necessary to ensure the Spill Management Team is capable of communicating efficiently with other members of the team, on-scene operational resources, and other agencies. This type of system is especially difficult to establish when a temporary command post is utilized for the response.  
  
During the initial hours of this response, the State Emergency Management Agency arranged for NYNEX to set up a suite of telephones that eventually expanded to 45 in number. This system was augmented by a Coast Guard District communications package, the Emergency Response Network Interface Equipment (ERNIE), and Coast Guard District staff to operate the equipment. Additionally, the Federal Emergency Management Agency provided satellite communications and cellular phones. Through the efforts of the Spill Management Team, particularly the Logistics Section headed up by the State Emergency Management Agency, most of the communications needs of the Incident Command System were satisfied. This all happened ad hoc, however; there was no plan for which equipment would be needed and for how this equipment would be obtained in the event of a significant incident.
7. LESSONS LEARNED: Absent a communication plan, Spill Management Team will have to devote precious time during the beginning stages of a response to planning and acquiring a satisfactory communications system.
8. RECOMMENDED ACTION: Area Committees should determine communications equipment needs prior to a spill. Sources of supply should be investigated and confirmed. The resulting communications plan explaining what type of equipment will be required and where it will be procured should become part of the Area Contingency Plan.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #3.4 - Information Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: INFORMATION MANAGEMENT SYSTEM, COMMUNICATIONS, COMMUNICATION EQUIPMENT
4. TITLE: Communications Equipment Interoperability
5. OBSERVATION: Commercial helicopters used to spot oil on the surface of the water could not communicate with vessels equipped with skimming devices to recover the oil.
6. DISCUSSION: Commercial helicopters were hired by the Responsible Party to over fly the impacted areas and locate oil on the surface of the water. Any reports of significant amounts of oil were to be communicated to Coast Guard Buoy Tenders equipped with the Vessel of Opportunity Skimming System (VOSS). Available radio frequencies of the two types of resources were not compatible; the commercial helicopters did not have Very High Frequency (VHF) capability. This resulted in the information having to be passed back to the command center, then further relayed to the Coast Guard vessels. This reduced the effectiveness of the skimming operations.
7. LESSONS LEARNED: Effectiveness of protection and recovery operations may be reduced if various response resources are incapable of communicating with each other directly.
8. RECOMMENDED ACTION: Communications equipment interoperability should be planned and included as part of the overall communications plan. Area Committees should include this information in the Area Contingency Plan.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #3.5 - Information Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: INFORMATION MANAGEMENT SYSTEM, INCIDENT COMMAND SYSTEM, PLANNING, INFORMATION AVAILABILITY, STATUS BOARDS
4. TITLE: Information Availability
5. OBSERVATION: Information regarding the status of the incident and the status of resources was not readily available to all members of the Spill Management Team.
6. DISCUSSION: In this response, an informal organization was used where key members of the Spill Management Team could communicate face to face to pass required information. Despite this advantage, however, there was a still a need to maintain the status of the incident and the numerous resources that were being used for the incident. It is helpful when this type of status information is displayed for all to see. Such a display would reduce the amount of information that needs to be continually passed verbally.  
  
The Incident Command System requires the Planning Section to maintain and display the status of the incident and the resources that are being used in the incident. In this response, the Planning Section neglected to perform this function.
7. LESSONS LEARNED: The status of the incident and the status of resources being used for the response to the incident should be maintained and displayed by the Planning Section of the Incident Command System. When this function is not performed by the Planning Section or another organizational element, the efficiency of the response will be reduced due to Spill Management Team members having to pass more information back and forth verbally. There is a likelihood that information that is not displayed may have to be repeated again and again. There is also a risk that information passed verbally may become inaccurate over time.
8. RECOMMENDED ACTION. Area Committees should ensure that the Planning Section or another element in the Incident Command System is tasked through the Area Contingency Plan to perform the functions of maintaining and displaying incident and resource status. Spill Management Teams should ensure that these functions are being performed during the response.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #3.6 - Information Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: INFORMATION MANAGEMENT SYSTEM,
4. TITLE: Coast Guard Briefings
5. OBSERVATION: Vertical information flow of information up the chain of command within the Coast Guard was extremely effective.
6. DISCUSSION: Several days into the spill response, the cognizant Coast Guard District marine environmental response staff devised a briefing document that satisfactorily served the information needs of the Commandant, the Coast Guard Area Commander, and Coast Guard Headquarters staff. This briefing document was developed each night by the Coast Guard District staff with input from the Spill Management Team and was approved by the Coast Guard District Commander by 0600 each morning. The report was sent by electronic means each morning to the Commandant, the Area Commander, and various staffs of the Coast Guard Marine Safety, Security, and Environmental Protection Directorate. This report augmented the tactical information contained in the daily pollution reports (POLREPS) being sent by the Federal On-Scene Coordinator. In addition to providing a summary of the previous day's events, the report provided information on environmental issues, economic issues, and political issues.
7. LESSONS LEARNED: The information needs of Coast Guard Headquarters and the Area Commander can best be served through the use of a daily summary report to augment the FOSC POLREPS.
8. RECOMMENDED ACTION:
  - a. Commandant (G-MRO) should consider establishing a requirement for all Coast Guard Districts to adopt a standard briefing format developed by Commandant (G-MRO).
  - b. In the meantime, all Coast Guard Districts should consider instituting a practice of requiring FOSCs to submit a daily incident summary which addresses environmental, economic, and political issues. This report would be in addition to existing requirements for tactical information in pollution reports.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #4.1 - Support System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: SUPPORT SYSTEM, POLITICAL SUPPORT
4. TITLE: Political Support
5. OBSERVATION: Senior government officials from the Federal and State government fully supported response efforts and lent confidence and credibility to the response.
6. DISCUSSION: At first light in the morning after the incident occurred, the State Governor and the Coast Guard District Commander visited the spill site. Two hours later, the Secretary of Transportation, the Commandant of the Coast Guard, and the two U.S. Senators from the affected state arrived at the command post. Later that day, the command post was visited by the Administrator of the U.S. Environmental Protection Agency. In the days that followed, the command post was visited by Senators and Congressmen as well as various State officials. During all of these visits, senior officials publicly expressed their confidence in the response organization. This vote of confidence helped to assure the public that the government was doing all they could to combat this situation. Additionally, the appearance of so many high level officials reinforced the notion that the Federal and State governments were working together to resolve the crisis.
7. LESSONS LEARNED: The public will be reassured that all that can be done is being done to resolve an environmental crisis when they see the immediate interest and presence of high level officials from the Federal and State government. When these officials express their confidence in the response organization, the morale of the Spill Management Team will be boosted and the public will detect a swift, coordinated effort to resolve the crisis.

