DEPARTMENT OF THE NAVY
VICE CHIEF OF NAVAL OPERATIONS
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IN REPLY REFER TO:
5800
Ser N09/15U100508
16 Mar 15

SECOND ENDORSEMENT on RDML Jeffrey A. Harley ltr 5800 Ser N00/089 of 1 May 14

From: Vice Chief of Naval Operations

To: File

Subj: INVESTIGATION INTO THE SHOOTING INCIDENT ONBOARD USS MAHAN (DDG 72) ON 24 MARCH 2014 AND ASSOCIATED INSTALLATION AND SHIPBOARD FORCE PROTECTION POLICIES AND PROCESSES

Ref: (d) OPNAVINST 5530.14E, Navy Physical Security and Law Enforcement Program Requirements
(e) Navy Doctrine for Antiterrorism/Force Protection (NTTP 3-07.2.3)
(f) DoDI 5210.56

1. On 24 March 2014, Petty Officer Second Class Mark Mayo perished after being shot at close range by an intruder on board Naval Station Norfolk and the USS MAHAN. This intruder obtained a weapon from a USS MAHAN watch stander by force after passing unchecked through layers of security that were intended to protect the installation, the ships and the people. While this intruder's actions are the direct cause of Petty Officer Mayo's death, the investigation revealed that individual errors at the gate onto Naval Station Norfolk were the predominant contributing factors. In the course of this investigation, other individual and institutional shortcomings were discovered that require correction or improvement.

2. This investigation[1] had multiple purposes: (1) to inquire into the facts and circumstances of this incident, to identify fault, neglect or responsibility and to recommend disciplinary action; and, (2) to inquire into relevant aspects of installation and shipboard force protection policies and procedures to inform decisions that might be implemented across the fleet.

3. I have reviewed the subject investigation and approve the findings, opinions and recommendations of the investigating officer as modified by the first endorser, except as specified below:

a. The primary contributing factors were individual watch standing failures at Gate 5 of Naval Station Norfolk. The Department

[1] A second investigation, conducted by the Naval Criminal Investigative Service, is still underway. It focuses on the criminal aspects of this incident, to include an effort to determine the intent of the intruder.

of the Navy Civilian Police Officers manning the gate failed to request or confirm the intruder's identification or authorization to enter the installation. They similarly failed to execute established vehicle turn-around procedures, failed to otherwise ensure that the intruder made the U-turn and exited Gate 5, failed to deploy the hardened anti-access control system, failed to pursue the intruder in a timely fashion, failed to radio or otherwise notify the Naval Station security dispatch, and failed to execute Standard Operating Procedures in response to an unauthorized individual on Naval Station Norfolk.

b. The investigating officer recommended that Naval Station Norfolk and Navy Region Mid-Atlantic reassess the validity of the Mission Profile Validation-Protection (MPV-P). This recommendation is disapproved. Pursuant to reference (e), the MPV-P model is the only approved model for determining and validating installation security post and staffing requirements. Installation validations are approved by the Office of the Chief of Naval Operations (N46) after review by the appropriate Navy Component Commander and the supported Geographic Combatant Commander. There are periodic reassessments of the model, but the model itself and the process of determining requirements should be maintained. Category A, recommendation 2 on pages 42, 67 and roman numeral x are revised to strike the language "and reassess the validity of the Mission Profile Validation-Protection." The central question going forward is whether and how to resource each installation to the requirements identified by the MPV-P model. These decisions shall be made in the context of the Planning, Programming, Budget, and Execution (PPBE) cycle and will be informed by the findings of this investigation and related assessments.[2]

c. The investigating officer found that the pay grade of Navy government service security guards are lower than those hired by other military Services and agencies and opined that this contributed to a lack of capability and professionalism. The investigating officer also opined that manpower shortages at Naval Station Norfolk had a negative effect on the supervisory performance of the Naval Security Force and that sequestration, furloughs, and a hiring freeze, along with high attrition rates, created delays in achieving and sustaining optimal levels of civilian manning.

At the time of this incident, each watch stander position was manned and in some cases, manned to excess with an under-instruction watch stander. Primary contributing factors of the incident speak to adherence to process and capability as identified by the investigating officer. In addition Commander, Navy Installations Command has created professional qualification standards for Navy Civilian Police

[2] The Department of Defense and Department of the Navy Inspector General's office as well as the Naval Audit service continue to assess elements of installation force protection and access controls.

and transitioned Navy Civilian Police initial training to the Federal Law Enforcement Training Center (FLETC) in Glynco, GA. 140 Navy civilian security officers graduated from this course in FY15 with 235 quotas reserved for FY15.

The ability to recruit and retain law enforcement officers is impacted by pay grade and our current practice of hiring at lower pay grades should be changed. Accordingly, Category A, recommendation 7 on page 44, 68 and roman number xi is revised to strike the language "and this may contribute to the lack of capability and professionalism." The following additional language is included: "Assistants Secretary of the Navy for Manpower and Reserve Affairs and Energy, Installations and Environment are requested to assess a Department of the Navy-wide increase in pay grade for Navy government service security guards in order to alleviate gapped billets and mitigate recruiting and retention concerns. Commander, Navy Installations Command is directed to re-evaluate civilian security force position descriptions across the enterprise and submit for reclassification to ensure DON civilian security force pay parity with sister services and other government agencies."

d. The investigating officer recommended that Commander, Navy Installations Command validate the availability of force protection and law enforcement equipment such as vests, communications, and weapons for watch standers. I concur. However, the watch standers and responders in this incident had been issued appropriate force protection equipment. At the time, the prevailing practice among Naval Station Norfolk watch standers was not to wear all of the assigned equipment.

e. The investigating officer opined that a lieutenant (O-3) does not have the experience to effectively lead a security department as large and as complex as Naval Station Norfolk. The Security Officer billet at the installation level is filled by officers from the Limited Duty Officer - Security community. Limited Duty Officers are commissioned from the enlisted ranks on the basis of their leadership and experience in the corresponding enlisted rating. These officers are commissioned with significant technical experience. However, not all have the necessary supervisory experiences which allows them to address the scope of security challenges at our largest installations. Category A new recommendation 16, is added to read a follows: "Deputy Chief of Naval Operations for Manpower, Personnel, Training and Education and Commander, U.S. Fleet Forces Command shall ensure that a career progression and training model is developed for the Limited Duty Officer- Security (6490) community in which officers gain experience as the security officer for smaller installations and/or deputy security officer at a larger installation prior to assignment as the security officer of a large installation."

In addition to failing to ensure that all assigned equipment was donned by watch standers, the Security Officer failed to address the

seniority of watch standers during after-hours and weekends. At Naval Station Norfolk, there was an apparent culture where senior personnel avoided after-hours watch standing. Balancing experience and seniority across watch bills is the responsibility of leadership. I have tasked the Commander, Navy Installations Command to assess whether a culture of entitlement exists in shore establishment security departments charge his commanders to ensure that watch bills reflect complementary skills, background and experiences across watch shifts.

f. The investigating officer opined that the USS MAHAN's watch team on the quarterdeck appropriately applied the use of force continuum. Reference (f) includes guidance for Naval Security Force personnel. In sum, it provides that a watch stander should not introduce deadly force into a circumstance unless he or she intends to use it. The Petty Officer of the Watch correctly articulated that deadly force was the final step on the use of force continuum, but drew her firearm rather than her baton or mace because she felt that by making her firearm visible, the intruder would be more responsive to voice commands. She did not believe that a person of her relative size compared to the intruder would be much of a deterrent if only wielding a baton.

When describing the continuum of force, reference (e) provides that "the standard for evaluating use of force shall be reasonableness under the facts and circumstances known to the NSF member at the time."

Reference (f) provides that the "reasonableness of a belief or decision must be viewed from the perspective of the employee on the scene, who may have been forced to make split-second decisions in circumstances that were tense, unpredictable and rapidly evolving. Reasonableness is not to be viewed from the calm vantage point of hindsight." While the Petty Officer of the Watch's actions may have violated established doctrine, I agree with the investigating officer's conclusion that the watch team appropriately applied the use of force continuum.

g. I concur with the opinions on the subject of Fault, Neglect, Responsibility, and Accountability, as modified by the first endorser of the investigation. A copy of this investigative report will be provided to Commander, Navy Installations Command for action as deemed appropriate for the named civilian and military personnel.

4. The following corrective actions have already been taken and will be augmented by the additional recommendations identified in this endorsement:

a. Commander, Navy Installations Command has standardized Personnel Qualification Standards and Job Qualification Standards for Department of the Navy Civilian Police Officers.

b. Commander, U.S. Fleet Forces Command and Commander, Navy Installations Command have revitalized the Anti-Terrorism/Force Protection (AT/FP) assessment process by combining Higher Headquarters Operational Assessment and Installation Protection Assessment Cell visits.

c. Commander, Navy Installations Command has increased the amount of human resources support available to support hiring actions for civilian security forces and has authorized "over-hiring" in the near-term to account for civilian personnel attrition. They have also created an internal process to ensure critical vacancies are highlighted and that there is oversight in the hiring process.

d. A review of the communications doctrine, training and equipment is ongoing.

e. Commander, Navy Installations Command has centralized the ordering and distribution of security forces equipment and has ensured installation inventories are standardized.

f. All installation commanders conducted a review and ensured their post orders and Standard Operating Procedures were up to date.

g. The annual installation force protection exercise has been updated to ensure integrated communications and a scenario such as the one presented in this event are tested and evaluated.

h. Commander, U.S. Fleet Forces is maintaining a requirement for two pier Entry Control Point watch standers.

i. Installations have reviewed and documented security-related materiel deficiencies and have repaired or mitigated the impacts of these deficiencies.

5. This event underscored the importance of watch teams adhering to processes that provide for secure bases. Defense in depth works if each watch stander performs their duties with vigilance. I am satisfied that the programmatic and policy corrective actions underway are sufficient to improve our physical security posture. However, security is guaranteed only when resources are coupled with leadership and vigilant watch standers.

Michelle J. Howard
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Copy to: SECNAV, CNO, DUSN(M), DUSN(P), ASN M&RA, ASN EI&E, ACMC, USFF, COMPACFLT, CNIC, NCIS

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5800
Ser N01/068
16 Oct 14

FIRST ENDORSEMENT on RDML Jeffrey A. Harley ltr 5800 Ser N00/089 of 1 May 14

From: Commander, U.S. Fleet Forces Command
To: Vice Chief of Naval Operations

Subj: INVESTIGATION INTO THE SHOOTING INCIDENT ONBOARD USS MAHAN (DDG 72) ON 24 MARCH 2014, AND ASSOCIATED INSTALLATION AND SHIPBOARD FORCE PROTECTION POLICIES AND PROCESSES

Ref: (a) JAGINST 5800.7F (JAGMAN), Chapter II
(b) DoD 5800.8-R, Physical Security Program
(c) Office of the Assistant Secretary of Defense for Homeland Defense and Americas' Security Affairs, "DoD Antiterrorism Officer Guide," December 2012

1. I have reviewed the subject investigation and approve the findings, opinions, and recommendations of the investigating officer (IO) as modified below, in accordance with reference (a).

2. Executive Summary

a. On 24 March 2014, Mr. Jeffrey Savage (the suspect), a civilian, drove his employer's semi-tractor cab onto Naval Station Norfolk through Gate 5 without showing the Gate 5 civilian police officer proper identification. As the suspect drove through Gate 5, the civilian police officer manning the gate, (b)(6) [redacted] (assigned as the Gate 5 Police Officer-in-Charge), thought the suspect was going to execute a U-turn. (b)(6) [redacted] watched the cab as it failed to execute the expected U-turn and continue onto the base. Contrary to protocol, (b)(6) [redacted] did not initiate "gate runner" procedures. (b)(6) [redacted] continued his duties of checking identification of cars coming onto the base for several more cars and then informed another civilian police officer at Gate 5, (b)(6) [redacted] that the driver of the semi-tractor cab did not show proper identification and did not execute a U-turn.

Minutes later, (b)(6) left Gate 5 in his police car to search for the suspect. Contrary to required procedures, neither (b)(6) nor (b)(6) attempted to use their radio to report the suspect's unauthorized access onto the base to Naval Station Norfolk police or anyone else.

In the meantime, the suspect drove his semi-tractor cab to the parking lot adjacent to Pier 1, exited his vehicle and approached the Pier 1 Entry Control Point. When the suspect approached the Pier 1 Entry Control Point, the Entry Control Point Sentry (the only sentry manning the Entry Control Point) was removing, and then replacing, two barrel-like traffic cones to allow the Chief of the Guard duty vehicle onto the pier, and was therefore not standing at the Entry Control Point pedestrian gate. The suspect walked through the Entry Control Point without showing identification. Upon seeing the suspect walk onto the pier, the Entry Control Point Sentry yelled for him to stop and provide identification for pier access, but the suspect did not comply with her direction. The Pier 1 Entry Control Point Sentry used her radio to immediately notify USS MAHAN's quarterdeck that a black male walked through the Entry Control Point and onto the pier without showing identification. The suspect walked toward the USS MAHAN quarterdeck, and the MAHAN Officer of the Deck (OOD) and Petty Officer of the Watch (POOW) shouted at the suspect to show proper identification. When the suspect ignored their directions, the MAHAN POOW notified the Waterfront Security Operations Center that an unauthorized individual was on Pier 1. The Waterfront Security Operations Center Chief of the Guard, Petty Officer Mark Mayo, and his Chief of the Guard Under Instruction, (b)(6) (b)(6) were in a vehicle on Pier 1 making their rounds when the notification was made to the Waterfront Security Operations Center. Petty Officer Mayo heard the MAHAN report to the Waterfront Security Operations Center on his radio and answered that he was on scene and would respond.

The suspect continued to ignore the direction of the MAHAN OOD and POOW to stop and produce identification, and, after he looked in several storage lockers located on the pier, the suspect walked up the MAHAN brow, ignored orders from both the MAHAN OOD and Petty Officer Mayo to stop, and approached MAHAN's quarterdeck stating he "just wanted to talk."

As the suspect stepped onto the quarterdeck, the POOW drew her sidearm. Upon seeing the POOW's weapon, the suspect stated,

"Give me that gun," and reached for the weapon. A struggle between the two ensued. While the suspect and the POOW struggled for the weapon, Petty Officer Mayo and (b)(6) (b)(6) ran up the brow and approached the quarterdeck. Petty Officer Mayo entered the quarterdeck as the suspect wrestled the weapon away from the POOW, and Petty Officer Mayo lunged between the two, shielding the POOW. The suspect fired the weapon multiple times, killing Petty Officer Mayo. (b)(6) (b)(6) and the MAHAN Topside Rover fired several rounds from their weapons at the suspect, killing him.

Petty Officer Mayo's bravery and selfless protection of his shipmates cannot be overstated. For his heroic actions, Petty Officer Mayo was awarded the Navy Marine Corps Medal.

b. Findings of the Investigation. The investigation concludes that the suspect gained access to the base because civilian police officers, (b)(6) and (b)(6) failed to execute basic security procedures. They both knew that the suspect drove onto the base without proper identification yet they failed to initiate established gate runner procedures and failed to notify anyone of the security breach. I agree with the Investigating Officer's assessment.

The investigation also concludes that layered security was ultimately successful in this case because the suspect was prevented from penetrating the ship. For the reasons stated below, I disagree with this conclusion.

Although, it is true that Mr. Savage never penetrated the ship, there is no evidence that he intended to penetrate the ship. As described in the investigation, his motive and intent that evening are unknown.

The Department of Defense (DoD) does not define the concepts of "defense-in-depth," "layered defense" or "security-in-depth."[1] The Navy uses references (b) and (c) to define these concepts in varying ways, leaving installation commanders to piece together working definitions of the layered security concept from these publications.[2] Generally, "defense in depth" or "layered

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[1] Joint Publication 1-02 does not define "defense-in-depth," "layered defense" or "security-in-depth."