8. RECOMMENDED ACTION:

a. Senior Federal and State Agency Officials and Members of Congress should continue the practice of arriving at the scene of a significant incident to express their confidence in the response organization.

b. One of the dangers of many senior agency personnel and elected officials arriving at the spill site is that their presence and demand for information will divert the attention of the Unified Command and senior Spill Management Team members. This did not happen in this case for two reasons: (1) The senior officials in this case appeared to be very sensitive to this danger, and (2) Coast Guard Headquarters provided a Congressional Affairs Officer to assist the Federal On-Scene Coordinator with protocol and arrangements for VIP visits. Area Committees should plan to assign someone the responsibility of performing protocol and VIP logistics arrangements. This function should be included as part of the Incident Command System.

c. Commandant (G-MRO) should consider institutionalizing the practice of dispatching an officer from Coast Guard Congressional Affairs to assist the FOOSC with protocol and VIP logistics arrangements.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #4.2 - Support System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: SUPPORT SYSTEM, SAFETY AND OCCUPATIONAL HEALTH, SITE SAFETY
4. TITLE: Site Safety
5. OBSERVATION: Safety of response personnel was of paramount concern during this response. This was reinforced continually by the Federal On-Scene Coordinator and the Unified Command. A site safety plan was quickly developed and was read and followed by all response personnel.
6. DISCUSSION: Safety of personnel was established as one of the primary objectives of this response by the Unified Commanders. Throughout the response, safety was emphasized. The Responsible Party drafted a Safety Management Plan, which directed safety measures to be taken by all contracted personnel. This was augmented by a Coast Guard personnel Site Safety Plan drafted by the cognizant Coast Guard District Safety and Environmental Health Officer who was dispatched to assist the Unified Command. All response personnel were required to read and comply with these plans. As a result of the prompt and repeated attention given to personnel safety, there were no personnel injuries in this response.
7. LESSONS LEARNED: The potential for personnel injuries will be greatly reduced when (1) the Unified Command stresses personnel safety as a major objective, (2) comprehensive safety plans are drafted promptly, (3) personnel are required to read and comply with these plans.
8. RECOMMENDED ACTION: Area Committees should ensure the functions relating to personnel safety are assigned as part of the Incident Command System in the Area Contingency Plan. The plan should identify personnel resources necessary to carry out these functions.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #4.3 - Support System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: SUPPORT SYSTEM, REGIONAL RESPONSE TEAM, DISPERSANTS
4. TITLE: Regional Response Team
5. OBSERVATION: With the notable exception of authorizing the use of dispersants, the Regional Response Team added little value to this response.
6. DISCUSSION: The Regional Response Team (RRT) was not activated for this response. The Federal On-Scene Coordinator (FOSC) did however, request that the RRT authorize the use of dispersants. Due to the prior planning of the RRT, the foundation for dispersant use authorization had already been laid; as a result, the FOSC received extremely prompt authorization. Besides this one issue, however, the FOSC did not request any assistance from the RRT.

Many Regional Response Teams have been taking an introspective look at their purpose and role since the passage of the Oil Pollution Act of 1990 and the establishment of Area Committees. Many of the functions performed by RRTs in the past are now being performed by Area Committees. Many question the value added by RRTs in today's post OPA 90 environment.

Further, with two planning and preparedness bodies still in existence, many agencies are designating the same individual to serve on both organizations. Many significant spills today will see RRT members responding on scene since they are also part of the Area Spill Management Team. If their presence is commanded by the RRT Chairman for an RRT activation, they will be forced to leave their Spill Management Team assignment. This is not a desirable situation.

7. LESSONS LEARNED. Federal On-Scene Coordinators and Unified Commands are becoming less dependent on assistance from the Regional Response Team since the establishment of Area Committees. Some agency personnel are finding themselves in conflict over which body, RRT or Area Committee, to direct their attention.

8. RECOMMENDED ACTION.

a. The purpose and role of the Regional Response Team needs re-evaluation following the establishment of Area Committees under the Oil Pollution Act of 1990. The National Response Team should examine these relationships and promulgate directives which clarify this issue.

b. Federal and State agencies should refrain from assigning the same individual to both the Regional Response Team and the Area Committee to avoid the potential for that individual having to serve in two different capacities during the same response.



## PLLS LONG REPORT

1. FOCUS AREA: ISPR #4.4 - Support System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: SUPPORT SYSTEM, SCIENTIFIC SUPPORT, SCIENTIFIC SUPPORT COORDINATOR, NATURAL RESOURCE DAMAGE ASSESSMENT, PLANNING, NATIONAL CONTINGENCY PLAN, INCIDENT COMMAND SYSTEM
4. TITLE: Scientific Support Coordinator
5. OBSERVATION: Spill Management Team members were confused regarding the role of the Scientific Support Coordinator.
6. DISCUSSION: The Scientific Support Coordinator (SSC) is one of the resources available to the Federal On-Scene Coordinator. For coastal spills, the SSC is provided by the National Oceanic and Atmospheric Administration (NOAA). The role of the SSC is defined in the National Oil and Hazardous Substances Pollution Contingency Plan as the principal advisor for scientific issues. The SSC is available to communicate with the scientific community and coordinate requests for assistance from state and federal agencies regarding scientific studies. During a response, at the request of the FOSC, in accordance with 40 CFR 300.145, the SSC may, lead the scientific team and be responsible for providing scientific support for operational decisions and for coordinating on-scene scientific activity... the SSC integrates expertise from governmental agencies, universities, community representatives, and industry to assist... in evaluating the hazards and potential effects of releases and in developing response strategies." At the request of the FOSC, the SSC may also be tasked to ensure coordination between data collection efforts in support of Natural Resource Damage Assessment (NRDA) and in support of response operations.

During this response, the SSC was originally assigned to the Planning Section, however the SSC also reported directly to the FOSC. As the response progressed, it became clear that the SSC was not functioning as a member of the Planning Section. The SSC brought in (under contract) his own environmental and scientific team. These contracted personnel were identified to the Spill Management Team members as "working for NOAA." In addition, there were personnel from NOAA involved who were performing Federal Trustee roles, both relating to providing advice for the protection of natural resources, and relating to Natural Resource Damage Assessment. What the Spill Management Team members had to deal with was many "NOAA personnel" doing different things, with the person they identified as the "senior" NOAA representative, the SSC, reporting directly to the FOSC. This left many unsure of what all these other people were doing and how their contributions were being integrated into the response organization. During this response, the Operations Section rather than the Planning Section took on the role of designing protection and recovery strategy. With some confusion regarding the role of the many NOAA personnel, the Operations Section did not reap the full benefit of the expertise of the available NOAA personnel.

The problem faced by Spill Management Teams today is not what the SSC should do, but rather how best to integrate the SSC's functions into the Incident Command System. The current National Contingency Plan was promulgated well before the Coast Guard's mandate to design Spill Management Teams based upon the National Interagency Incident Management System (NIIMS) Incident Command System (ICS). Prior to that mandate, most FOSC's assigned the SSC to report directly to the FOSC as a personal scientific advisor. That is the relationship that the FOSC and SSC had during this response. While this arrangement worked well for the FOSC and the SSC, the rest of the Spill Management Team did not benefit fully from the SSC's participation.

Now that Spill Management Teams are organizing in accordance with ICS, it is the Planning Section that is responsible for designing response strategy that incorporates sensitive area, resources at risk, scientific, and environmental considerations. If the SSC is reporting directly to the FOSC, then the FOSC inherits the burden of continually sharing SSC recommendations with the strategy-makers, wherever they happen to be in the organization.

7. **LESSONS LEARNED:** Unless the various roles of the many scientific personnel participating in the response are well defined and understood, and well integrated into the Incident Command System, the effectiveness and certainly the efficiency of the response will be adversely affected.

8. **RECOMMENDED ACTION:**

a. Area Committees should carefully examine the role of the SSC in light of the mandate to base the response organization on NIIMS ICS. The old model of having the SSC report directly to the FOSC may not be the most effective way to ensure the perspectives and concerns of the scientific community are incorporated into response strategy. A model worth considering is to have the SSC as part of the Planning Section where all scientific and environmental issues will be considered when formulating response strategy. This description should be included as part of the Incident Command System in the Area Contingency Plan.

b. Area Committees should decide in advance of a spill what resources are necessary for scientific support. These resources should be identified and responsibilities assigned as part of the Incident Command System in the Area Contingency Plan.

c. Likewise, the role of Federal and State Trustees should be well defined. Area Committees should recognize the difference between a trustee acting in the capacity of response advisor and one who is performing Natural Resource Damage Assessment. The roles and responsibilities of trustees should be included as part of the Incident Command System in the Area Contingency Plan.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #4.5 - Support System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: SUPPORT SYSTEM, NAVY SUPERVISOR OF SALVAGE, SUPSALV, SALVAGE
4. TITLE: U.S. Navy Supervisor of Salvage
5. OBSERVATION: The assistance of the U.S. Navy Supervisor of Salvage was not requested by the Spill Management Team.
6. DISCUSSION: The U.S. Navy Supervisor of Salvage (SUPSALV) is one of the resources available to assist the Federal On-Scene Coordinator (FOSC). In accordance with 40 CFR 300.145, "SUPSALV has an extensive salvage/search and recovery equipment inventory with the requisite knowledge and expertise to support these operations, including specialized salvage, firefighting, and petroleum, oil and lubricants offloading capability."

The National Oil and Hazardous Substances Contingency Plan encourages FOSCs to obtain this specialized salvage expertise:

"For marine salvage operations, OSCs/RPMS [On-Scene Coordinators/Remedial Project Managers] with responsibility for monitoring, evaluating, or supervising these activities should request technical assistance from DOD, the Strike Teams, or commercial salvors as necessary to ensure that proper actions are taken... Each [type of operation] requires different knowledge and specialized types of equipment. The complexity of such operations may be further compounded by local environment and geographic conditions. The nature of marine salvage and the conditions under which it occurs combine to make such operations imprecise, difficult, hazardous, and expensive. Thus, responsible parties or other persons attempting to perform such operations without adequate knowledge, equipment, and experience could aggravate, rather than relieve, the situation." (40 CFR 300.145)

In this response, the Responsible Party immediately contracted a salvage company to lighten and refloat the grounded tank barge. The salvage company's salvage plan was approved by the Unified Command. Additionally, personnel from the Coast Guard Marine Safety Center and the Coast Guard Atlantic Strike Team were available to assist the FOSC in reviewing the adequacy and feasibility of the plan. In this case the actual salvage company employed was a company that serves as a primary salvage contractor for SUPSALV. Perhaps for that reason, the Unified Command did not feel it necessary to request assistance from SUPSALV. Nevertheless, SUPSALV is a resource available with specialized salvage expertise, who can provide a second opinion or validity check regarding salvage plans. The fact that the salvor used was a contractor for SUPSALV does not reduce the value that SUPSALV can add by reviewing the proposed actions of the salvor and making recommendations to the FOSC or Unified Command on other methods/resources available to conduct effective salvage operations.

7. LESSONS LEARNED: U.S. Navy Supervisor of Salvage is a resource available to FOSCs which can add value to salvage operations.