[2] Reference (b) defines "Security-in-Depth" as "[a] determination by the senior agency official that a facility's security program consists of layered and

defense" involves the application of multiple levels of security at varying intervals and/or distances from the assets to be protected.

Determining whether an aspect of a security program was a "success" requires an understanding of the program's desired end state. While the Navy's various security programs have different lenses, their goals are the same. Both the anti-terrorism program and the physical security program are focused on different types of bad actors, but both are designed to protect the Navy's personnel, property, and assets. Reference (b) defines "Physical Security Program" as "that part of security concerned with active and passive measures designed to prevent unauthorized access to personnel, equipment, installations, information, and to safeguard them against espionage, sabotage, terrorism, damage, and criminal activity." Reference (c) states that the policy of the anti-terrorism program is to ensure that "DoD Components, elements and personnel will be protected from terrorist acts through a high-priority, comprehensive AT program using an integrated systems approach." The desired end state of both of these programs is safe and secure people, property, and assets.

While I understand his rationale, I disagree with the IO's conclusion that events of 24 March 2014 represent a success of "defense in depth." The suspect was able to penetrate the layered defense system and put personnel at risk, contrary to the goals of references (b) and (c). The suspect was able to gain unauthorized access to the Naval Station, then the pier,

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complimentary security controls sufficient to deter, detect, and document unauthorized entry and movement within the facility." Reference (c), in chapter 4-21, states that "[t]he physical security systems installed in and around DoD installations and facilities form the physical backbone of DoD AT efforts. The facilities, equipment, and personnel making up the installation security force are the first lines of defense against terrorist attack. … Physical security systems should be designed employing a layered "defense in depth" concept." Reference (c) goes on to describe "Layered Security Concept" in chapters 4-27 through 4-29. In chapter 4-27 it states "ATOs need to think of physical security as a system that provides defense in depth. In some cases, defense in depth can be obtained by constructing 'islands' of extreme or high security within a 'sea' of moderate security. This concept is also referred to as 'enclaving.'" And in chapter 4-28, it further states "[t]he DoD assets to be protected are located within an innermost ring of security. Additional layers of security are provided at increasing distances from the asset to be protected. The number of layers, the components that compromise them, and their resistance to penetration depend on the threat and the importance of the asset to be protected."

and ultimately MAHAN's quarterdeck. The multiple defense layers intended to protect the ship and the people on it failed to protect those people; they were not even warned until the suspect was already in the vicinity of MAHAN's brow. At close proximity, the suspect then overpowered the Petty Officer of the Watch, wrestled her weapon away from her, and shot and killed the Chief of the Guard. Lives were lost, and Navy personnel and critical assets were exposed to unnecessary risk. This was an unacceptable security failure, and improvements in our security program are required to ensure this never happens again.

The failure of the Gate 5 civilian police to initiate gate runner procedures, or otherwise notify security watchstanders on the base that an unauthorized individual had accessed the base, set in motion the chain of events that led to Petty Officer Mayo's death. Had the Pier 1 Entry Control Point Sentry been notified regarding the intruder, she could have notified the ships on the pier and taken steps to stop the individual prior to his accessing the pier. Instead, the Pier 1 Sentry had no knowledge that the individual who walked onto the pier without showing identification was on the base illegally. The situation was exacerbated because the USNS COMFORT, manned by a significant number of civilians, was also berthed at Pier 1, so there were more civilians in and around that pier than there likely would have been at a pier berthing only Navy warships. The MAHAN watchstanders, Chief of the Guard and Chief of the Guard Under Instruction were placed in the very difficult position of determining the suspect's intent, and deciding in seconds the appropriate actions to take. This incident reemphasizes the requirement of command leadership and watchstanders to constantly conduct scenario training so that they are prepared to take appropriate actions when the situation warrants.

The investigation identified several deficiencies in the Naval Station security program that left it vulnerable to this unacceptable security breach and provides recommendations to correct those deficiencies and strengthen our security posture. As detailed below, in the aftermath of previous DoD installation security events, work to improve Navy installation security has been underway for the past eighteen months. This tragic event demonstrates that we must dedicate even more effort, manpower, and resources to strengthening our installation security.

3. Per reference (a), I provided Commander, Navy Installations Command and Commander, Naval Surface Force Atlantic an opportunity to comment on this investigation and I have considered and incorporated their comments in this endorsement as appropriate.

4. Modifications to Investigation Report

The following changes are incorporated into the investigation report:

a. Executive Summary.

(1) Page I. Delete the last sentence, "In spite of the tragic loss of life, the Naval Station layered security was ultimately successful in preventing an outside threat from penetrating the ship."

(2) Page VIII. Delete the phrase, "In spite of the success demonstrated in precluding Mr. Savage's access to USS MAHAN"

(3) Page XV. Delete the phrase, "the layered defense worked and precluded access to the interior spaces of USS MAHAN."

For reasons stated in paragraph 2(b) above, this incident should not be characterized as a successful application of layered defense.

b. Incident Synopsis. Section 1.1, Page 1.

Delete the sentence, "In spite of the tragic loss of life, Naval Station Norfolk's layered security was ultimately successful in preventing a threat from penetrating the ship beyond the quarterdeck."

c. Findings. Section 3.8, Page 41.

The Finding, "The physical material condition of access controls and pier equipment contributed to this incident" is disapproved. Although substandard material condition is never acceptable, the condition of access controls did not contribute to this event. Even if the alternate ECP hinge had been in sound material condition, with only one watch stander at the ECP (which was the standard up until the MAHAN event), the suspect would likely have been able to walk onto the pier while the ECP watchstander

opened the gate to allow the authorized vehicle access to the pier. Immediately following this incident, USFF ordered a minimum of two watchstanders on duty at all times at each pier ECP to correct this deficiency.

d. Recommendations. Section 3.9, Paragraph (10), Page 45.

The following language is added after the last sentence: "In order to accomplish this, officers responsible should ensure that force protection-related material deficiencies at Naval Station Norfolk are documented in the CNIC Resourcing Allocation Module. If funding levels do not support immediate repair of force protection equipment, this reduction in mission capability should, if appropriate, be documented in DRRS-N."

Note: This change is also incorporated into Recommendations listed in the Executive Summary and in Section 6.0, Summary of Recommendations.

e. Findings. Section 4.7, Page 58.

Delete the third paragraph and replace it with the following: "USS MAHAN had an effective Force Protection plan. This incident sadly resulted in the loss of life, and although the suspect's ultimate intent remains unclear, actions of the watch team on the quarterdeck, the topside rover, along with actions of the Chief of the Guard, and Chief of the Guard Under Instruction, prevented possible unauthorized access to the ship at the quarterdeck."

f. Recommendations. Section 5.4.

(1) Page 63. Delete paragraph (1) and replace it with the following:

"Commander, Navy Installations Command, in concert with Commander, U.S. Fleet Forces Command, should establish a Pre-Planned Response for an unidentified and non-responsive individual on the pier and/or brow to help determine whether this individual is a threat."

(2) Page 65. Add Paragraph (8):

"Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk

should include in the annual SOLID CURTAIN-CITADEL SHIELD exercise the integrated Force Protection and Physical Security communications plan to test communications compatibility and integration between shore and ship personnel."

(3) Add Paragraph (9):

"U.S. Fleet Forces Command should review Force Protection training to ensure there is sufficient emphasis on CONUS scenarios, along with the current OCONUS training."

Note: The above three changes are also incorporated into Recommendations listed in the Executive Summary and in Section 6.0, Summary of Recommendations.

g. Fault, Neglect, Responsibility, and Accountability. Section 7.0.

(1) Page 74. Delete paragraph (3) addressing "strict liability" as the accountability standard by which to measure the Commanding Officer's performance, and replace it with the following description of the commanding officer's responsibility from Navy Regulations:

"The responsibility of the commanding officer for his or her command is absolute, except when, and to the extent to which, he or she has been relieved therefrom by competent authority, or as provided otherwise in [Navy] regulations. The authority of the commanding officer is commensurate with his or her responsibility. While the commanding officer may, at his or her discretion, and when not contrary to law or regulations delegate authority to subordinates for the execution of details, such delegation of authority shall in no way relieve the commanding officer of continued responsibility for the safety, well-being and efficiency of the entire command."

(2) Page 76. Delete the sentence, "Much has been made of the decision by the quarterdeck watchstanders to not sound either a Security Force Protection Alert, however, the actions of Mr. Savage were not deemed threatening until he inexplicably wrestled for the Petty Officer of the Watch's weapon."

Replace it with the following: "The Investigation Team reviewed the decision by the quarterdeck watchstanders to not sound either a Security or Force Protection Alert. The watchstanders

did not sound either a Security or Force Protection Alert because they did not deem the suspect a threat until he suddenly and without warning wrestled for the Petty Officer of the Watch's weapon."

(3) Naval Station Norfolk Personnel

Page 77. Delete paragraphs 2-4, and replace them with the following:

"Appropriate administrative or disciplinary action should be considered against Gate 5 Officers (b)(6) (b)(6) (b)(6) (b)(6) (b)(6) (b)(6)

Although properly trained and aware of his duties and responsibilities, (b)(6) failed to properly demand identification of the suspect, failed to properly execute vehicle turnaround procedures, failed to notify either Security Dispatch or the Waterfront Security Operations Center that the suspect did not execute a U-turn as expected, and failed to ensure that the suspect was pursued in a timely manner in accordance with existing procedures.

Even though he was aware that the vehicle driver did not execute a U-turn and of the lack of procedural compliance by (b)(6) (b)(6) (b)(6) also failed to follow procedures and take reasonable and expected actions (e.g., initiate gate runner procedures, radio other security forces) when he had knowledge of an unidentified individual on the installation.

Since a finding of this investigation is the lack of supervisory oversight of the Gate 5 police officers, appropriate corrective or disciplinary action should be considered for (b)(6) (b)(6) (b)(6) and (b)(6)

Upon final endorsement, I recommend a copy of this investigative report be provided to the Commanding Officer, Naval Station Norfolk (or other designated authority) for action as deemed appropriate, in accordance with applicable law, regulations and departmental policies and procedures, and in consultation with Navy Region Mid-Atlantic Human Resources and Office of General Counsel."

(4) Naval Station Norfolk Leadership. Section 7.0, Page 78

Delete both paragraphs and replace them with the following:

"I recommend a copy of this investigation be provided to a designated authority for administrative or disciplinary actions, if deemed appropriate under the authority's discretion, for the (b)(6) [redacted], (b)(6) [redacted], and any other active duty members whose action or inactions may have contributed to this incident."

5. Corrective Actions Underway

The following summary regarding actions already taken or currently underway is provided to assist in assessing the way ahead in our effort to strengthen our CONUS base security posture.

a. Actions taken by CNIC

(1) Section 3.9 paragraph (14) recommends that the Installation Commanding Officer should "institute standardized Personnel Qualification Standards or Job Qualification Requirements for DON Police officers." A standardized Personnel Qualification Standards and Job Qualification Requirements for Department of Navy (DON) police officers initiative was underway across the shore enterprise before the MAHAN event. Navy Region Mid-Atlantic is expected to complete implementation by December 2014.

(2) CNIC conducted a review of the MAHAN and other recent security incidents and assessments to identify common Installation AT/FP program deficiencies. Recurring deficiencies, along with corrective actions, are provided below:

(a) To address inadequate AT/FP program oversight & assessment, in FY14 USFF and CNIC began conducting Higher Headquarters Operational Assessments in conjunction with Installation Protection Assessment Cell visits. Results of these assessments are reviewed quarterly with Commander, Navy Installations Command and Commander, USFF Command.

(b) To address the low overall manning of the security force, OPNAV N4 is leading a detailed review of the Mission Profile Validation—Protection model, which sets

installation security force manning requirements. The level at which to fund this requirement is being considered in the POM 17 planning process. Additionally, CNIC has increased the amount of human resources support available to support hiring actions and authorized "over-hiring" in the near-term to account for historical attrition rates.

(c) To address critical security department billet vacancies, CNIC has increased the amount of human resources support available to support hiring actions and authorized "over-hiring" in the near-term to account for historical attrition rates. CNIC also created an internal process to highlight critical vacancies to ensure proper oversight is applied to the hiring process.

(d) To address communication shortfalls and the lack of integration between civilian and military security personnel, CNIC N3 is conducting a full review of existing communications doctrine, training and equipment. Results of this review and additional recommended actions will be provided to USFF and OPNAV N4 no later than 30 November 2014.

(e) To address Naval Security Force equipment shortages, prior to this incident CNIC commenced actions to improve the process of equipping security forces. Prior to 2013, each installation was responsible for ordering and accounting for security forces equipment, including ballistic vests. In 2013, CNIC developed a single distribution point and a centralized ordering system for the enterprise. CNIC will continue to assess and order the proper equipment, including equipment for the Reserve Component when required for increased force protection conditions. Although the use of a single centralized distribution of equipment will continue, CNIC will complete actions to bring the equipment at each installation to standard no later than 30 November 2014.

(f) To address the out-of-date post orders and Standard Operating Procedures, CNIC directed all installation Commanding Officers to ensure their post orders and Standard Operating Procedures are up to date. This action was completed on 31 July 2014.

b. Actions taken by USFF

(1) Over the past eighteen months, USFF conducted two thorough physical security program reviews to ensure the Navy's posture is appropriate to protect our warfighting capability and assets. The reviews informed the development of three major changes to Navy physical security as detailed below, and specific guidance to mitigate identified physical security gaps. Additionally, the reviews led to a redesigned assessment process to better evaluate execution capability of Navy Security Forces and the Navy Antiterrorism Program.

(2) The first of the two reviews, conducted prior to the Washington Navy Yard shooting, the 2013 U.S. Fleet Forces Force Protection Baseline Review, examined current physical security posture for capability gaps and appropriateness to the current risk. This was a total review of physical security and antiterrorism requirements using the defense-in-depth security model for the USNORTHCOM AOR. This review also examined execution of the physical security and antiterrorism requirements through Readiness Kill Chain analysis. The review resulted in identification of six key elements required for effective force protection:

- access control;
- pier security;
- waterside security;
- high value unit escort;
- response;
- and random antiterrorism measures (RAM).

The second review, following the tragedy at the Washington Navy Yard, "The Navy Base, Station and Installation Physical Security Assessment" dated 31 October 2013, assessed worldwide Navy physical security for appropriateness and compliance, resulting in 40 findings and 80 recommendations for improvements to Navy physical security.

(3) The combined reviews identified three major areas for improvement:

- antiterrorism command and control;
- antiterrorism resourcing;
- and Navy Security Forces organization and professionalization.

Currently, ashore antiterrorism tactical control for force protection (TACON for FP) chain of command flows from USNORTHCOM through U.S. Fleet Forces and CONUS Navy regions to installations, but execution funding lies with Commander, Navy Installations Command. To align tactical control with execution funding an initiative is in place to tie the execution responsibility and funding within one chain of command. Additionally, the results of the combined reviews led to the development of a total force solution that will reorganize Navy Security Forces under a single type commander responsible for organizing, training and equipping Navy Security Forces.

The reviews identified potential areas of improvement in our security program which resulted in the following tasks which remain in progress:

- an examination of small-arms training, readiness and proficiency requirements,
- examination of simulator utilization, and watchstander arming requirements;
- assessment of security personnel career progression;
- establishing force protection as a separate afloat capability area in Defense Readiness Reporting System-Navy to synchronize efforts with the ashore enterprise and better inform commanders of the current status of security forces.

(4) USFF has operationalized antiterrorism program assessments through Higher Headquarters Operational Assessments (HHOA) which, together with CNIC's Installation Protection Assessment Cell process, provide an enhanced level of oversight for CONUS Navy physical security. Historically, assessments examined installation physical security from a program administrative compliance standpoint through an assist visit with Navy Region security personnel. This process did not provide adequate feedback on the execution of security requirements. Last year, in coordination with Commander, Navy Installations Command and applicable Navy Region personnel, the FFC antiterrorism team conducted eighteen HHOAs, providing a program assessment to leadership, as well as constructive feedback to installation commanding officers on program execution. Coordinated into a triennial program with Joint Staff Integrated Vulnerability Assessments (JSIVA) led by Defense Threat Reduction Agency, and Chief of Naval Operations Integrated Vulnerability Assessments (CNOIVA), the USFF antiterrorism team is scheduled to conduct sixteen assessments this year.

Subj: INVESTIGATION INTO THE SHOOTING INCIDENT ONBOARD USS MAHAN (DDG 72) ON 24 MARCH 2014, AND ASSOCIATED INSTALLATION AND SHIPBOARD FORCE PROTECTION POLICIES AND PROCESSES

6. As evidenced by the Naval Station Norfolk security breach and tragic death of Petty Officer Mayo on 24 March 2014, the work being done to improve our security posture is not enough. We must dedicate the manpower and resources required to ensure our installations are secure. Our Sailors, civilians, and family members deserve nothing less.

WILLIAM E. GORTNEY

Copy to:
COMNAVSURFLANT
CNIC

REPORT OF THE INVESTIGATION INTO THE SHOOTING INCIDENT ONBOARD USS MAHAN (DDG 72) ON 24 MARCH 2014 AND ASSOCIATED INSTALLATION AND SHIPBOARD FORCE PROTECTION POLICIES AND PROCEDURES

INVESTIGATIVE REPORT

1 MAY 2014

Table of Contents

Executive Summary I

1.0 Introduction 1

1.1 Incident Synopsis 1

1.2 Scope of Investigation 1

1.3 Investigation Methodology 2

1.4 Naval Station Norfolk 8

1.5 USS MAHAN (DDG 72) 9

1.6 Chains of Command 10

1.7 Investigative Report Administrative Matters 11

2.0 Summary of Incident 13

3.0 Naval Station Norfolk Force Protection 21

3.1 Structure of Naval Station Norfolk's Security Department 21

3.2 Naval Station Norfolk Force Protection Regulatory Requirements and Responsibilities .. 23

3.3 Naval Station Norfolk Force Protection Manning 23

3.4 Naval Station Norfolk Force Protection Training 27

3.5 Naval Station Norfolk Force Protection Equipment 29

3.6 Naval Station Norfolk Force Protection Oversight 34

3.7 Incident Assessment 39

3.8 Findings 40

3.9 Recommendations 42

4.0 USS MAHAN (DDG 72) Force Protection 47

4.1 USS MAHAN Force Protection Regulatory Requirements and Responsibilities 47

4.2 USS MAHAN Force Protection Manning 48

4.3 USS MAHAN Force Protection Training 48

4.4 USS MAHAN Force Protection Equipment 49

4.5 USS MAHAN Force Protection Oversight 52

4.6 Incident Assessment 52
4.7 Findings 58
4.8 Recommendations 59
5.0 Shipboard and Shore Installation Force Protection Integration 59
5.1 Levels of Integration 61
5.2 Incident Assessment 61
5.3 Findings 63
5.4 Recommendations 63
6.0 Summary of Recommendations 66
Category A: Naval Station Norfolk and other U.S. Navy installations Force Protection and Physical Security 66
Category B: USS MAHAN and other U.S. Navy ships Force Protection 71
Category C: U.S. Navy ships and shore installation Force Protection and Physical Security integration 72
7.0 Fault, Neglect, Responsibility, and Accountability 74
8.0 Conclusions 79
Tab A: U.S. Navy Force Protection and Physical Security 81
General 81
Installation Force Protection, Physical Security, and Law Enforcement 81
Shipboard Force Protection 91
Tab B: Media Executive Summary 97

Appendices

Table of Contents

Appendix A	Appointing Order/List of Investigation Team
Appendix B	Master List of References
Appendix C	Personnel Nomenclature/Suspects Rights and Acknowledgement Forms/Interview Summaries
Appendix D	Naval Instructions
Appendix E	Naval Messages
Appendix F	Training Records/Certifications
Appendix G	Additional Supporting Documents

Executive Summary

Incident Summary

At approximately 11:00 p.m. on March 24, 2014, Mr. Jeffrey Savage, an unauthorized civilian, breached Naval Station Norfolk's Gate 5, Naval Station Norfolk's Pier 1's Entry Control Point, and USS MAHAN's (DDG 72) quarterdeck but failed to breach the ship's interior spaces. Onboard USS MAHAN, Mr. Savage physically assaulted and disarmed a quarterdeck watchstander and used that weapon to shoot and kill a Naval Station Norfolk Chief of the Guard Master-at-Arms before being shot and killed by a USS MAHAN watchstander and a Naval Station Norfolk security officer. In spite of the tragic loss of life, the Naval Station layered security was ultimately successful in preventing an outside threat from penetrating the ship.

Scope of Investigation

On March 25, 2014, Commander, U.S. Fleet Forces Command directed an investigation into the facts and circumstances related to the March 24, 2014 shooting incident, in order to determine fault, neglect, responsibility, and recommend administrative or disciplinary actions. Commander, U.S. Fleet Forces Command specifically directed an inquiry into all relevant aspects of Naval Station Norfolk and USS MAHANshipboard Force Protection policies and procedures, including, but not limited to, installation access; pier Entry Control Point access;

infrastructure; and security manpower, training, and equipment. Additionally, Commander, U.S. Fleet Forces Command directed a line of duty opinion and recommendation concerning the death of the Chief of the Guard. By letter approval dated April 16, 2014, Commander, U.S. Fleet Forces Command removed the line of duty requirement for the Chief of the Guard because Commander, Navy Region Mid-Atlantic was the appropriate determination authority. Commander, Navy Region Mid-Atlantic determined the Chief of the Guard's death was incurred in the line of duty and not due to his own misconduct.

Methodology

This investigation attempted to answer several core questions all with an eye to preventing similar future incidents. These core questions are:

--What happened?
--Why did it happen?
--Was this the result of an insider threat?
--Was this a failure of layered defense?
--What potential gaps in security must be addressed?
--Have we learned from other similar security incidents?
--Who is accountable and should anyone be disciplined?
--What is the way ahead for the security of Naval Station Norfolk?

An executive summary of these core questions follows:

What happened?

Late in the evening of March 24, 2014, Mr. Savage, a civilian truck driver, drove his employer's semi-tractor cab onto Naval Station Norfolk via Gate 5. Since neither Mr. Savage nor his private employer had a legitimate reason to enter Naval Station Norfolk, Mr. Savage's intent or motive to attempt access remains unknown. Despite stopping at Naval Station Norfolk's Gate 5, a Department of the Navy civilian police officer failed to determine Mr. Savage's intent or purpose for attempting access at Gate 5, and neither requested nor confirmed Mr. Savage's identification and authorization to enter the installation. While Mr. Savage had in his possession a valid Transportation Worker's Identification Credential (TWIC), it was not a factor in his entry onto Naval Station Norfolk because the Gate 5 civilian police officer never required Mr. Savage to produce any form of identification or authorization to enter the installation.

Believing Mr. Savage wanted to execute a U-turn and exit Gate 5, and failing to execute proper vehicle turnaround procedures, the Gate 5 civilian police officer allowed Mr. Savage to go through the gate onto the installation. Mr. Savage failed to execute the turnaround and continued to drive away from Gate 5. The Gate 5 civilian police officer failed to ensure Mr. Savage exited Gate 5, failed to deploy the hardened anti-access control system, failed to pursue Mr. Savage in a timely manner, failed to notify Naval Station Norfolk Security Department

dispatch, and failed to execute any Standard Operating Procedures required in response to an unauthorized individual on Naval Station Norfolk.

Mr. Savage drove his truck cab from Gate 5 to Pier 1 where he then walked through the pedestrian gate while the Pier 1 Entry Control Point sentry (supplied by USS MAHAN) was coordinating adjacent vehicle gate access to the pier for the Chief of the Guard (a Naval Station Norfolk Security Department active duty Master-at-Arms responsible for the security of all the station's piers). The Pier 1 Entry Control Point sentry saw Mr. Savage walk through the unmanned pedestrian gate and called after him to stop and produce required identification but Mr. Savage proceeded onto Pier 1. Reportedly talking into a wireless cellular phone headset earpiece and apparently intoxicated or otherwise impaired, Mr. Savage displayed no weapons, issued no verbal threats, exhibited no harmful manifestations, and displayed no indications of malicious intent. Following required procedures, the Pier 1 Entry Control Point sentry radioed USS MAHAN's quarterdeck watchstanders that an individual had entered the pier without showing identification.

Mr. Savage proceeded to the area near the brows of USNS COMFORT (T-AH 20) and USS MAHAN and opened various tool boxes that were located on the pier. Since USNS COMFORT was on Pier 1 and because USS MAHAN was undergoing maintenance availability, a large number of civilian maintenance personnel as well as civilian mariners had access to the pier. Given the lack of a radio broadcast by the Gate 5 civilian police officer, the volume of civilian personnel transiting the pier, and the fact that Mr. Savage appeared to be an

intoxicatedmariner or a civilian worker not posing a threat, the watchstanders onboard USS MAHAN observed Mr. Savage on the pier and radioed the Naval Station Waterfront Security Operations Center that they had an individual on the pier who had not shown his identification and was not responding to their verbal calls for identification.

The Chief of the Guard and a Chief of the Guard (Under Instruction) who were at this time already on Pier 1, responded to USS MAHAN's radio call to the Waterfront Security Operations Center for assistance by then driving their van back towards the USNS COMFORT and USS MAHAN ship brows. With the approach of the security van, Mr. Savage walked past the brows, turned, and started up the USS MAHAN's brow. Mr. Savage was followed up the brow by the Chief of the Guard and Chief of the Guard (Under Instruction) shouting for Mr. Savage to stop, which Mr. Savage failed to do. Simultaneously, onboard USS MAHAN the Officer of the Deck and the Petty Officer of the Watch repeatedly called for Mr. Savage to stop and identify himself; a request Mr. Savage also failed to comply with.

Although Mr. Savage did not exhibit a threat towards any personnel, the watch team on USS MAHAN appropriately chose to execute the required use of force continuum with the Officer of the Deck exhibiting presence on the ship's end of the brow backed up by an armed Petty Officer of the Watch and an armed USS MAHAN Topside Rover who had taken up station near the quarterdeck as part of the response to the ongoing disturbance.

When the USS MAHAN's Officer of the Deck stepped back to show Mr. Savage the presence of the armed quarterdeck watchstanders, Mr. Savage walked aboard USS MAHAN onto its quarterdeck, failed to comply with repeated requests to provide identification, and exhibited no threatening behavior until he inexplicably attempted to wrestle a weapon away from the Petty Officer of the Watch.

When Mr. Savage acquired the weapon, the Chief of the Guard, who by this time arrived on the quarterdeck, pushed the Petty Officer of the Watch clear and stood between the Petty Officer of the Watch and the now-armed Mr. Savage. Walking toward the Chief of the Guard and the Petty Officer of the Watch, Mr. Savage shot at the Chief of the Guard killing him. In response, the Chief of the Guard (Under Instruction) and USS MAHAN's Topside Rover shot and killed Mr. Savage.

Pier and shipboard procedures were followed to include the use of force continuum, and the Chief of the Guard executed his duties appropriately in responding to an unidentified individual on the pierselflessly sacrificing his life to protect that of the Petty Officer of the Watch and the other Sailors onboard USS MAHAN.

Why did it happen?

Mr. Savage's motive and intent that evening are both unknown, will likely remain unknown, and outside the scope of this inquiry.

Was this an insider threat?

An insider threat is defined as one where the use of appropriate credentials or identification allows access to the government facility. Mr. Savage was an outsider threat because he never had proper authorized access to Naval Station Norfolk. Mr. Savage's unauthorized access via Gate 5 was due to the civilian police officer's failure to implement and enforce required Force Protection and Physical Security procedures. Despite Mr. Savage's possession of a valid Transportation Worker Identification Credential (TWIC), he did not use that identification credential, or any other means of identification, to access Naval Station Norfolk on the evening of March 24, 2014. Even assuming proper identification procedures were followed that evening at Gate 5, Mr. Savage's Transportation Worker Identification Credential would not have been sufficient by itself to gain access to the Naval Station Norfolk.

Was this a failure of layered defense?

The protection of our ships and facilities relies on multiple layers of defense. In spite of the egregious failure by Gate 5 security personnel, the actions of the Pier 1 Entry Control Point sentry and those of the Chief of the Guard, Chief of the Guard (Under Instruction), and USS MAHAN watchstanders were appropriate and reasonable under the circumstances. As tragic as the regrettable loss of life is, the layers of defense applied correctly at the Pier 1 Entry Control Point and on the quarterdeck of USS MAHAN ultimately protected the ship and minimized personal injury and the loss of life.

What potential gaps in security must be addressed?

In spite of the success demonstrated in precluding Mr. Savage's access to USS MAHAN, the incident illuminated a number of errors and discrepancies that require remedy.

The causes and contributing factors to the incident include:

- Personnel failure
- Lack of integration within the Naval Station Norfolk Security Force
- Lack of mid-level management and supervisors not supervising
- A daytime bias for senior watchstanders
- Equipment and equipage degradations

Have we learned from other security incidents?

Unlike the 2013 Washington Navy Yard and 2009 Fort Hood shootings, this incident was the result of an outsider threat. Nonetheless, there are significant lessons to be learned concerning Force Protection, Physical Security, and Law Enforcement policies and procedures. Commander, Navy Region Mid-Atlantic and Commanding Officer, Naval Station Norfolk have appropriately integrated and responded to the lessons of other security incidents to include completion of the directed security self-assessment as well as procedural changes designed to enhance Force Protection and security.

Who is accountable and should anyone be disciplined?

This report concludes that several applicable Force Protection, Physical Security, and/or Law Enforcement policy and procedural requirements were not fully complied with on the night of the incident. In addition to these deficiencies, the Investigating Officer also concluded that several personnel responsible for other acts or omissions either directly or indirectly contributed to the incident and should also be held accountable.

What is the way ahead for security of Naval Station Norfolk?

An upcoming Commander, U.S. Fleet Forces Command and Commander, Naval Installations Command Assessment of Naval Station Norfolk will have the opportunity to holistically review all aspects of Force Protection in the effort to ensure the safety of our Sailors, civilians, ships, and facilities.

Recommendations

Recommendations for improving Force Protection and Physical Security policies and procedures as a result of this incident are as follows:

Category A: Naval Station Norfolk and other U.S. Navy installations Force Protection and Physical Security

1) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should address the lack of seniority of the Naval Station Norfolk Security Officer.

2) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should immediately address the lack of mid-level Naval Station Norfolk Security Department civilian supervision and re-assess the validity of the Mission Profile Validation - Protection.

3) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should immediately address the lack of procedural compliance, accountability and oversight of the civilian police force by targeted infusion of motivated mid-level personnel and proper oversight by both civilian and military supervisors.

4) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should address the lack of integration between Naval Station Norfolk's civilian police force, active duty Master-at-Arms, and Auxiliary Security Force personnel.

5) The Commanding Officer, Naval Station Norfolk, should address the lack of seniority within Naval Station Norfolk's Waterfront Security Operations Center.

6) The Commanding Officer, Naval Station Norfolk, should address the lack of seniority of personnel assigned to Chief of the Guard duties in accordance with the NAVSTA OPORD AT-3300 (Change 3).

7) The Commander, Navy Installations Command should consider increasing the pay grades of the Department of the Navy police forces. The GS-3s and GS-5s hired by the Navy are one pay grade lower than those hired by other military Services and this may contribute to the lack of capability and professionalism.

8) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should improve the training and professionalism of naval installation Department of the Navy police forces.

9) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should validate the availability of required Force Protection and Law Enforcement equipment such as vests, communications, and weapons for the watchstanders.

10) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should immediately repair broken Naval Station Norfolk equipment and fixtures such as cameras, turnstiles, access control gates, and duress buttons. Additionally, consideration

should be given to improving Physical Security at pier Entry Control Points to include gates and turnstiles or creating a waterfront enclave.

11) The Commander, Navy Region Mid-Atlantic Inspector General should investigate the conduct of the Naval Station Norfolk Security Department Deputy Commander senior civilian for possible time and attendance violations.

12) Although the Transportation Worker Identification Credential was not used to access the Naval Station Norfolk, Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk should retain the new policy of banning access to holders of a Transportation Workers Identification Credential who have a conviction in the last ten years, or a misdemeanor within the last five years for crimes of violence; larceny, drugs; habitual offenders; and convictions for sex offenses. Additionally, the Department of Defense should engage the Department of Homeland Security to ensure Transportation Worker Identification Credential holders are vetted to the same standard.

13) Commanding Officer, Naval Station Norfolk should review, sign, and update Operation Order and Post Orders to include the development of a Standard Operating Procedure for securing all gates when required.

14) Commanding Officer, Naval Station Norfolk should institute standardized Personnel Qualification Standards or Job Qualification Requirements for Department of Navy (DON) police officers. Additionally, level of knowledge

training at Guardmount and during supervisor oversight should be required and properly documented.

15) The Memorandum of Understanding (MOU) with local authorities should be updated with current guidance.

Category B: USS MAHAN and other U.S. Navy ships Force Protection

1) Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet should consider adding a requirement for quarterdeck personnel other than the Petty Officer of the Watch to be properly equipped with non-lethal and/or lethal capabilities sufficient to prevent unauthorized ship incursions.

2) Commander, U.S. Fleet Forces Command, and Commander, U.S. Pacific Fleet should consider the feasibility of purchasing and implementing locking barrier gate mechanisms for standard U.S. Navy brows.

3) Commander, U.S. Fleet Forces Command should consider improving shipboard Pre-Planned Responses for lower-end security threats such as unidentified personnel confrontations.

4) Commander, U.S. Fleet Forces Command should consider the re-implementation of "Antiterrorism Officer" billets in ship Immediate Superior in Commands (e.g., Destroyer Squadrons, Amphibious Squadrons).

5) Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet should consider adding a requirement for all Naval Security Force watchstanders issued sidearms to be equipped with a lanyard. A lanyard is used to retain a weapon from falling overboard and not from being taken away from the watchstander, however, equipment standardization is appropriate.

Category C: U.S. Navy ships and shore installation Force Protection and Physical Security integration

1) Although pier security is the responsibility of the Naval Station Norfolk, increased integration between ships and Naval Station personnel is recommended. Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic, in concert with the Type Commander and the Afloat Training Group, should develop a Pre-Planned Response for an "unidentified and presumably unauthorized individual with unknown intentions on the pier and/or brow."

2) The Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk should consider funding and manning the pier Entry Control Points with active duty Master-at-Arms personnel to improve standardization and communications integration.

3) The Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk should develop and exercise an integrated Force Protection and Physical Security communications

plan to eliminate incompatibility and the lack of integration between shore and ship personnel.

4) The Commander, U.S. Fleet Forces Command should retain the requirement for multiple pier Entry Control Point sentries at all times.

5) All commanders should reinforce the requirement for all military and civilian Naval Security Force to have required equipment on them prior to Guardmount.

6) The Commanding Officer, Naval Station Norfolk should ensure the training of pier Entry Control Point sentries on available communications and duress equipment, and how to properly operate them. Additionally, Naval Station Norfolk should develop standardized pier procedures and training for pier Entry Control Point sentries.

7) The Commander, U.S. Fleet Forces Command, and Commander, Navy Installations Command should review the application of these investigation recommendations during the June 2014 Security Review of Naval Station Norfolk.

Conclusion

Ultimately, the success of a Force Protection plan is based upon success to deter attempts to threaten the Force, or success in thwarting an attack if it comes. In the case of the incident with Mr. Savage on March 24, 2014, there were significant failures, however, the layered defense worked and precluded access

tothe interior spaces of USS MAHAN. In spite of the tragic loss of life, the Naval Station forces and those of USS MAHAN were able to stop the threat once known.

This incident was exacerbated by a significant decline in funding and manning in order to decrease costs while absorbing risk. Those bearing the risk, however, are not aligned with those controlling funding or manning, and it is the opinion of the Investigating Officer that this balance between risk and funding limitations must be constantly reviewed and should be addressed by navy leadership as part of the upcoming review of Naval Station Norfolk security in June 2014.

Finally, the individual failures of key individuals were matched by the heroism of a Petty Officer of the Watch who was prepared to engage a gunman with only a baton after numerous shots were already fired, or that of a selfless Master-at-Arms who gave his life shielding that same Petty Officer of the Watch and the crew of the USS MAHAN.

1.0 Introduction

This Chapter provides an introductory overview of the incident, the investigation's purpose, scope, and methodology, a summary description of the U.S. Navy commands involved, and pertinent administrative matters to aid the reader.

1.1 Incident Synopsis

At approximately 11:00 p.m. on March 24, 2014, Mr. Jeffrey Savage, an unauthorized civilian, breached Naval Station Norfolk's Gate 5, Naval Station Norfolk's Pier 1 Entry Control Point, and USS MAHAN's (DDG 72) quarterdeck where he then physically assaulted and disarmed a USS MAHAN quarterdeck watchstander. He used that weapon to shoot and kill an active duty Naval Station Norfolk Chief of the Guard security officer before being shot and killed by a USS MAHAN watchstander and a Naval Station Norfolk security officer. In spite of the tragic loss of life, Naval Station Norfolk's layered security was ultimately successful in preventing a threat from penetrating the ship beyond the quarterdeck.

A comprehensive summary of the incident is provided in Chapter 2.

1.2 Scope of Investigation

On March 25, 2014, Commander, U.S. Fleet Forces Command directed an investigation into the facts and circumstances related to the March 24, 2014 shooting incident, in order to determine fault, neglect, responsibility, and

recommend administrative or disciplinary actions. Commander, U.S. Fleet Forces Command specifically directed an inquiry into all relevant aspects of Naval Station Norfolk and USS MAHAN shipboard Force Protection policies and procedures, including, but not limited to, installation access;pier Entry Control Point access; infrastructure; and security manpower, training, and equipment. Additionally, Commander, U.S. Fleet Forces Command directed a line of duty opinion and recommendation concerning the death of Chief of the Guard, Master-at-Arms Second Class Petty Officer Mark A. Mayo, USN. By letter approval dated April 16, 2014,Commander, U.S. Fleet Forces Command removed the line of duty requirement for Master-at-Arms Second Class Petty Officer Mayo because Commander, Navy Region Mid-Atlantic was the appropriate determination authority. On April11, 2014, Commander, Navy Region Mid-Atlantic determined Master-at-Arms Second Class Mayo's heroic death was incurred in the line of duty and not due to his own misconduct.

1.3 Investigation Methodology

The Investigation Team, led by Rear Admiral (Lower Half) Jeffrey Harley, consisted of a range of subject matter experts, to include personnel with extensive experience in command, installation management, law, and the fields of Antiterrorism, Force Protection, and Physical Security. A complete roster of team members is included as an appendix.

This investigation attempted to answer several core questions all with an eye to preventing similar future incidents. These core questions were:

--What happened?

--Why did it happen?

--Was this the result of an insider threat?

--Was this a failure of layered defense?

--What potential gaps in security must be addressed?

--Have we learned from other similar security incidents?

--Who is accountable and should anyone be disciplined?

--What is the way ahead for the security of Naval Station Norfolk?

The Investigation Team focused on the non-criminal aspects of the incident, and at no time did its investigation interfere with the ongoing investigation by the Naval Criminal Investigative Service. This report does not evaluate any aspect of Mr. Savage's motive, intent, mental state, or criminal acts; nor does it address matters that are included in the criminal investigation still underway. The Naval Criminal Investigative Service briefed the Investigation Team on its interim investigation results early in the investigation process and provided the copies of written factual witness statements that supplemented our findings of fact as set forth in Chapter 2's summary of incident. Since these source documents are part of an ongoing Naval Criminal Investigative Service interim investigation they cannot, and have not, been reproduced and included as supporting documents for this investigative report. Parties interested in obtaining releasable information from the final Report of Investigation are encouraged to contact the Freedom of Information Act Office of the Naval Criminal Investigative Service Headquarters located at Quantico, Virginia.

During initial preparation, the Investigating Officer reviewed copies of the November 5, 2009 Fort Hood and the September 16, 2013 Washington Navy Yard shootings investigative reports for investigative approach, report format, information organization, and supporting document control. While helpful in scoping the investigative requirements and instructive on report formatting, they were not substantively similar to this incident. Unlike the 2013 Washington Navy Yard and 2009 Fort Hood shootings, this incident was not the result of an insider threat defined as one where the use of appropriate credentials or identification allows the responsible individual authorized access to the government facility. Mr. Savage was, and remained at all times, an outsider threat to Naval Station Norfolk, USS MAHAN, and their personnel.

Mr. Savage's unauthorized access via Gate 5 was solely due to the Department of the Navy civilian police officer's failure to implement and enforce required Force Protection, Physical Security, and Law Enforcement policies and procedures. Despite Mr. Savage's possession of valid Transportation Worker Identification Credential (TWIC), he did not use that card, or any other means of identification, toaccess Naval Station Norfolk or USS MAHAN on the evening of March 24, 2014. Assuming Norfolk Naval Station's Gate 5 proper identification procedures were followed that evening, Mr. Savage's Transportation Worker Identification Credential would not have been sufficient by itself to gain access to the Naval Station Norfolk.

That said, the above-referenced investigation reports provide Department of the Navy leadership significant lessons to be learned concerning Force Protection, Physical Security, and Law Enforcement policies and procedures. This investigation also documents Commander, Navy Region Mid-Atlantic and Commanding Officer, Naval Station Norfolk efforts underway prior to the March 24incident to appropriately initiate and integrate the lessons and recommendations of the above-referenced investigative reports and other security incidents to include completion of a directed security self-assessment as well as procedural changes designed to enhance Force Protection and Physical Security.

This investigation was significantly aided by several "outside" experts and subject matter experts including the U.S. Fleet Forces Command Public Affairs Office for external communications guidance. The Investigation Team also benefited greatly from an executive oversight consultation review by Rear Admiral Mark "Buz" Buzby, USN (Ret.) who graciously provided his time, experience, and advice to help counter possible Investigative Team "Groupthink" and greatly improve the final work-product.

The Command Investigation Team reviewed documents, interviewed witnesses, and conducted numerous site visits. Additionally, the Investigating Officer or a representative discussed the purpose and scope of the investigation soliciting subject matter expertise and any information relevant to the investigation with Commander, U.S. Fleet Forces Command; Commander, Navy Region Mid-Atlantic;

Commanding Officer, Naval Station Norfolk; Commander, Destroyer Squadron TWO; and Commanding Officer, USS MAHAN.

The report is organized in chapters that analyze the major elements of the Appointing Order. The Executive Summary is self-explanatory. Chapter 1 is an introductory overview of the investigation. Chapter 2 is a factual summary of the March 24, 2014 incident. Chapter 3 analyzes Naval Station Norfolk's installation Force Protection, Physical Security, and Law Enforcement policies and procedures, focusing on Gate 5 and Pier 1 Entry Control Point access. Chapter 4 provides a parallel analysis of USS MAHAN's Force Protection policies and procedures, focusing on quarterdeck and shipboard access. Chapter 5 summarizes discovered gaps in the integration and execution of Naval Station Norfolk installation and shipboard Force Protection programs, policies, and procedures. Chapter 6 is a consolidation of the Investigating Officer's recommended follow-on actions. Chapter 7 summarizes the Investigating Officer's Fault, Neglect, Responsibility, and Accountability rationale, specific determinations, and recommended corrective actions. Chapter 8briefly sets forth the investigative report's conclusions. Finally, the report includes a summary overview of U.S. Navy installation and shipboard Force Protection, Physical Security, and Law Enforcement program regulatory requirements and fundamentals (Tab A) and a proposed investigative report Executive Summary for media release purposes (Tab B).

The recommendations of this investigation fall into the following three categories:

- Category A: Recommendations relating to Force Protection, Physical Security, and Law Enforcement programs at Naval Station Norfolk on March 24, 2014. Focusing on activities at Gate 5 and Pier 1 Entry Control Point, the recommendations consist of both recommendations related directly to the March 24th incident and other recommendations, while not directly related to the incident, that pertain to general installation Force Protection, Physical Security, or Law Enforcement programs execution or oversight.

- Category B: Recommendations relating to the Force Protection program onboard USS MAHAN on March 24, 2014. As with the Naval Station Norfolk recommendations, these recommendations also consist of both recommendations related directly to the March 24th incident and other recommendationsthat pertain to USS MAHAN's or operational Fleet Force Protection program execution.

- Category C: Recommendations relating to the integration of Naval Station Norfolk's installation and USS MAHAN's execution of integrated Force Protection programs on March 24, 2014 as well as additional recommendations applicable to Fleet-wide U.S. Navy shipboard and Force Protection integration.

1.4 Naval Station Norfolk

Geographically located in Norfolk, Virginia, Naval Station Norfolk supports the operational readiness of the U.S. Navy's Atlantic Fleet forces operating in the Atlantic Ocean, Mediterranean Sea, and Indian Ocean. The world's largest naval station houses the largest concentration of U.S. Navy forces occupying about four miles (6 km) of waterfront space and seven miles (11 km) of pier and wharf space, Naval Station Norfolk supports 75 ships and 134 aircraft alongside 14 piers and 11 aircraft hangars. Its Port Services control more than 3,100 ships' movements annually, its Air Operations conduct over 100,000 flight operations annually, and its Air Mobility Command terminal transports over 150,000 passengers and 264,000 tons of mail and cargo annually to the European and Central Command theaters of operations, and to the Caribbean.[1]Its gates process approximately 55,000 vehicles per day during the week and almost 10,000 per day on weekends. Figure 1 shows the brow configuration on Pier 1 as viewed from the foot of the pier.