8. RECOMMENDED ACTION: FOSCs are encouraged to request the assistance of SUPSALV to provide expertise in the review of intended salvage plans. The value of SUPSALV expertise is not diminished by the involvement of Strike Team, Marine Safety Center, or commercial salvage personnel.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #4.6 - Support System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: SUPPORT SYSTEM, ADMINISTRATIVE SUPPORT
4. TITLE: Administrative Support
5. OBSERVATION: The Spill Management Team had insufficient administrative support available during the response.
6. DISCUSSION: During this response, as with many other significant responses, the Spill Management Team found themselves insufficiently supported administratively. There were no personnel initially assigned to perform administrative functions such as typing, filing, copying, maintaining logs and records, and delivering forms and documents. As the response progressed, personnel were assigned to perform these functions. Assignment of personnel to perform administrative functions is a common oversight in the design of Spill Management Teams. Organization designers should recognize the value and absolute necessity of these types of resources during a response.
7. LESSONS LEARNED: The efficiency of a response will be adversely affected when there is insufficient administrative support for the Spill Management Team.
8. RECOMMENDED ACTION: Area Committees should plan sufficient administrative support as part of the Incident Command System. Resources should be identified and their responsibilities defined in the Area Contingency Plan.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #5.1 - Resource Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESOURCE MANAGEMENT, OIL SPILL RESPONSE ORGANIZATION, OIL SPILL RESPONSE ORGANIZATION CLASSIFICATION SYSTEM, VESSEL RESPONSE PLAN
4. TITLE: Accuracy and Adequacy of the Oil Spill Response Organization Classification System
5. OBSERVATION: The Oil Spill Response Organization employed by the Responsible Party did not perform at its level of classification.
6. DISCUSSION: The Vessel Response Plan (VRP) for the tank barge involved in this incident was prepared and submitted by the vessel's owner in accordance with Navigation and Vessel Circular (NVIC) 8-92, Interim Guidelines for the Development and Review of Vessel Response Plans. The vessel owner identified response resources from a Class E (all environments including Rivers and Canals, Inland and Nearshore, and Offshore and Open Oceans environments) Oil Spill Response Organization (OSRO) classified under NVIC 12-92, Guidelines for the Classification and Inspection of OSROs.

In accordance with these two NVICs, based upon worst case discharge calculations for this tank barge (capacity of 102,778 barrels), the VRP submitted by the owner would have to ensure the availability of response resources by contract or other approved means as follows:

Tier 1: 15,415 barrels (bbls)/day on-water recovery capacity (subject to a contracting cap of 10,000 bbls/day) and 20,000 bbls temporary storage capacity to arrive on scene within 24 hours.

Tier 2: 25,695 bbls/day on-water recovery capacity (subject to a contracting cap of 20,000 bbls/day) and 40,000 bbls storage capacity to arrive on scene within 48 hours.

Tier 3: 41,110 bbls/day on-water recovery capacity (subject to a contracting cap of 40,000 bbls/day) and 80,000 bbls temporary storage capacity to arrive on scene within 72 hours.

The VRP at the time of the incident listed a Coast Guard classified OSRO, however the Responsible Party had intended to switch OSROs and did in fact use the new OSRO for this response (The Responsible Party had not yet amended the VRP at the time of this discharge and response). This new OSRO had received an interim Class E OSRO classification from the Coast Guard National Strike Force Coordination Center less than a month prior to this spill.

To mount an effective response (and meet the planning requirements for on-water recovery), it was necessary for the Unified Command (Federal On-Scene Coordinator, State, and Responsible Party) to employ a bevy of private and public resources. In addition to those resources provided by the responding OSRO, these included: two Class E OSROs, one Class B OSRO, two Class C OSROs, two Coast Guard buoy tenders equipped with Vessel of Opportunity Skimming Systems (VOSS), and temporary storage provided by one Class E OSRO, the VOSS, and the Coast Guard Atlantic Strike Team. The only

skimmers on scene capable of working the nearshore environment were the two additional Class Es and the two Coast Guard vessels equipped with VOSS, which combined had an "effective daily recovery capability" of 42,000 bbls/day, meeting the required tier 3 requirements. The temporary storage capacity on scene would not have met the 80,000 bbls tier 3 requirement without the addition of the temporary storage capacity of the additional Class E and the VOSS. Further, temporary storage barges provided by the Responsible Party's OSRO were used primarily for lightering; had there been a worst case discharge, these barges would not have been completely available to support skimming operations.

The action of the Unified Command to procure additional Class E OSRO resources for this response is an indication that the newly-classified OSRO did not provide sufficient recovery capability. The inability of the newly-classified OSRO to mobilize response resources in accordance with NVICs 8-92 and 12-92 to adequately respond to this incident raises questions as to the validity of the OSRO classification process.

Soon after the implementation of NVIC 12-92, weaknesses were identified in the OSRO classification system that prevented the Coast Guard from assessing realistically the geographic response capabilities of OSROs. As a result, the Coast Guard reexamined the OSRO classification process and solicited comments on the process through a series of public workshops. Using information from these workshops, combined with the experience gained from implementing facility and vessel response planning regulations, the Coast Guard issued guidelines revising the OSRO classification process on December 28, 1996.

7. **LESSONS LEARNED:** The capabilities of an Oil Spill Response Organization may not be accurately reflected by their classification. The capabilities of a responding OSRO may not match those described in a Vessel Response Plan.

8. **RECOMMENDED ACTION:**

a. Commandant (G-MRO) should implement as soon as possible the OSRO resource assessment process contained in the revised OSRO classification guidelines, which calls for assessing OSRO capabilities through Coast Guard verification visits, Preparedness for Response Exercise Program (PREP) exercises, random resource availability spot checks, actual response, or information gathered during the course of normal business;

b. Commandant (G-MRO) should consider the feasibility and value of implementing a formal after-action OSRO capability evaluation, similar to the current Incident Specific Preparedness Review (ISPR) process. Criteria should be devised for targeting appropriate responses for OSRO evaluation. The evaluation process would provide a reality check on the capabilities of OSROs and would provide additional information to assess the validity of the OSRO classification process. Further, such an evaluation would provide valuable feedback on the numerous assumptions (response times, skimming capacity, storage capacity) which are the basis of the response planning program, including Vessel and Facility Response Plans and OSRO classifications. These evaluations may be conducted as an additional responsibility of ISPRs or by an independent evaluation team. The evaluations should not, however, be conducted by members of the National Strike Force Coordination Center or others involved in the classification of the specific OSRO.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #5.2 - Resource Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESOURCE MANAGEMENT, DEMOBILIZATION, PUBLIC RESOURCES, VESSEL OF OPPORTUNITY SKIMMING SYSTEM
4. TITLE: Demobilization of Public Resources
5. OBSERVATION: The Coast Guard's Vessel of Opportunity Skimming System was very effective. This public resource was not demobilized and replaced by private resources.
6. DISCUSSION: One of the resources which proved to be extremely effective during this response was the Coast Guard's Vessel of Opportunity Skimming System (VOSS). Two of these systems were deployed on Coast Guard buoy tenders which responded immediately to the scene of the discharge. The Spill Management Team was pleased with the performance of these resources; they provided a valuable on-water recovery capability that enhanced the response. The VOSS-equipped Coast Guard buoy tenders remained on scene throughout the duration of the response.

The concept of using public oil spill response resources for "first aid" response has been around for a long time. The concept is based upon the premise that the government should not compete with private industry and that the industry should be given every fair opportunity to respond with equipment of their choosing, provided that equipment is capable of meeting the needs of the Federal, State, and Responsible Party stakeholders. While this concept is widely accepted, it is just that - a concept only. No guidance or direction exists for Federal On-Scene Coordinators (FOSCs) or Unified Commands regarding when it is inappropriate to continue the use of public resources.

In this response, the Unified Command elected not to replace the public resources with private ones. This decision is quite understandable given the effectiveness of the public resources on scene and the short duration of the response. This decision did not however, permit the testing of the Responsible Party's Oil Spill Response Organization (OSRO). If the Responsible Party is not held accountable for ensuring the OSRO performs in accordance with the Vessel Response Plan, the FOOSC will be reluctant to release public resources already on scene, no matter how long the response operation takes. This could reduce the readiness of those public resources to perform their other statutory missions.

7. LESSONS LEARNED: If the Responsible Party is not held accountable for ensuring appropriate and necessary response resources of the OSRO listed in the Vessel Response Plan are obtained on scene, the FOOSC will be reluctant to release effective on scene public resources. Overuse of these public resources may impact adversely on other statutory missions.



8. RECOMMENDED ACTION:

- a. Commandant (G-MRO) should publish guidance to FOSCs and Unified Commands on the use and demobilization of public resources for oil spill response.
- b. In the meantime, Area Committees should ensure guidance on the use and demobilization of public resources is included in their Area Contingency Plan.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #5.3 - Resource Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESOURCE MANAGEMENT, SALVAGE, LIGHTERING. STRIKE TEAM
4. TITLE: Salvage and Lightering Resources
5. OBSERVATION: All available resources for salvage and lightering operations were not effectively used.
6. DISCUSSION: The tank barge which grounded and discharged some of its cargo in this incident did so on the evening of January 19, 1996. One of the primary focuses of the initial response was to lighten the barge so that it might be refloated prior to any further release of cargo. Lightering and wreck removal resources contracted by the Responsible Party started arriving on the morning of January 20. Resources from the Coast Guard Atlantic Strike Team also started to arrive at the same time. The Strike Team's lightering resources were substantial, state of the art, and in top condition. While the contracted commercial salvage company did borrow some minor equipment (albeit extremely valuable) from the Strike Team, most of the Strike Team's lightering equipment was not used during this response.  
  
Lightering operations commenced in the morning on January 21 and were suspended on January 23 due to the projected arrival of a severe storm with forecasted 45 knot winds and six to nine foot waves on January 24. Since sufficient cargo had not been removed during this three day window of opportunity, the barge was forced to ride out the storm, extending the possibility of a further release of cargo. The barge survived the storm and was subsequently lightered, refloated, and completely offloaded.  
  
While there may be varying opinions on whether as much oil as possible was offloaded during the three day window before the severe storm, there is evidence to support the notion that some of the best available lightering equipment went unused.
7. LESSONS LEARNED: Available opportunities for conducting salvage operations may suddenly disappear due to changes in weather, vessel conditions, or equipment operation.

8. RECOMMENDED ACTION:

a. Completing salvage while conditions are favorable requires (1) commencing operations as soon as feasible, (2) continuing operations for as long as possible (within the 24 hour cycle), (3) maximizing the use of all available resources, and (4) preplanning backup contingencies should the situation change or equipment malfunction.

b. Maximizing the use of available salvage resources requires a realistic assessment of salvage capability and the substitution or addition of more capable equipment. Three basic and separate elements comprise the generic term, "salvage." These are generally thought of as (1) emergency towing, (2) lightering, and (3) wreck removal. Lumping all three together as "salvage" is in many instances a misnomer. A salvage company may not have equal capabilities in all three areas. While a particular salvage company may have a significant capability in one element, that may not be the element required for a particular response. FOSCs should carefully evaluate a salvage company's specific capability in the element that is required for the response. The U.S. Navy Supervisor of Salvage can assist with this evaluation. All necessary and available resources should be employed.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #5.4 - Resource Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESOURCE MANAGEMENT, COMMAND POST, SECURITY
4. TITLE: Command Post Security
5. OBSERVATION: Command post security measures were not implemented until several days into the response.
6. DISCUSSION: Providing security for the command post is a function that is often overlooked by contingency planners. During this response, it became apparent after several days that too many people had easy access to the Unified Command and the Spill Management Team. Eventually, local law enforcement authorities were used to limit access to the command post.
7. LESSONS LEARNED: Unless command post security is planned and implemented at the outset of a spill response, many people will gain access to the Spill Management Team. This in turn may disrupt the proper functioning of the Incident Command System and may reduce the efficiency of the organization.
8. RECOMMENDED ACTION: Area Committees should ensure measures for implementing security at the command post are included in the Area Contingency Plan. Identification and access procedures should be included as part of the security plan. Unified Commands should ensure these procedures are implemented immediately upon activating a command post.