[1]http://www.military.com/base-guide/naval-station-norfolk

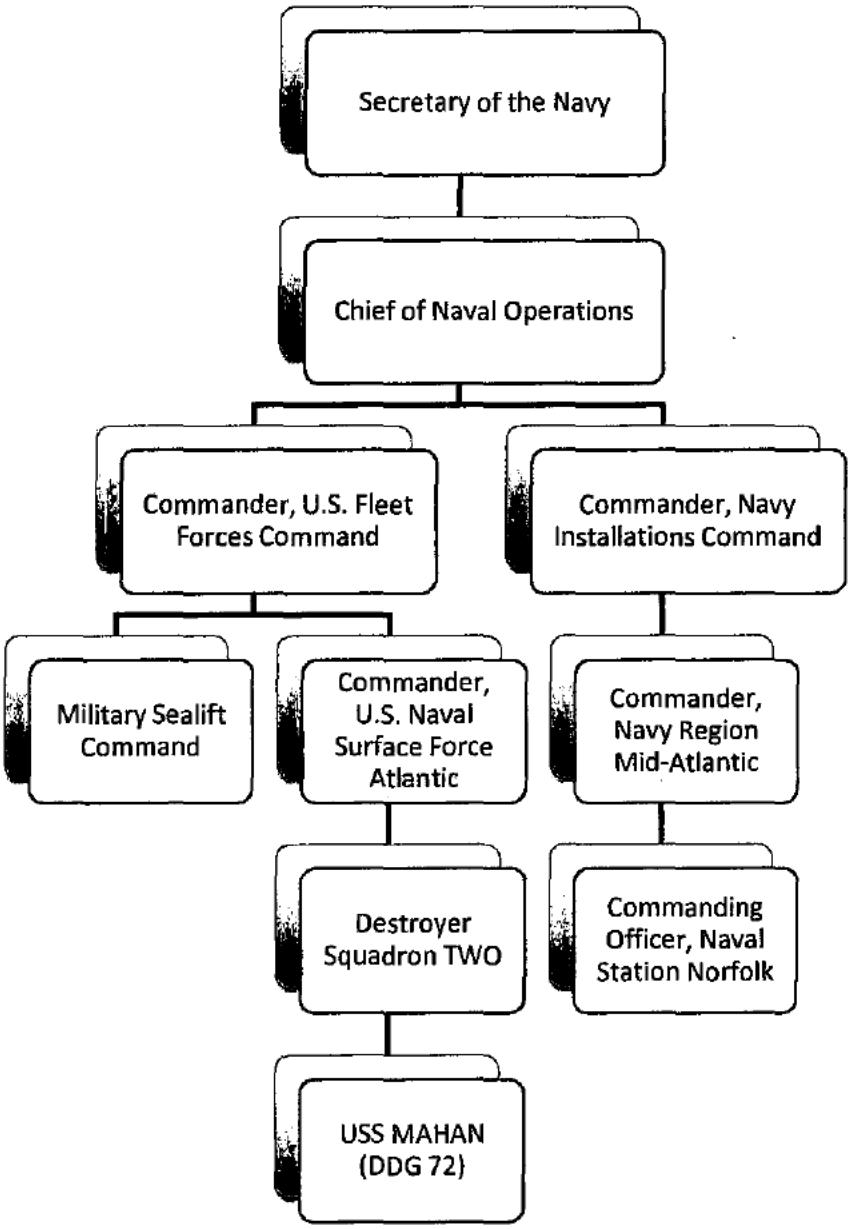
Figure 1 Naval Station Norfolk Pier 1 Ship's Brow Configuration

1.5U5S MAHAN (DDG 72)

USS MAHAN (DDG 72) is an Arleigh Burke-class multi-mission surface combatant guided missile destroyer homeported at Naval Station Norfolk.

1.6 Chains of Command

The chains of command pertinent to this investigation are depictedbelow.



1.7Investigative Report Administrative Matters

To enhance transparency, readability, and to reduce required Federal Privacy Act redactions, this investigative report refers, where applicable, to individuals by their official position, rank, or title. Chapter 7, however, contains privacy sensitive information and Appendix C identifies the relevant individual's full names to their assigned investigative report designated nomenclature. This privacy protected information will be, where appropriate, will be redacted from the final publically released version of this investigative report.

Throughout the investigative report, applicable references are cited in the Chapter footnotes and the references are provided as investigative report appendices. Only the relevant portions of often voluminous referenced directives, instructions, and other documents are included in the report's attached appendices. For readers seeking more context, or otherwise desire to consult the complete document, a master list of referenced documents is provided at Appendix B.

All investigative witness interviews were recorded and summarized for purposes of this investigation, and all referenced interview summaries are included in the relevant cited appendices. Electronic verbatim recordings of all witness interviews will be retained by the Investigating Officer.All civilians interviewed were appropriately notified of their rights and provided the opportunity to have a union representative present.

At the time of this report,neither the autopsy nor toxicological results for Mr. Savage were available for review.

Finally, as tragic as this incident was, it needs to be noted that the actions of Petty Officer Mayo were truly heroic; his selfless actions saved the lives of countless shipmates.

2.0 Summary of Incident

At approximately 11:00 p.m. on March 24, 2014, Mr. Jeffrey Savage, a civilian, pulled into Gate 5 at Naval Station Norfolk driving a tractor truck cab without a trailer. Contrary to Force Protection and Physical Security requirements, the civilian Department of the Navy police officer, who was the Gate 5 Police Officer in Charge, did not have a conversation with Mr. Savage, did not check his identification, and did not properly ascertain his purpose and authorization to enter Naval Station Norfolk. Although Mr. Savage possessed a valid Transportation Worker Identification Credential (TWIC), it was not used to access the installation nor was it ever shown to the Gate 5 Police Officer in Charge or any other Gate 5 assigned security personnel. Stating he believed Mr. Savage wanted to execute a U-turn and exit the installation, the Gate 5 Police Officer in Charge allowed Mr. Savage's entry into Naval Station Norfolk. Despite his assumption that Mr. Savage intended to conduct a U-turn and exit the installation, the Gate 5 Police Officer in Charge did not conduct proper required gate vehicle turnaround procedures for Mr. Savage's vehicle.

Leaving Gate 5, Mr. Savage did not execute a U-turn to exit the installation but proceeded onto Naval Station Norfolk, traveled west on B Avenue, made a left turn onto 3rd Street, and continued to the foot of Naval Station Norfolk Pier 1. After allowing several more cars through Gate 5, the Gate 5 Police Officer in Charge notified three other civilian police officers and one active duty Master-at-Arms watchstander assigned to Gate 5 that Mr. Savage's truck was supposed to

turn around but did not. Despite required policies and procedures, at no time did any Gate 5 assigned security personnel notify Naval Station Norfolk police dispatch, or anyone else, that an unauthorized vehicle had entered the installation.

The Gate 5 Police Officer in Charge asked another police officer who was conducting an Administrative Vehicle Inspection if he would go check on the truck. The officer stated that he could not because he did not have the authority to stop doing random vehicle inspections to check on the truck.

Approximately nine minutes after the truck entered Gate 5, the Gate 5 Police Officer in Charge got into a Naval Station Norfolk Security Department vehicle and went to find the truck.

USS MAHAN, hospital ship USNS COMFORT (T-AH 20), and USS KAUFFMAN (FFG 59) were located at Pier 1.

In the vehicle parking lot adjacent to the Pier 1 Entry Control Point, Mr. Savage parked his truck, exited the vehicle, and left the motor running. Mr. Savage walked towards the Pier 1 Entry Control Point manned by an active duty pier Entry Control Point sentry provided by USS MAHAN but working for the Naval Station Norfolk Security Department Chief of the Guard.

Without stopping, Mr. Savage walked through the Pier 1 Entry Control Point's open pedestrian gate and continued onto Pier 1. The Pier 1 Entry Control Point

was manned by a properly trained and qualified USS MAHAN sentry who was properly equipped with an M-9 sidearm, baton, and pepper spray. The Pier 1 Entry Control Point sentry was not manning the pedestrian access gate because she was removing and then replacing two barrel-like traffic cones to facilitate the entry of a Naval Station Norfolk Security Department vehicle through the adjacent vehicle access gate. In the security vehicle were the Naval Station Norfolk Security Department Chief of the Guard, Master-at-Arms Second Class Petty Officer Mark A. Mayo, USN, who was sitting in the passenger seat, and the Chief of the Guard (Under Instruction) as the driver. The Chief of the Guard was the installation's Naval Security Force Officer responsible for Naval Station Norfolk pier security, and he entered Pier 1 to check on a pier sentry located at the head of the pier. The Entry Control Point sentry did not, and could not, secure the pedestrian access gate while she was controlling the adjacent vehicle access gate because the pedestrian access gate was chained and locked in the open position and the Pier 1 Entry Control Point sentry did not have a key.

After the Chief of the Guard and the Chief of the Guard (Under Instruction) drove onto Pier 1, the Pier 1 Entry Control Point sentry noticed Mr. Savage had passed through the Pier 1 Entry Control Point pedestrian access gate. The Pier 1 Entry Control Point sentry instructed Mr. Savage to stop and provide proper identification for pier access. Mr. Savage did not stop, did not return to the Pier 1 Entry Control Point, and did not provide proper identification to the Pier 1 Entry Control Point sentry. Mr. Savage seemed intoxicated, waved his arms, and appeared to have been talking via a cellular phone ear piece.

When Mr. Savage did not comply with her instructions, the Pier 1 Entry Control Point sentry used her USS MAHAN ship's radio to notify USS MAHAN's quarterdeck that a black male went through the Pier 1 Entry Control Point without showing proper identification. The Pier 1 Entry Control Point sentry's radio call that an unidentified individual had accessed Pier 1 was not copied by either USNS COMFORT or USS KAUFFMAN watchstanders or by Naval Station Norfolk's Security Department's Waterfront Security Operations Center because the sentry was communicating solely via USS MAHAN's ship's radio.

Meanwhile, the Gate 5 Police Officer in Charge arrived at the Pier 1 vehicle lot, located Mr. Savage's truck idling, looked in the truck, and did not see the driver. Contrary to required policies and procedures, the Gate 5 Police Officer in Charge did not notify Naval Station Security Dispatch of the abandoned idling truck. The Gate 5 Police Officer in Charge got back into his vehicle and returned to Gate 5.

On Pier 1, USS MAHAN's quarterdeck watchstander team was manned by an unarmed Officer of the Deck (E-7); a Petty Officer of the Watch (E-5), properly equipped with a M-9 sidearm, baton, and pepper spray; and a Topside Security Rover (E-5), properly equipped with a M-16 firearm, M-9 sidearm, baton, and pepper spray. All USS MAHAN's watchstanders were properly trained and qualified.

After observing Mr. Savage on Pier 1 walking towards USS MAHAN and USNS COMFORT, USS MAHAN's Officer of the Deck and Petty Officer of the Watch attempted to get Mr. Savage's attention by shouting at him directing he show

proper identification. USS MAHAN's watchstanders did not order either a shipboard Security or Force Protection Alert because they perceived Mr. Savage was not a threat, but instead believed him to be an intoxicated civilian mariner or civilian contractor.

After ignoring USS MAHAN's quarterdeck watchstanders' repeated requests to stop and produce identification, Mr. Savage approached and examined several storage lockers located on the pier. The USS MAHAN's Officer of the Deck telephoned his Command Duty Officer who was in his onboard stateroom, explained Mr. Savage's status and actions, and received the Command Duty Officer's concurrence to notify Naval Station Norfolk's Security Department's Waterfront Security Operations Center. USS MAHAN's Petty Officer of the Watch notified the Waterfront Security Operations Center via their Waterfront Security Operations Center radio that there was an individual on the pier who had not shown his identification.

USS MAHAN's Waterfront Security Operations Center radio call was copied by the USNS COMFORT watchstander across the pier from USS MAHAN and the Chief of the Guard and the Chief of the Guard (Under Instruction). USS MAHAN's Waterfront Security Operations Center radio call of an unidentified individual on the pier was not copied by USS KAUFFMAN because Naval Station Norfolk Security Department Waterfront Security Operations Center radios were unavailable.

The Waterfront Security Operations Centerwatchstander acknowledged USS MAHAN's radio call and the Chief of the Guard responded that he was already on Pier 1 and would respond. The Chief of the Guard (Under Instruction) turned the security vehicle around and then proceeded back up Pier 1 from the head of the pier towards the brows of USS MAHAN and USNS COMFORT.

Meanwhile, after rummaging through some tool boxes and other gear near USS MAHAN's brow, Mr. Savage walked toward the USNS COMFORT's brow, and he then turned and re-approached USS MAHAN's brow. By this time, the Chief of the Guard and Chief of the Guard (Under Instruction) had reached Mr. Savage, and before Chief of the Guard (Under Instruction) could stop the security vehicle, the Chief of the Guard exited the vehicle, and followed Mr. Savage as Mr. Savage climbed up USS MAHAN's brow stairs shouting for Mr. Savage to stop.

Simultaneously, USS MAHAN's Officer of the Deck was standing on the ship end of the brow also shouting instructions for Mr. Savage to stop and not attempt to board USS MAHAN. Mr. Savage ignored the instructions of both the Chief of the Guard and USS MAHAN's Officer of the Deck and continued walking up the brow toward USS MAHAN's quarterdeck. At this point, USS MAHAN's Topside Rover was near the quarterdeck in response to the ongoing disturbance.

When Mr. Savage stepped onto USS MAHAN's brow, USS MAHAN's Petty Officer of the Watch standing on the quarterdeck drew her M-9 sidearm, kept the weapon's safety engaged, pointed it towards the deck, and turned away from the threat to obscure the weapon and minimize her exposure. Concurrently, the

Officer of the Deck moved off the brow in order to allow Mr. Savage to see the armed Petty Officer of the Watch. Unimpeded, Mr. Savage stepped off the brow and onto USS MAHAN's quarterdeck facing the Petty Officer of the Watch. The Petty Officer of the Watch attempted to have Mr. Savage identify himself. When Mr. Savage saw the Petty Officer's drawn weapon, he stated "give me that gun" and then reached for the sidearm. Mr. Savage and the Petty Officer of the Watch struggled for control of the weapon during which the Petty Officer of the Watch was unsuccessful in disengaging the weapon's safety lock in order to fire the weapon at Mr. Savage. After a couple of seconds struggling for the weapon, Mr. Savage forcibly spun the Petty Officer of the Watch throwing her several feet onto the ship's lifelines adjacent to the ship's starboard 25mm gun mount and gained control of her sidearm. During the brief struggle, the unarmed Officer of the Deck unsuccessfully attempted to assist the Petty Officer of the Watch by reaching between them to grab her sidearm.

After Mr. Savage gained control of the Petty Officer of the Watch's sidearm the Chief of the Guard entered USS MAHAN's quarterdeck and stepped in between Mr. Savage and the Petty Officer of the Watch. The Chief of the Guard positioned himself to shield the Petty Officer of the Watch from Mr. Savage. Meanwhile, Mr. Savage disengaged the safety lock of the Petty Officer of the Watch's weapon, pointed the weapon toward the Chief of the Guard and Petty Officer of the Watch, and fired multiple times at the Chief of the Guard killing him. Once in a position to do so, the Chief of the Guard (Under Instruction) and USS MAHAN's Topside Rover fired at Mr. Savage killing him.

Meanwhile, USS MAHAN's Petty Officer of the Watch moved herself from under the Chief of the Guard and the ship's starboard 25mm gun mount, withdrew her baton to engage Mr. Savage, and once she saw Mr. Savage was down she called away a Security Alert via the ship's 1MC internal communication system. She then notified Norfolk Security Department Waterfront Security Operations Center of "shots fired" and requested assistance. Despite having operable Naval Station Norfolk Security Dispatch radio capability, Waterfront Security Operations Center operators tried to notify Naval Station Norfolk Security Dispatch by telephone which was unsuccessful resulting in a watchstander having to run across the street to the police precinct to notify dispatch to send response units and medical assistance. Naval Station Norfolk Security Dispatch made the "shots fired" notification to Naval Security Forces via radio for security and medical responses.

The Gate 5 Police Officer in Charge copied the Pier 1 "shots fired" call immediately prior to returning to Gate 5.

3.0 Naval Station Norfolk Force Protection

This chapter reviews Naval Station Norfolk's Force Protection, Physical Security, and Law Enforcement policies and procedures as implemented on the date of the incident, focusing on the installation's Gate 5 and Pier 1 access controls.

The Investigation Team examined the following: (1) the physical structures that establish the Naval Station Norfolk including the Gate 5 and Pier 1 Entry Control Point for pedestrian and vehicle entrance; (2) locally developed orders, Standard Operating Procedures and Pre-Planned Responses developed by the Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk; and (3) the procedures that govern Physical Security and Law Enforcement operations and policy at Naval Station Norfolk.