## PLLS LONG REPORT

1. FOCUS AREA: ISPR #5.5 - Resource Management System, submitted by Incident Specific Preparedness Review Team, (202) 267-0423
2. TYPE: Oil Spill Response, Tank Barge NORTH CAPE spill, Block Island Sound off Point Judith, RI, 1/19/96
3. KEYWORDS: RESOURCE MANAGEMENT, VOLUNTEERS, VOLUNTEER ORGANIZATIONS, BIRD CLEANING, WILDLIFE RECOVERY, AREA CONTINGENCY PLAN
4. TITLE: Use of Volunteers
5. OBSERVATION: The Area Contingency Plan did not address the use of volunteers for wildlife recovery operations.
6. DISCUSSION: Approximately 1,000 of the estimated 3,000 volunteers that responded to this spill were used to support activities such as beach damage assessment, logistics, public dissemination of information, and wildlife rescue and recovery. During the beginning stages of the response, the Spill Management Team was overwhelmed with volunteers. The State Governor designated a representative of "Save the Bay" as the Volunteer Coordinator. The coordinator was responsible for indoctrinating, training, utilizing, and monitoring the volunteers selected to assist in the response. The coordinator was familiar with the Area Committee planning process and assimilated into the Incident Command System. The use of volunteers could have been more efficiently and effectively managed, however, if there had been a plan for their use.
7. LESSONS LEARNED: Large numbers of volunteers typically will show up at the site of a significant oil spill. They can be used most efficiently and effectively when the Area Committee has determined ahead of time the best use for these volunteers. Their contributions will increase when they are properly managed.
8. RECOMMENDED ACTION: Area Committees should ensure the use of volunteers is planned and included in the Area Contingency Plan. Volunteer organizations willing to participate in wildlife recovery should be identified and listed in the plan. When no volunteer organizations can be identified ahead of time, the Area Committee should include in the Area Contingency Plan procedures for handling "walk-in" volunteers. The Area Committee should determine the most appropriate agency -federal, state, or local - to coordinate volunteers and this assignment should be included in the Area Contingency Plan. Training and health and safety concerns should be fully addressed in the plan.

## THE ISPR PROCESS

### Getting Started

Three weeks after the worst oil spill in Rhode Island history in which the Tank Barge NORTH CAPE ran aground on the south shore of Rhode Island spilling 820,000 gallons of no. 2 home heating oil into Block Island Sound, Commandant (*G-M*) formally convened this Incident Specific Preparedness Review (ISPR). The members of the ISPR Team were:

CAPT Dennis A. Sande, CO MSO Hampton Roads (chairman)  
LCDR Joseph Pancotti, Commandant (G-RER)  
LCDR Walter M. Hunt, Commandant (G-MRO)  
Mr. John Morhman, Delaware Department of Natural Resources  
Mr. John Joeckel, Ashland Petroleum Company  
LTjg Lauren V. Kabler, Commandant (G-MRO) (recorder)

The first task of the ISPR Team was to define some broad areas of focus or emphasis. To help in this regard, the Chairman sought and received candidate areas from the Chief of the Coast Guard Response Division and branches within the division. With this preliminary identification, the ISPR Team conducted their first meeting at Coast Guard Reserve Training Center (RTC) Yorktown. The goals of this meeting were to select focus areas and map out a strategy for data collection and analysis. Fortunately, by this time, the ISPR Team had available to them the following:

1. A Briefing Book prepared by Commandant (G-MRO) which contained all POLREPS from the response, Incident Summaries prepared by the First Coast Guard District, a representative sample of news clippings, and other briefing material.
2. A draft "Lessons Learned" document prepared by the First Coast Guard District.
3. "Lessons Learned" compiled by the FOSC Providence and the NORTH CAPE Spill Management Team.

With this material in hand, coupled with the candidate focus areas, the ISPR Team developed broad focus areas, with accompanying questions to be resolved for each area. Fortunately, the meeting at RTC Yorktown coincided with the convening of the On-Scene Coordinator Crisis Management Course. The team was able to listen to a presentation made to the class on the NORTH CAPE response by the FOSC. Later, the FOSC was interviewed by the team, their first interview.

## Methodology

The team selected three methods of obtaining data:

1. Pertinent plans and documents were obtained and reviewed for information that would help provide evidence for the conclusions to be drawn from the review. A list of these documents is included as Attachment A.
2. A survey (questionnaire) was developed to assess strengths and weaknesses of the response in an effort to narrow the focus of the review. This survey (Attachment B) was distributed to all key players in the response.
3. Personal interviews were conducted. In all, 19 key personnel were interviewed in person by the ISPR Team. The Recorder took handwritten notes from these interviews which were later typed. At the conclusion of the last interview there were 120 pages of handwritten notes.

The personnel selected to be interviewed were identified by their Spill Management Team position, but the team also selected a cross-section of personnel among Federal, State, and Responsible Party/Oil Spill Response Organization (OSRO) personnel who participated in the response. Personnel from the following organizations were interviewed:

Coast Guard Marine Safety Office Providence  
Coast Guard Marine Safety Office Boston  
First Coast Guard District  
Atlantic Strike Team  
Scientific Support Coordinator  
National Oceanic and Atmospheric Administration (NOAA) Trustee  
Rhode Island Department of Environmental Management  
Rhode Island Emergency Management Agency  
University of Rhode Island  
The Responsible Party's OSRO

The team traveled to Providence, Rhode Island; Boston, Massachusetts; Newark and Atlantic City, New Jersey; and Staten Island, New York. One clear disappointment of the interview process involved the Responsible Party. Arrangements were made to interview key personnel from the Responsible Party's company, however upon arrival at the company's offices in Staten Island, New York, the Chairman of the Team was advised that the owners had been directed by their legal counsel not to say anything to the ISPR Team due to pending criminal investigation involving the spill. Completion of the ISPR was delayed for a time waiting to see if the Responsible Party would feel free to discuss the response, but in the interest of coming to closure with the review, a decision was made to complete the report without the benefit of personal interviews with the Responsible Party.

## **Putting It All Together**

Members of the team had scored and analyzed the data obtained from the surveys. Additional documents were obtained. Each of the team members was assigned an area of specialization and they prepared themselves to discuss their findings. Then, the team met for four days in Norfolk, Virginia to draw conclusions from the review and select lessons learned. The team identified 108 aspects of the response that deserved comment in the form of lessons learned. Team members each drafted preliminary lessons learned.

Later, the Chairman and the Recorder met for a week in Norfolk, Virginia to consolidate the lessons learned into 32 formal lessons learned in accordance with the PLLS format. The final drafting of the ISPR report took an additional two-week period.

## **Recommendations**

Having participated in the ISPR process, the team makes the following recommendations which may be of assistance to future ISPR Teams:

### **1. Issue: Team Membership - Industry and State**

Discussion: One change to team membership since the first ISPR has been the addition of a State representative and an industry representative on the team. This ISPR Team found the inclusion of these two members to be invaluable. The State representative was particularly helpful with State organization and policies, Regional Response Team roles, wildlife issues, NRDA, and the contingency planning process. The industry representative was extremely helpful regarding industry practices, OSROs, Vessel Response Plans, salvage, and response techniques.

Recommendation: Commandant (G-MRO) should continue the practice of assigning an industry and State representative to the ISPR Team.

### **2. Issue: Team Membership - Coast Guard**

Discussion: It has become the practice to assign in addition to the Chairman and the Recorder, two Coast Guard members to the team. While helpful to have another Coast Guard member with spill response expertise, besides the Chairman, a second Coast Guard member is unnecessary. Limiting the membership to the Chairman, Recorder, State and Industry representatives, and one other Coast Guard member would reduce the ISPR travel costs by one-sixth.



Regarding the expertise of the group, the decision to select an active FOSC as Chairman is wise. Another good choice would be an active Chief of a District Marine Safety Division. Individuals filling both of these positions are likely to be well versed in the latest policy and practices regarding Regional Response Team and Area Committee contingency planning processes. Other Coast Guard members should likewise be chosen for their expertise. Good candidates for the other Coast Guard member would be an MSO Chief of Port Operations or a Strike Team member.

Recommendation: Commandant (G-MRO) should evaluate the value vs. the cost of assigning two Coast Guard members in addition to the Chairman and the Recorder. Active FOSCs and Chiefs, District Marine Safety Divisions are well suited to serving as Chairman. Commandant (G-MRO) should seek MSO Chiefs of Port Operations or Strike Team members for the other Coast Guard member.

### 3. Issue: Team Recorder

Discussion: The Recorder for this ISPR did a commendable job in making all logistical arrangements for the team as well as conducting all administrative functions of the ISPR. This is a big job, and one that requires much interaction with the Chairman. The cost and duration of the ISPR could be reduced significantly if the Recorder was selected from the same command as the Chairman. While some Chairmen might find this to be an extra burden upon their command, many would recognize the time that would be saved. In the end by being able to deal directly with the Recorder on a daily basis and being able to adjust the Recorder's normal workload accordingly.

Recommendation: In selecting the ISPR Team, Commandant (GMRO) should offer prospective Chairmen the opportunity to select an ISPR Team Recorder from their own command.

### 4. Issue: **ISPR Team Preparation**

Discussion: The briefing book assembled by Commandant (GMRO) was particularly valuable to the ISPR Team's familiarization with the response. On the other hand, there were some logical documents that every ISPR will need that this team had to search out. These also could be provided ahead of time.

Recommendation: Commandant (G-MRO) should continue the practice of providing the ISPR Team with a collection of POLREPS, news clippings, and briefing material at the outset of the ISPR. It is recommended that upon convening the ISPR, Commandant (GMRO) obtain from the FOSC, for distribution to the ISPR Team, a response organization chart indicating the name and agency of each key member of the Spill Management Team. The ISPR Team should also be provided with copies of the following:

- past ISPRs
- applicable Area Contingency Plans
- applicable Vessel and/or Facility Response Plans
- applicable Regional Response Team Contingency Plans
- applicable Coast Guard District Operations Plans

5. Issue: **ISPR Dissemination**

Discussion: There was overwhelming evidence obtained during this review to conclude that much of the response community is unaware of the lessons learned from past ISPRs. This was especially true outside the Coast Guard. The ISPR process is a lengthy and costly process, but it is a process that yields much help for contingency planners and response personnel. ISPR reports should have the widest distribution possible.

Recommendation: Commandant (G-MRO) should ensure all regional offices of Federal agencies represented on the National Response Team and all State environmental and emergency management agencies receive copies of ISPRs. Commandant (G-MRO) should explore and implement methods of effecting wide distribution of ISPRs throughout the maritime industry.

## ISPR Document List

### Background

Commandant (G-M) ltr 16465 dtd 09 FEB 96

COMDTINST 16465.42, Incident Specific Preparedness Review (ISPR)

Final ISPR Report, MORRIS J. BERMAN spill

Final ISPR Report, Guadalupe Beach, CA spill

Pollution Incident Review, Tampa Oil Spill (collision of M/V BALSAM, T/B OCEAN 255, and T/B BOUCHARD 155)

"Scandia Complete Phone List" - MSO Providence submission POLREPS, Incident Summaries, and News Clippings - Commandant (G-MRO) submission

"Chronology of Events T/B North Cape and Tug Scandia Casualty -Donjohn Marine Company, Inc. submission

### References

National Oil and Hazardous Substances Pollution Contingency Plan,  
40 CFR 300

COMDTNOTE 16471, establishment of Area Committees and Development of Area Contingency Plans

Navigation and Vessel Circular (NVIC) 8-92, Interim Guidelines for the Development and Review of Vessel Response Plans

Navigation and Vessel Circular (NVIC) 12-92, Guidelines for the Classification and Inspection of OSROs

COMDTINST 2014.1, Emergency Response Network Interface Equipment (ERNIE)

## **Plans**

Rhode Island/Southeastern Massachusetts Area Contingency Plan

Eklof Marine Corporation Vessel Response Plan

Eklof Marine Incident Action Plan

Barge North Cape Incident Dispersant Plan

Coast Guard Site Safety Plan: North Cape/Scandia Salvage and Cleanup; Moonstone Beach, Rhode Island

Eklof Marine Safety Management Plan; Salvage and Spill Response Operations

Eklof Marine Safety Management Plan; North Cape Response; Site Decontamination procedures

Decontamination Plan

Donjohn Environmental Marine Services Proposed Demobilization Plan

Donjohn Marine Co., Inc. Salvage Plan Tug Scandia Donjohn Marine Co., Inc. Refloating Plan for T/B

NORTH CAPE

Lessons Learned/Debriefs/Testimony

Minutes, COTP Providence Area Committee Meeting Debrief of NORTH CAPE Spill - MSO Providence submission

Lessons Learned During MSO Providence's Response to T/B NORTH CAPE Oil Spill (pre-decisional document) - CCGDONE (mep) submission

"NORTH CAPE Spill" - FOSC presentation to On-Scene Coordinator Crisis Management Course