3.1 Structure of Naval Station Norfolk's Security Department

Naval Station Norfolk's Security Department's Naval Security Force is made up active duty Master-at-Arms, civilian Department of the Navy police officers, and augmented by trained Auxiliary Security Forces. This Auxiliary Security Force consists of non-Master-at-Arms active duty personnel supplied by tenant commanders for an extended period of time and integrated into the Security Department's force structure.[2] Naval Station Norfolk's Force Protection strategy is to provide defense-in-depth, requiring an individual or individuals to circumvent

[2] Naval Station Norfolk Security Department Active Duty Roster – Appendix G1.

multiple layers of security in order to gain access to critical assets aboard the installation.

Naval Station Norfolk's Security Department is divided into two sections: the Landside and the Waterside. Waterside is further broken into pier security and harbor patrol units. Landside consists of active duty military Master-at-Arms, Auxiliary Security Forces, and civilian Department of the Navy police officers who are assigned to the Sewell's Point Police Department.[3] It also includes the administrative building, the administrative staff, the main installation gates, and the administration of the vehicle patrol zones.[4]

The Waterside consists of the Waterfront Security Operations Center and its watchstanders, the Chief of the Guard watchstanders, pier Entry Control Points, the harbor security, and roving watchstanders. Additionally, the Waterfront Security Operations Center watchstanders conduct oversight of the waterborne patrol zones immediately outside of Naval Station Norfolk's piers and the Waterside restricted areas of the installation.[5] The Waterside manning consists of only active duty military members.[6]Naval Station Norfolk's pier security consists

[3] Id.
[4] Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4; Regional Security Manning Report dated March 31, 2014 – Appendix G2; Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix CS; Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6.
[5]Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4.
[6]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5; Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6; Gold Nights Section Watchbill dated March 24, 2014 – Appendix G3.

of sentries at the Entry Control Points, who are Sailors from berthed ship's company.[7]

3.2 Naval Station Norfolk Force Protection Regulatory Requirements and Responsibilities

This subsection assesses Naval Station Norfolk's compliance with regulatory requirements for shipboard Force Protection. The Investigation team reviewed Naval Station Norfolk's Physical Security and Antiterrorism/Force Protection program, Naval Station Norfolk Operation Order (OPORD) AT-3300, as well as the governing Navy Region Mid-Atlantic Instruction 5530.14; Commander, Navy Installation Command Instruction 5530.14A; and OPNAVINST 5530.14E. Additionally, Naval Station Norfolk just completed a self-assessment of their administrative compliance with higher headquarters' guidance.[8]Specific Naval Station Norfolk compliance discrepancies are detailed below.

3.3 Naval Station Norfolk Force Protection Manning

Landside Force Protection Manning

On March 24, 2014, Gate 5 of Naval Station Norfolk was fully manned in accordance with the installation manning model.[9] In terms of overall manning, Naval Station Norfolk is currently manned at 92% of the Mission Profile Validation–Protection model,[10] and this is above the Commander, Navy

[7]Pier 1 Entry Control Point sentry, Witness Interview – Appendix C7; Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Commanding Officer, USS KAUFFMAN, Witness Interview – Appendix C8.
[8]Vice Chief of Naval Operations Memorandum 3301 Ser N09/13U100551 dated December 3, 2013 – Appendix G4.
[9]Fiscal Year 14 Manpower Activity Report dated March 31, 2014 – Appendix G5.
[10] Id.

Installations Command's average of 86%.[11] The Counter Terrorism Program of Record is funded at $791 million for both labor and non-labor for Fiscal Year 14.[12] This provides resources for manning at 86% of Mission Profile Validation–Protection (MPV-P) across Commander, Navy Installations Command.[13]

Commander, Navy Region Mid-Atlantic provides Naval Station Norfolk with resources to man, train, and equip its security program. Commander, Navy Region Mid-Atlantic provides funding to pay for 142 civilian personnel (for approximately $9.2 million in labor) and $1.5 million in non-labor for Fiscal Year 14.

Even though the Naval Station Norfolk's Security personnel manning was above the Commander, Navy Installations Command average, there were key manpower shortages that had a negative effect on the supervisory performance of its Naval Security Force. A delay in the Fiscal Year 13 hiring process and the general fiscal landscape exacerbated the already challenging manning shortfalls at Naval Station Norfolk. Naval Station Norfolk has the funding and authority to hire 20 additional Department of the Navy police officers, but they have not been hired yet. Sequestration, furloughs, and a hiring freeze that began in Fiscal Year 13, along with a high attrition rate, have created delays in achieving and sustaining optimal levels of civilian manning.[14] Police, fire, and other first responder

[11] Chief of Naval Operations Instruction 5530.14E, Appendix A, Post-Validation Model and Staffing dated January 28, 2009 – Appendix D1; Fiscal Year 14 Manpower Activity Report dated March 31, 2014 – Appendix G5.
[12] Fiscal Year 14 Funding Spreadsheet – Appendix G12.
[13] Chief of Naval Operations Instruction 5530.14E, Appendix A, Post-Validation Model and Staffing dated January 28, 2009 – Appendix D1.
[14] Commander, Navy Region Mid-Atlantic, N3AT, Witness Interview – Appendix C9.

vacancies are authorized for fill and in some cases over-hired in an attempt to recover from the hiring challenges of Fiscal Year 13.

Naval Station Norfolk also has a total of nine civilian supervisors in its Security Department, but only two of them were on duty on the evening of March 24. There were no active duty military supervisors on duty during the incident.[15]

One significant gap in manning is the Naval Station Norfolk Security Department senior civilian Precinct Commander. The Precinct Commander originally had his retirement scheduled for the end of April 2014, but instead retired on April 3, 2014.[16]The Precinct Commander was absent for 172.5 hours during the first three months of 2014 and was absent for approximately 6 months of calendar year 2013.[17]His absence as the senior civilian Naval Station Norfolk Security Department supervisor hampered the operational capability of the department and its assigned forces. This billet is now vacant and should be filled as soon as the qualified individual is identified. The Assistant Precinct Commander billet, the second most senior civilian, was vacated in August of 2012.[18] This billet remains unfilled,[19] and should be filled immediately.

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[15]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5; Sewell's Point Police Precinct Watchbill dated March 24, 2014 – Appendix G6.
[16]Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4; Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Civilian Precinct Commander, Standard Labor Data Collection and Distribution Application Timekeeping Records, 2013-2014 – Appendix G7.
[17]Id
[18]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4.
[19]Id.

There is also a lack of seniority in leadership of key billets. Naval Station Norfolk's Security Officer is a designated Lieutenant Commander (O-4) billet, and the previous Security Officer was a Lieutenant Commander.[20] The current Security Officer is a Lieutenant (O-3) who did not have installation experience prior to this assignment.[21] Because of the large scope and complexity of Naval Station Norfolk's security apparatus, it is the opinion of the Investigation Team that a Lieutenant does not have the experience to effectively lead this department.

Waterside Force Protection Manning

As a subset of Naval Station Norfolk's Security Department, Waterside is manned exclusively with Master-at-Arms with the exception of a small number of administrative support. The Waterside section contains 25% of Naval Station Norfolk's overall security manning.[22] They are on an adjusted schedule, working a rotation of three days on, two days off, two days on and three days off. Additionally, the day and night sections of Waterside will rotate, providing the opportunity for oversight not provided to Landside. There was no scheduled E-6 and above leadership on March 24, 2014 because Chief Petty Officers or Officers are not scheduled to work at night.[23] The Leading Chief Petty Officer of Waterside typically works day shift but on occasion attends the night Guardmount.[24] The watch section is led by the Waterfront Security Operations Center Operator. The

[20]Commander, Navy Region Mid-Atlantic, N3, Witness Interview – Appendix C11; Fleet Training Management and Planning System (FLTMPS), Commander, Navy Installation Command, Security Officer Billets – Appendix G8; Naval Station Norfolk Security Department Post Orders, Gate 5 Entry Control Point dated November 16, 2012 – Appendix D2.
[21]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10.
[22] Naval Station Norfolk Security Department Active Duty Roster – Appendix G1.
[23]Gold Nights Section Watchbill dated March 24, 2014 – Appendix G3.
[24] Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.

Chief of the Guard is the direct supervisor of the pier Entry Control Point sentries and the seaward sentries. He is responsible for any Random Antiterrorism Measures in place on the piers. The Chief of the Guard spends his shift ensuring the pier Entry Control Point sentries are standing their post properly.

3.4 Naval Station Norfolk Force Protection Training

Landside Force Protection Training

The Naval Station Norfolk Naval Security Force police officers at Gate 5 were properly trained. The training records of the Police Officers in Charge, the watchstanders, and the police officers assigned to the Random Antiterrorism Measures show that the Naval Security Force police officers posted at Gate 5 all had refresher weapons training, active shooter training, and had proper equipment assigned to them.[25] The Gate 5 Police Officer in Charge, a civilian, was trained according to the established Department of Navy police officer standards, which included the Regional Accessions Academy, Annual Refresher Training, and Semi-Annual Refresher Weapons Training.[26] There was no formal qualification process, however, in place for civilian Department of Navy police officers to qualify as Police Officers in Chargewhen the Gate 5 watchstanders were hired. Commander, Navy Installations Command Instruction 5530.14 (dated July

[25]Commander, Navy Region Mid-Atlantic, N3AT, Witness Interview – Appendix C9; Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6; Training Jackets – Naval Station Norfolk Security Personnel – Appendix F1.

[26]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12; Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Training Jackets – Naval Station Norfolk Security Personnel – Appendix F1.

2011,and vetted through the local collective bargaining unit and implemented in March 2012) directed civilians to use a standardized training syllabus for Police Officers in Charge.[27]

Naval Station Norfolk has no formal positional qualification process for Department of Navy police officers.[28] The Department of Navy police officers at Naval Station Norfolk are simply designated as Police Officers in Charge when they have been on a shift "for a period of time" and when the supervisor begins scheduling them for the shift.[29] At Naval Station Norfolk, there are no letters of designation or other tools to determine positional competency and qualification.[30]

The active duty Master-at-Arms personnel assigned to the Naval Station Norfolk Security Department, on the other hand, have a delineated and required syllabus for attaining various positional responsibilities, including patrolman, Petty Officer of the Watch, seaboard sentry, Chief of the Guard, and Waterfront Security Operations Center watchstander.[31]Additionally, Naval Station Norfolk's Security

[27]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14; Commander, Navy Installations Command Instruction, 5530.14A dated May 29, 2013, Chapter 0707 – Appendix D3.

[28]Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13;Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Commander, Navy Region Mid-Atlantic, N3AT, Witness Interview – Appendix C9.

[29]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12; Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14.

[30]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12.

[31]Commander, Navy Installations Command Instruction, 5530.14A dated May 29, 2013, Chapter 0707 – Appendix D3; Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6; Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.

Department maintains training records for Naval Security Force personnel assigned to the installation.[32]

Waterside Force Protection Training

On March 24, 2014, the Chief of the Guard, responsible for monitoring Naval Station Norfolk's pier Entry Control Points and ship-supplied pier sentries, was fully trained and qualified, and he also had refresher weapons training and active shooter training.

3.5 Naval Station Norfolk Force ProtectionEquipment

Landside Force Protection Equipment

Naval Station Norfolk's Naval Security Force has the necessary equipment to stand sentry duty at the main gates.[33] On the evening of March 24, 2014, all security personnel assigned to Naval Station Norfolk had ballistic vests provided to them.[34]

[32]Commander, Navy Region Mid-Atlantic, N3AT, Witness Interview – Appendix C9; Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6; Training Jackets – Naval Station Norfolk Security Personnel – Appendix F1.
[33]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14; Naval Station Norfolk Gate 5 Guard 2, Witness Interview – Appendix C16; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13.
[34]Id.

However, not every ballistic vest is properly fitted to the individual nor is there proper administrative tracking of the protective gear to ensure accountability.[35] Even though there was both oral and written guidance mandating the wearing of ballistic vests, there was no supervision to ensure compliance with this direction.[36] In practice, the watchstanders routinely failed to wear the protective ballistic vests because of sizing and "fit" issues.[37] Several of the police officers at Gate 5, including the Police Officer in Charge, were not wearing their ballistic vest contrary to the Security Officer's orders or signed Post Orders.[38] Every Gate 5 watchstander admitted that they have not read the Post Orders or Pre-Planned Responses in over seven months, and the supervisors on watch on the evening of March 24th also admitted that they have not read them.[39]

Equipage and Equipment

Prior to 2013, individual Regions and Installations were responsible for supplying their Naval Security Forces with the proper personal equipment to stand a sentry post. Lack of standardized equipment purchases and detailed accounting led

[35]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12; Naval Station Norfolk Security Roving Sergeant, Witness Interview – Appendix C17; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14.
[36]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10; Naval Station Norfolk Security Department Post Orders, Gate 5 Entry Control Point dated November 16, 2012 – Appendix D2.
[37]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.
[38]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Gate 5 Guard 2, Witness Interview – Appendix C16; Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13.
[39]Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12; Naval Station Norfolk Security Roving Sergeant, Witness Interview – Appendix C17; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C1S; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14; Naval Station Norfolk Gate 5 Guard 2, Witness Interview – Appendix C16.

gates because the key to unlock the gates could not be located.[43] Gate 5 is continuously open unless specifically ordered to close.[44] The watchstanders used police vehicles and other gate personnel to ensure the Gate 5 was secure.[45] There are no written procedures to secure Gate 5 when necessary.

Waterside Force Protection Equipment

The Chief of the Guard and Chief of the Guard (Under Instruction) were properly equipped, but neither was wearing his issued ballistic vest at the time of the incident,[46] although the ballistic vests were available and in their vehicle. There was both oral and written guidance mandating the wearing of protective gear but there was no supervision to ensure compliance with this direction. It was common Waterside practice for watchstanders and supervisors alike to routinely not wear ballistic vests.[47]

Not every pier Entry Control Point is configured the same way. The Pier 1 Entry Control Point on the night of the incident was an alternate Entry Control Point located approximately 100 feet east from the foot of Pier 1. This location allowed access to the area surrounding the adjacent parking lot and the southern quay wall adjacent to Pier 1. A more secure Entry Control Point is available at the foot

[43] Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14.
[44] Naval Station Norfolk Security Department Post Orders, Gate 5 Entry Control Point dated November 16, 2012 – Appendix D2.
[45] Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15.
[46] Chief of the Guard (Under Instruction,) Witness Interview – Appendix C2; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.
[47] Id.

theCommander, Navy Installations Command to transition into acentralized equipment management system from an installation-centric system. This transition has not been completed to date. Additionally, the Fiscal Year 14 budget includes close to $20 million for the purchase of standardized equipment for both active duty and civilian Naval Security Force, as well as reserve augmentees. This includes weapon holsters, helmets, ballistic vests, flashlights, Automatic Extension Baton, handcuffs and keys. After the Washington Navy Yard shootings, hands free radio headsets were also included.

Naval Station Norfolk Gate 5

Naval Station Norfolk's Gate 5 was constructed in accordance with Unified Facilities Criteria guidance. It has functioning hardened access control systems, and active vehicle barriers for both inbound and outbound traffic lanes. The radios, the hardened access control systems, and other Force Protection tools and equipment were present and in working order.[40] According to the Gate 5 logbook, the daily testing of the hardened access control systems was completed at 2115 on March 24, 2014.[41] Gate 5 also has functioning surveillance cameras.[42]

On March 24, Naval Station Norfolk was ordered to lockdown the installation after the post-incident report of "shots fired" was transmitted from Security Dispatch. The security personnel at Gate 5 were unable to secure the swinging

[40]*See* Unified Facilities Criteria 4-022-01, Unified Facilities Criteria for Security Engineering: Entry Control Facilities and Access Control Points dated May 25, 2005; Naval Station Norfolk Security Roving Sergeant, Witness Interview – Appendix C17; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15.
[41]Naval Station Norfolk Security Roving Sergeant, Witness Interview – Appendix C17; Logbook, March 24, 2014 – Naval Station Norfolk Gate 5 – Appendix G9.
[42]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10.

of the pier, but its use would not have provided entry control for a ship moored at the quay wall as USS KAUFFMAN was.

On March 24th, the Pier 1 Entry Control Point consisted of two gates: (1) a two-piece large heavy chain-link-fenced hinged vehicle gate; and, (2) a single heavy chain-link-fenced pedestrian gate.[48] There is no pedestrian turnstile located on this pier. These gates were very difficult, if not impossible, for one person to maneuver. The vehicle lane was blocked by two empty orange construction barrels and no additional obstructions were present at the pedestrian gate.[49] The Entry Control Point sentry was expected to control traffic at the pedestrian gate and move the barrels for authorized vehicle traffic.[50]

The alternate Pier 1 Entry Control Point did not have a functioning hard-wired radio that allowed communication directly with the Waterfront Security Operations Center. The Pier 1 Entry Control Point sentry also did not have a portable radio that could communicate directly with the Waterfront Security Operations Center.[51]

There are no standardized communications between ships, pier Entry Control Points, the Chief of the Guard, and the Waterfront Security Operations Center.[52] Depending on the status of a ship's radios and the pier where the ship is berthed,

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[48]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10.
[49]Id; Pier 1 Entry Control Point Sentry, Witness Interview – Appendix C7.
[50]Pier 1 Entry Control Point sentry , Witness Interview – Appendix C7.
[51] Id.
[52]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.

communications may be handheld radio, telephone, or hard-wired radio.[53] Not every pier's Entry Control Point has a functioning hard-wired radio that allows communication directly with the Waterfront Security Operations Center, and not all of the cameras on the installation are in working order.[54] Duress Alarms at both main installation and pier Entry Control Points were also not fully functioning.[55] The records documenting functional checks of the alarms are incomplete,[56]and not all pier sentries were familiar with the equipment in the Entry Control Points or how to use them. The Pier 1 Entry Control Point guard shack in use on March 24, 2014 had a telephone and an alarm button, but both were inoperable.[57]

3.6 Naval Station Norfolk Force Protection Oversight

In accordance with higher headquarters' guidance, Commanding Officer, Naval Station Norfolk provided guidance for Force Protection oversight in a signed Operation Order 3300/N3AT dated November 16, 2012. The Operation Order has been translated into signed Post Orders and Pre-Planned Responses at the installation's Entry Control Points.[58]

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[53]Chief of Naval Operations Instruction 5530.14E, Enclosure (1) Chapter 10, Section 1001 dated January 28, 2009 – Appendix D4.
[54]Naval Station Norfolk Security Officer, Witness Interview – Appendix C10.
[55]Weekly Checks of Pier Comm Radios Chart dated December 16, 2013 – Appendix G10.
[56]Id.
[57]Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6.
[58]Naval Station Norfolk Security Department Post Orders, Gate 5 Entry Control Point dated November 16, 2012 – Appendix D2; Naval Station Norfolk Navy Security Forces Pre-Planned Response, Entry Control Point Unauthorized Access dated February 9, 2012 – Appendix D5; Naval Station Norfolk Navy Security Forces Pre-Planned Response, Active Shooter dated January 6, 2012 – Appendix D6.

Additionally, the Commanding Officer of Naval Station Norfolk signed a series of Random Antiterrorism Measures for the month of March 2014.[59] The actual execution of these Random Antiterrorism Measures, however, has not been verified,[60] and there is no systematic way to verify compliance with the direction of the Commanding Officer.[61] There are no audits or quality reviews to ensure Random Antiterrorism Measures have been conducted properly and as scheduled.[62]On March 24, 2014, two of the five Naval Security Force personnel at Gate 5 were assigned to conduct a Random Antiterrorism Measure. They were tasked with conducting administrative vehicle inspections, however, the personnel admitted they did not conduct that Random Antiterrorism Measure as ordered by the installation Commanding Officer and there is no means to ensure compliance with the requirement.[63]

Previous Assessments

Since the 2013 Washington Navy Yard shooting incident, all Navy installations have conducted administrative Security and Emergency Management self-assessments.[64] These assessments were used to determine administrative compliance with higher headquarters' security guidance and policies.[65] Naval Station Norfolk's self-assessment was scored a "low" compliance with security

[59]Commanding Officer, Naval Station Norfolk letter 5585 N00 – Appendix G11.
[60]Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13; Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4.
[61]Id.
[62]Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13; Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4.
[63]Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13; Logbook, March 24, 2014 – Naval Station Norfolk Gate 5 – Appendix G9.
[64]Vice Chief of Naval Operations Memorandum 3301 Ser N09/13U100551 dated December 3, 2013 – Appendix G4.
[65]Vice Chief of Naval Operations Memorandum 3301 5er N09/13U100551 dated December 3, 2013 – Appendix G4.

directives and a "low" compliance with emergency management directives. These findings were reviewed and endorsed by Commander, Navy Region Mid-Atlantic.[66]

The last external assessment of Naval Station Norfolk's security capabilities was conducted in 2012.[67] The results of the Chief of Naval Operations Installation Vulnerability Assessment are classified. A plan to correct noted deficiencies was not provided to the Naval Station Norfolk's Commanding Officer, although he was briefed on the contents and the plan to correct the noted deficiencies.[68]

Commander, Navy Installations Command and Commander, Navy Region Mid-Atlantic did not conduct a Naval Station Norfolk enforcement oversight review in the last 12 months as was required.[69]Naval Station Norfolk is scheduled for a joint U.S. Fleet Forces Command and Navy Installations Command Higher Headquarters Operational Assessment in June 2014.[70] This assessment will not only review the installation's administrative compliance with guidance from the higher headquarters, but also assess the installation's ability to train and execute during an operational security exercise.

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[66]Classified Naval Station Norfolk's Installation Protection Assessment Cell (IPAC) Results Spreadsheet dated February 2014.
[67] Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4.
[68]Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4.
[69]Commanding Officer, Naval Station Norfolk, Witness Interview – Appendix C4.
[70]Commander, United States Fleet Forces Command, Message 082027Z JAN 14, Higher Headquarters Operation Assessment and Program Review – Appendix E1.

Landside Operational Oversight

There was a lack of supervision during the night-shift. There is a notable lack of mid-level supervisors who work past normal business hours, and there are no military First Class Petty Officers or above scheduled to work the third shift (from 2000-0400) on Landside, nor night-shift (1900-0700) on Waterside in spite of Naval Station Guidance that specifies, as an example, that the Chief of the Guard will be an E-6 and preferably a Chief Petty Officer.[71] There is also no training officer scheduled to work on third-shift and civilian Department of the Navy police officers do not rotate to day-shift to gain more experience and training.[72]

Naval Station Norfolk has a total of nine civilian supervisors in its department, and there are three civilian supervisors normally scheduled for third shift.[73] On March 24, 2014, there were only two supervisors on the third shift.[74]

Interviews with the Roving Sergeant and Assistant Watch Commander on shift showed a lack of formal supervisory steps at Gate 5.[75] The Roving Sergeant supervision consists of checking on post watchstanders and seeing if they have the proper equipment, but there is no evidence that supervisors determine the level of knowledge of the watchstanders. The Roving Sergeant conducted the hardened access control systems checks, but did not quiz the watchstanders on

[71]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5; Naval Station Norfolk Operation Order AT-3300, Chapter 3, C-3-D-1 – Appendix D7.
[72]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15.
[73]Regional Security Manning Report dated March 31, 2014 – Appendix G2.
[74] Sewell's Point Police Precinct Watchbill dated March 24, 2014 – Appendix G6.
[75]Naval Station Norfolk Security Roving Sergeant, Witness Interview – Appendix C17; Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12.

proper procedures on March 24.[76] The Guardmount only disseminates work assignments for the shift and administrative remarks.[77] It does not consist of training or reinforcement of procedures.

The Watch Commander occasionally visited the Landside gate posts, but not routinely.[78] Master-at-Arms Chief Petty Officers or Commissioned Officers do not routinely attend third-shift Landside Guardmount.[79] The Naval Station Norfolk Security Department Watch Commander's desk journal was notably incomplete on March 24and March 25, 2014.[80]

Waterside Operational Oversight

On the Waterside, there is also a lack of mid-level supervisors who work past normal business hours. There are no military First Class Petty Officersor above scheduled to work Waterside night-shifts (1900-0700).[81]

[76]Naval Station Norfolk Security Roving Sergeant, Witness Interview – Appendix C17; Logbook, March 24, 2014 – Naval Station Norfolk Gate 5 – Appendix G9.
[77]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Gate S Guard 1, Witness Interview – Appendix C14; Naval Station Norfolk Gate 5 Guard 2, Witness Interview – Appendix C16; Naval Station Norfolk Gate S RAM 1, Witness Interview – Appendix C13; Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.
[78]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Gate 5 Guard 1, Witness Interview – Appendix C14; Naval Station Norfolk Gate S Guard 2, Witness Interview – Appendix C16; Naval Station Norfolk Gate S RAM 1, Witness Interview – Appendix C13; Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.
[79]Naval Station Norfolk Security Roving Sergeant, Witness Interview – Appendix C17; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12.
[80]Desk Journal, Naval Station Norfolk dated March 24, 2014 – Appendix G13; Desk Journal, Naval Station Norfolk dated March 25, 2014 – Appendix G14
[81]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.

On March 24, a Second Class Petty Officer was the Duty Section Leader and the Waterfront Security Operations Center operator, and was in charge of Waterside operations. There are no military or civilian Naval Security Force supervisors on the Waterside at night. If a situation arose that could not be rectified by the Duty Section Leader, the Naval Station Norfolk Security Department Watch Commander on the Landside is contacted for assistance. The Watch Commander does not routinely attend Waterside Guardmount conducted by the assigned Duty Section Leader. [82]

3.7 Incident Assessment

- The Gate 5 Police Officer in Charge failed to properly assess Mr. Savage's credentials and failed to execute the proper procedure for the truck's turnaround in accordance with the signed post orders.[83]

- Although Mr. Savage possessed a valid Transportation Workers Identification Credential (TWIC) it was never presented to Gate 5 watchstanders. Mr. Savage had no valid reason to access the installation on March 24, and he should not have been allowed access to Naval Station Norfolk on March 24, 2014.[84]

[82]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5; Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6.
[83]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Security Department Post Orders, Gate 5 Entry Control Point dated November 16, 2012 – Appendix D2.
[84]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15.

- When the Gate 5 Police Officer in Charge determined that Mr. Savage was not going to exit the installation, he did not follow the proper procedure for unauthorized access to the installation.[85]

- All other security personnel at Gate 5 failed to notify the Naval Station Norfolk Security Department Watch Commander or Security Dispatcher about Mr. Savage's unauthorized access to Naval Station Norfolk.[86] Additionally, the security personnel assigned to conduct administrative vehicle inspections as a Random Antiterrorism Measure failed to execute their directed measure per Naval Station Norfolk's Commanding Officer's direction of March 24, 2014.[87]

3.8 Findings

- Gate 5 personnel were clearly negligent in the performance of their duties, and there is a gross lack of procedural compliance, accountability and oversight of the civilian police force.

- Although manned above designated requirements, there are nonetheless serious manning gaps in the number and seniority of police officers and civilian supervisors, as well as shortfalls in the seniority of personnel

[85]Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15; Naval Station Norfolk Security Department Post Orders, Gate 5 Entry Control Point dated November 16, 2012 – Appendix D2.
[86]Naval Station Norfolk Security Assistant Watch Commander, Witness Interview – Appendix C12; Naval Station Norfolk Gate 5 Guard 2, Witness Interview – Appendix C16; Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13; Naval Station Norfolk Gate 5 Police Officer in Charge, Witness Interview – Appendix C15.
[87]Naval Station Norfolk Gate 5 RAM 1, Witness Interview – Appendix C13; Commanding Officer, Naval Station Norfolk letter 5585 N00 – Appendix G11.

assigned as Security Officer, Chief of the Guard, and within the Waterfront Security Operations Center among others.

- Communications shortfalls, inadequate watch rotations to enable training, and a lack of integration between civilian and military security personnel contributed to this incident.

- A lack of equipage and a lack of accountability coupled with lax enforcement of the requirements to wear body armor are indicative of the lack of oversight and procedural compliance.

- The physical material condition of access controls and pier equipment contributed to this incident.

- Although the Transportation Workers Identification Credential was not a factor, the vetting practices of personnel authorized access to government facilities is worthy of review.

- Guidance and policies for watchstanders and sentries as well as qualifications standards require periodic updates and forcing functions to ensure their review and training application.

3.9 Recommendations

The Investigation Team's recommendations for improving Naval Station Norfolk Force Protection are as follows:

1) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should address the lack of seniority of the Naval Station Norfolk Security Officer. Although billeted and funded as a Lieutenant Commander (O-4), the billet is filled by a Lieutenant (O-3) who had no U.S. Navy installation facility experience prior to assuming duties at Naval Station Norfolk. The Investigation Team also recommends a minimum of a Commander (O-5) with at least one previous shore facility security tour be immediately assigned as Naval Station Norfolk's Force Protection Officer immediately superior to the Norfolk Naval Station Security Officer.

2) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should immediately address the lack of mid-level Naval Station Norfolk Security Department civilian supervision and re-assess the validity of the Mission Profile Validation - Protection. The Naval Station Norfolk Precinct Commander civilian Lieutenant Colonel billet was vacant for a period of up to 6 months in 2013 due to alleged medical leave and it became permanently vacant two weeks after the incident following the individual's early retirement. This position should be filled immediately. Additionally, the Naval Station Norfolk Security Department's third-in-command civilian Major billet, although authorized and funded, has been unfilled for over a year but should be filled immediately.

Appreciating hiring freezes and the effects of Sequestration in 2013, the lack of mid-level management contributed to a lack of supervision for the Naval Station Norfolk Security Department's police force.

3) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should immediately address the lack of procedural compliance, accountability and oversight of the civilian police force by targeted infusion of motivated mid-level personnel and proper oversight by both civilian and military supervisors.

4) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should address the lack of integration between Naval Station Norfolk's civilian police force, active duty Master-at-Arms, and Auxiliary Security Force personnel.

5) The Commanding Officer, Naval Station Norfolk, should address the lack of seniority within Naval Station Norfolk's Waterfront Security Operations Center. The senior person assigned to the evening watches is an E-5 which is inconsistent with the level of responsibility and the number of Officers and Chief Petty Officers available.

6) The Commanding Officer, Naval Station Norfolk, should address the lack of seniority of personnel assigned to Chief of the Guard duties in accordance with the NAVSTA OPORD AT-3300 (Change 3) which directs a First Class Petty Officer and preferably a Chief Petty Officer.

7) The Commander, Navy Installations Command should consider increasing the pay grades of the Department of the Navy police forces. The GS-3s and GS-5s hired by the Navy are one pay grade lower than those hired by other military Services and this may contribute to the lack of capability and professionalism.

8) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should improve the training and professionalism of naval installation Department of the Navy police forces. For example, the Naval Station Norfolk night watchstanders never stand watch in the daytime and thus do not receive the same level of oversight and training as other watch shifts. Creating a watch rotation that rolls through the 24hour clock would enhance supervision, training, and professionalism.

9) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should validate the availability of required Force Protection and Law Enforcement equipment such as vests, communications, and weapons for the watchstanders. Missing equipment, ill-fitted equipment (particularly for female watchstanders), and incompatible equipment contributed to a lax environment where watchstanders chose not to wear or use their equipment greatly increasing risk.

10) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should immediately repair broken Naval Station Norfolk equipment and fixtures such as cameras,

turnstiles, access control gates, and duress buttons. As an example, half of Naval Station Norfolk's pier cameras and pier Entry Control Point duress buttons were inoperable on the day of the incident. Additionally, consideration should be given to improving Physical Security at pier Entry Control Points to include gates and turnstiles or creating a waterfront enclave.