NORTH CAPE Communications Lessons Learned - MSO Providence submission

T/B NORTH CAPE Grounding After Action Report - CCGDONE (dt) submission

NORTH CAPE Salvage Team Involvement: Lessons Learned - Coast Guard Marine Safety Center Submission

Barge NORTH CAPE Oil Spill Lessons Learned - USCGC SENECA submission

SORREL Lessons Learned - USCGC SORREL submission NOAA Trustee ltr of 29 MAR 96 to FOSC

Statement of Professor William R. Gordon, Jr., University of Rhode Island, Before the Committee on Environment and Public Works, United States Senate, 27 March 1996

INCIDENT SPECIFIC PREPAREDNESS REVIEW (ISPR)  
T/B NORTH CAPE

DATA COLLECTION SURVEY

PURPOSE: The purpose of the Incident Specific Preparedness Review (ISPR) is to conduct a thorough review and assessment of the preparedness process by focusing on an objective review of the response actions. It is not the intent of the ISPR team to evaluate or grade response effort<sup>5</sup> but rather to identify strengths and weaknesses in planning methodology in order to foster improvement in the planning process.

The information in this survey is designed to assist the ISPR team in collecting pertinent data about the response to this incident. All surveys will be used only by the ISPR Team and will be kept strictly confidential

Name \_\_\_\_\_

Organization/Affiliation \_\_\_\_\_

Job Title \_\_\_\_\_

Your Role in the Event \_\_\_\_\_

1=strongly disagree, 2=disagree, 3=neither agree nor disagree, 4= agree, 5=strongly agree, no answer=not observed  
4= agree,

I RESPONSE MANAGEMENT SYSTEM(RMS)

A. The Incident Command System/Unified Command System (ICS/UCS) was fully implemented and followed by all stakeholders.	1	2	3	4	5
B. Utilization of th~ICS/UCS was successful.	1	2	3	4	5
C. Decision making was strengthened due to effective use of the ICS/UCS.	1	2	3	4	5
D. All stakeholders (Responsible Party [RPJ, federal, state, local) were fully cognizant of all of their roles and responsibilities in the decision making process.	1	2	3	4	5
E. The RP Spill Management Team (SMT) managed the salvage.	1	2	3	4	5
F. The Coast Guard managed the salvage.	1	2	3	4	5
G. The SXT plugged into the Area's ICS/UCS without •missing a beat.	1	2	3	4	5
H. The Joint Information Center (JIC) functioned appropriately.	1	2	3	4	5

I. Coast Guard cleanup equipment outnumbered RP cleanup equipment approximately 3 to 1.	1	2	3	4	5
J. It is realistic to expect the RP to put together an effective and efficient SMT.	1	2	3	4	5
K. The employed RMS matched that called for in the Area Contingency Plan (ACP) and the Vessel Response Plan (VRP).	1	2	3	4	5

COMMENTS:

II. NATIONAL PREPAREDNESS FOR RESPONSE EXERCISE PROGRAM(NPREP)

A. The participation in NPREP exercises facilitated effective response and allowed for easy coordination among all parties.	1	2	3	4	5
B. Adequate opportunity for participation in NPREP exercises was provided to all parties involved prior to this incident.	1	2	3	4	5
C. The parties involved participated in NPREP exercises prior to this incident.	1	2	3	4	5
D. The parties involved trained in exercises other than NPREP that aided in the success of this response.	1	2	3	4	5

COMMENTS:

III INFORMATION MANAGEMENT SYSTEMS

A. Information flow (vertical, horizontal) mechanisms were pre-planned (i.e. in the ACP), clearly understood and implemented quickly with minimum of confusion.	1	2	3	4	5
B. The information management system utilized contributed greatly to the success of the response.	1	2	3	4	5
C. Pertinent information was passed to other states and Federal Agencies in a timely and effective manner.	1	2	3	4	5
D. Communication systems (phone/fax/radios/mail/situation boards) were adequate for all participants.	1	2	3	4	5

COMMENTS:

IV. SUPPORT SYSTEMS, i.e. Special Forces, Regional Response Team (RRT), Scientific Support Coordinator (SSC)...

A. There was a mechanism in place to effectively blend separate support system elements into a unified, productive team.	1	2	3	4	5
B. The RRT assisted in key areas of the response.	1	2	3	4	5
C. The NOAA SSC was properly utilized and able to make the appropriate contribution to the success of the response.	1	2	3	4	5
D. All other special forces (Atlantic Strike Team, Navy Supervisor of Salvage [SUPSALVJ], National Pollution Funds Center, Public Information Action Team, Natural Resource Damage Assessment Team) made appropriate contributions to the success of the response.	1	2	3	4	5
E. The non-notification of Navy SUPSALV did not hinder the response.	1	2	3	4	5

COMMENTS:

V. PLANNING SYSTEM

A. The ACP, VRP, the RI/SE MASS Plan, and the CG First District Operations Plan were sufficiently aligned and effectively integrated.	1	2	3	4	5
B. The response to the incident was a "planned" operation and not a "saddle up and go" operation.	1	2	3	4	5
C. The plans referenced above were user friendly providing just the right amount of information to effect an efficient response.	1	2	3	4	5
D. Administrative support is sufficiently planned for in the ACP.	1	2	3	4	5



- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| E. The plans referenced above had a strategy in place to respond to the oil dispersing into the water column. | 1 | 2 | 3 | 4 | 5 |
| F. There was an effective site safety plan.   | 1 | 2 | 3 | 4 | 5 |
| G. There was an effective and timely action plan provided for by the RP.                                      | 1 | 2 | 3 | 4 | 5 |
| H. The response resources listed in the plans referenced above were adequate for the response.                | 1 | 2 | 3 | 4 | 5 |
| I. The SMT offered an effective salvage plan.   | 1 | 2 | 3 | 4 | 5 |
| J. The Coast Guard offered an effective plan and timeline for demobilizing Coast Guard resources.             |   |   |   |   |   |

COMMENTS:

VI RESOURCE MANAGEMENT SYSTEM

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| A. Augmenting forces were mobilized and used effectively according to plan.   | 1 | 2 | 3 | 4 | 5 |
| B. The Oil Spill Response Organization (OSRO) classification system is accurate and gives a realistic picture of the response capability. | 1 | 2 | 3 | 4 | 5 |

COMMENTS:

Please mail/fax surveys to:

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