11) The Commander, Navy Region Mid-Atlantic Inspector General should investigate the conduct of the Naval Station Norfolk Security Department Deputy Commander senior civilian for possible time and attendance violations for not coming to work for several months and the fact he only re-appeared when Commanding Officer, Naval Station Norfolk personally intervened. His absence contributed to the lack of supervision and laxity of standards by the Naval Station Norfolk police force.

12) Although the Transportation Worker Identification Credential was not used to access the Naval Station Norfolk, Commander, Navy Installations Command, Commander, Navy Region Mid-Atlantic, and Commanding Officer, Naval Station Norfolk should retain the new policy of banning access to holders of a Transportation Workers Identification Credential who have a conviction in the last ten years, or a misdemeanor within the last five years for crimes of violence; larceny, drugs; habitual offenders; and convictions for sex offenses. Additionally, Directive Type Memo (DTM) 09-12 directs Department of Defense entities to honor the Transportation Worker Identification Credential; the Department of Defense should therefore engage the Department of Homeland Security to ensure

Transportation Worker Identification Credential holders are vetted to the same standard.

13) Commanding Officer, Naval Station Norfolk should review, sign, and update Operation Order and Post Orders to include the development of a Standard Operating Procedure for securing all gates when required.

14) Commanding Officer, Naval Station Norfolk should institute standardized Personnel Qualification Standards or Job Qualification Requirements for Department of Navy (DON) police officers. Additionally, level of knowledge training at Guardmount and during supervisor oversight should be required and properly documented.

15) The Memorandum of Understanding (MOU) with local authorities is dated and should be updated with current guidance.

4.0 USS MAHAN (DDG 72) Force Protection

Paralleling the previous chapter's installation Force Protection analysis, this chapter addresses shipboard Force Protection policies and procedures as implemented on the date of the incident, focusing on USS MAHAN's quarterdeck and shipboard access.

4.1 USS MAHAN Force Protection Regulatory Requirements and Responsibilities

This subsection assesses USS MAHAN's compliance with regulatory requirements for shipboard Force Protection.

The Investigation Team reviewed USS MAHAN's Physical Security and Antiterrorism/Force Protection (MAHANINST 5530.1G) program. This Antiterrorism/Force Protection program, watchstander qualification program, and weapons qualification program met all substantive requirements.[88] With the exception of some minor administrative errors, the ship's programs are in accordance with requirements set forth in higher-level directives.[89]

[88] Training Jackets – USS MAHAN – Appendix F2; Commander Naval Surface Forces Pacific/Commander Naval Surface Forces Atlantic 3300.1A(5)(c) – Appendix D8; Commander, Naval Surface Forces Atlantic, Message 181820Z MAR 12, Standards for Weapons Qualifications– Appendix E2; Chief of Naval Operations Instruction 3591.1F, ENCLOSURE 3(1), and ENCLOSURE 4(1) dated August 12, 2009 – Appendix D9.

[89] Commander Naval Surface Forces Pacific/Commander Naval Surface Forces Atlantic 3300.1A(5)(c) – Appendix D8.

4.2 USS MAHAN Force Protection Manning

USS MAHAN was overall manned at 80% fit and 86% fill, and the ship had the required personnel onboard and at watch stations.[90] This level of manning is appropriate for MAHAN's current phase in the deployment cycle, the sustainment phase.[91]

USS MAHAN had all the required Force Protection qualified personnel at the time of the incident.[92]The Force Protection Officer is a second tour Division Officer and is designated as the Antiterrorism Officer.[93] The ship's Master-at-Arms is a Chief Petty Officer who is designated as the Antiterrorism Training Supervisor.[94] The ship had sufficient qualified crewmembers in the duty section to provide watchstanders to meet watch bill requirements. The Investigation Team concludes USS MAHAN was properly manned.

4.3 USS MAHAN Force Protection Training

USS MAHAN was Force Protection certified on August 24, 2012 by Commander, Strike Force Training Atlantic during the certification exercise for the ship's

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[90] *See* United States Fleet Forces Operation Orders 3300-13, ENCLOSURE 1 TO TAB B TO APPENDIX 3 TO ANNEX N TO USFF OPORD, ISP Arming Requirements; USS MAHAN Watchbill dated March 24, 2014 – Appendix G1S; Section Leader USS MAHAN, Witness Interview – Appendix C19.

[91] Commanding Officer, USS MAHAN, Witness Interview – Appendix C20.

[92] *See* United States Fleet Forces Operation Orders 3300-13, ENCLOSURE 1 TO TAB B TO APPENDIX 3 TO ANNEX N TO USFF OPORD, ISP Arming Requirements; Force Protection Officer USS MAHAN, Witness Interview – Appendix C25; USS MAHAN Watchbill dated March 24, 2014 – Appendix G15.

[93] Force Protection Officer Designation Letter – Appendix G16; Antiterrorism Officer Level II Certification – Appendix F3.

[94] Command Master-at-Arms USS MAHAN, Witness Interview – Appendix C21; Fleet Training Management and Planning System (FLTMPS), Command Master-at-Arms, USS MAHAN – Naval Education Code 9501 – Appendix G17.

independent deployment from December 2012 - September 2013.USS MAHAN maintained certification by completing required repetitive exercises.[95] Prior to the incident, USS MAHAN was conducting focused training on Force Protection to ensure readiness for recertification in April of 2014.[96]The Investigation Team concludes USS MAHAN met all Force Protection training requirements.

4.4 USS MAHAN Force Protection Equipment

Weapons

USS MAHAN watchstanders had all of the equipment they required the night of the incident with the exception of a lanyard for the M-9 service pistols although the lanyard is designed to prevent loss over the side and not the personal retention of a weapon.[97] USS MAHAN conducted a complete Allowance Equipment List inventory on the April 1, 2014, and has identified and ordered all items to fill the shortfalls.[98]

Brow

In reviewing brow equipment for ships, standard Navy brows do not have a physical barrier or gate, other than the physical presence of a watchstander, to impede access to the quarterdeck once an intruder has accessed the pier. The

[95] Executive Officer, USS MAHAN, Witness Interview – Appendix C22.
[96]Force Protection Officer USS MAHAN, Witness Interview – Appendix C25.
[97] USS MAHAN Weapons Log Sheet – Appendix G18.
[98] Weapons Officer USS MAHAN, Witness Interview – Appendix C23; Allowance Equipment List Inventory Sheet – Appendix G19.

quarterdeck configuration and brow type may limit the progression of the use of force continuum. The use of force continuum escalates as follows: (1) presence; (2) verbal; (3) restraining techniques – soft control; (4) compliance techniques – hard control); (5) intermediate weapons – including pepperspray and baton strikes; and, (6) deadly force. The use of force continuum provides the watch team with guidelines to increase the use of force as the situation progresses.[99] These methods are proven effective when the watch team has time and space to evaluate and elevate as necessary.[100] Some quarterdeck configurations are constrained in size and orientation, not providing adequate room to make determinations in an effective manner.[101] If the watch team does not determine that an individual is a threat early enough, the quarterdeck watchstanders may be forced to accelerate through the use of force continuum, omitting intermediate steps and progressing directly to deadly force.[102] A physical barrier or gate to the quarterdeck, controlled by the watch team, would allow the watch team more time to clearly define a threat. An individual climbing over or around a gate on the brow will provide more time to determine intent, clarifying a threat from an innocent or deliberate trespasser on the pier.[103] The Investigation Team recommends a physical barrier be designed and installed on all navy brows or quarterdeck entrances.

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[99] Navy Tactics, Techniques, and Procedures 3-07.2.1, Section 7.2, Figure 7-1 – Appendix D10.
[100] Navy Tactics, Techniques, and Procedures 3-07.2.1, Section 7.2 – Appendix D11; Navy Tactics, Techniques, and Procedures 3-07.2.3, Figure S-2(1)(b) – Appendix D12.
[101] Commander, Destroyer Squadron TWO, Witness Interview – Appendix C24.
[102] Navy Tactics, Techniques, and Procedures 3-07.2.3, Figure S-2(1)(b) – Appendix D12; Command Master-at-Arms USS MAHAN, Witness Interview – Appendix C21.
[103] Commander, Destroyer Squadron TWO, Witness Interview – Appendix C24.

Communications

As discussed in Chapter 3, there are no standardized communications between ships, pier Entry Control Points, the Chief of the Guard, and the Waterfront Security Operations Center.[104] At any given pier, a combination of sentry-to-ship, sentry-to-Waterfront Security Operations Center, or ship-to-Waterfront Security Operations Center radio paths may be employed.[105] Depending on the status of ships' radios, and the pier where the ship is berthed, communications could include radio, telephone, or base station.

In observing the operations at several piers, most pier Entry Control Point sentries are communicating with their own ship via radio; however, all ships are on different frequencies from each other and Naval Station Norfolk Waterfront Security Operations Center.[106] Situational awareness of all watchstanders is decreased because all watchstanders are not on the same frequency. This inconsistency in the data path creates gaps in the flow of communications between all vested recipients including the ship, sentry, and Waterfront Security Operations Center. The Investigation Team recommends that all pier Entry Control Point sentries, Chief of the Guard, Waterfront Security Operations Center, and ship quarterdecks should have radios on the same frequency, or capable of the same frequency, and pass all security related traffic over that frequency.

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[104] Pier 1 Entry Control Point sentry , Witness Interview – Appendix C7; Force Protection Officer USS MAHAN, Witness Interview – Appendix C25; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Command Master-at-Arms USS MAHAN, Witness Interview – Appendix C21.

[105] Naval Station Norfolk Waterside Security Leading Chief Petty Officer, Witness Interview – Appendix C6.

[106] Pier 1 Entry Control Point sentry , Witness Interview – Appendix C7; Command Master-at-Arms USS MAHAN, Witness Interview – Appendix C21; Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.

4.5 USS MAHAN Force ProtectionOversight

Prior to the incident, Commodore, Destroyer Squadron TWO and his Force Protection Officer (Immediate Superior in Command for USS MAHAN) had been engaged in monitoring and mentoring the ship's leadership, and the chain of command was engaged and involved in preparations for their upcoming Force Protection recertification. The leadership aboard USS MAHAN was also properly monitoring and ensuring its Force Protection program was on track.[107]

A USS MAHAN Force Protection drill and training schedule for each inport duty section was published and tracked.[108] An Allowance Equipment List inventory was conducted and noted some shortfalls beyond what was required the night of the incident. All significant shortfalls are on order, identified in the ship's eight o'clock reports, and known by the Commanding Officer.[109]

4.6 Incident Assessment

This sub-section provides the Investigative Team's assessment of USS MAHAN's shipboard Force Protection policies and procedures as implemented on the date of the incident.

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[107] Executive Officer, USS MAHAN, Witness Interview – Appendix C22; Force Protection Officer USS MAHAN, Witness Interview – Appendix C25; Commander, Destroyer Squadron TWO, Witness Interview – Appendix C24.
[108] Force Protection Officer USS MAHAN, Witness Interview – Appendix C25; Weapons Officer USS MAHAN, Witness Interview – Appendix C23; Allowance Equipment List Inventory Sheet – Appendix G19; Commanding Officer, USS MAHAN, Witness Interview – Appendix C20.
[109] Force Protection Officer USS MAHAN, Witness Interview – Appendix C25; Commander, Destroyer Squadron TWO, Witness Interview – Appendix C24; Allowance Equipment List Inventory Sheet – Appendix G19.

- The USS MAHAN watchstanders did not perceive the actions of Mr. Savage on the pier as a threat. The assessment by the watch team was that Mr. Savage was an intoxicated mariner or civilian worker.[110] It was reasonable for the watch team to assess him as such since Mr. Savage was apparently allowed to be on the Naval Station since he was allowed in the main entry gate (Gate 5).

- Mr. Savage was acting erratically, but this was perceived by the watch team to either be a result of intoxication, talking on the phone with his hands,[111] or dancing to music.[112] All of these determinations contribute to or explain why Mr. Savage did not respond to verbal attempts to get his attention. Additionally, Mr. Savage simply appeared to be looking for something on the pier.[113]

- The Pier 1 Entry Control Point sentry notified the USS MAHAN quarterdeck of Mr. Savage's action on her ship's radio, the only radio she had.[114] The radio communicated only with USS MAHAN.[115] The other ships on Pier 1,

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[110] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.
[111] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Pier 1 Entry Control Point sentry , Witness Interview – Appendix C7.
[112] Topside Rover USS MAHAN, Witness Interview – Appendix C26.
[113] Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Topside Rover USS MAHAN, Witness Interview – Appendix C26.
[114] Pier 1 Entry Control Point sentry , Witness Interview – Appendix C7; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Command Master-at-Arms USS MAHAN, Witness Interview – Appendix C21.
[115] Pier 1 Entry Control Point sentry , Witness Interview – Appendix C7; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Command Master-at-Arms USS MAHAN, Witness Interview – Appendix C21.

other ships on other piers, the Chief of the Guard, Naval Station Norfolk Waterfront Security Operations Center, and Naval Station Norfolk police dispatch were unaware of an unidentified individual that penetrated Pier 1 while USS MAHAN watchstanders were trying to assess whether Mr. Savage was a threat.[116]

- At no point prior to the incident did USS MAHAN quarterdeck watchstanders call a Force Protection or Security Alert.[117] USS MAHAN quarterdeck Petty Officer of the Watch called a Security Alert after shots were fired on USS MAHAN.[118] Mr. Savage was determined to be a threat only when he made his first overt action to obtain the Petty Officer of the Watch's sidearm.[119] Since Mr. Savage was not determined by the watchstanders to be a threat until he attempted to gain control of the Petty Officer of the Watch's weapon, a Force Protection Alert was not deemed necessary by the quarterdeck watch team.[120]

- Although Mr. Savage failed to show identification and failed to turn and leave the ship as requested by the watchstanders, he stated that he just wanted to talk and that the watchstanders should just relax or words to

[116] Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1.
[117] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Duty Armorer USS MAHAN, Witness Interview – Appendix C27.
[118] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Duty Armorer USS MAHAN, Witness Interview – Appendix C27.
[119] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18; Topside Rover USS MAHAN, Witness Interview – Appendix C26.
[120] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.

that effect.[121] Subsequently, he overpowered the Petty Officer of the Watch, disarmed her, and started firing.[122]

- The quarterdeck watch team appropriately applied the use of force continuum. Presence was established on the brow by the Officer of the Deck.[123] Once Mr. Savage continued up the brow, the Officer of the Deck decided that physical engagement on the brow (hard and soft controls) was an excessive risk because there was a strong possibility one or both individuals would end up over the side and into the water.[124] Use of non-lethal measures on the brow was also likely to result in a man overboard.[125] Based upon the Petty Officer of the Watch's observations of Mr. Savage and the physical constraints of the brow and quarterdeck, she determined that non-lethal weapons would not be effective.

- As a result, the Petty Officer of the Watch drew her weapon and pointed it at the deck beside her with the safety on to show presence and to indicate that Mr. Savage should take the situation seriously.[126] The deadly

[121] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1.
[122] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.
[123] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.
[124] Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.
[125] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.
[126] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.

forcetriangle was not met until Mr. Savage reached for the Petty Officer of the Watch's weapon.[127]

- The USS MAHAN Petty Officer of the Watch was the only armed watchstander on the quarterdeck.[128] Had the Officer of the Deck also been armed, with lethal and/or non-lethal capabilities, he may have been able to assist the Petty Officer of the Watch during the brief struggle over control of the weapon. The Investigation Team recommends arming both members of U.S. Navy ship quarterdeck watch team.

- The Petty Officer of the Watch's sidearm was not secured with a lanyard as required by SURFLANT/PAC instruction 3301.1A.[129] Lanyards shall be utilized to secure all pistols to prevent loss during Antiterrorism or visit, board, search and seizure duties.[130] A lanyard is a cord attached to a sidearm intended to maintain contact with the weapon,[131] and lanyards prevent the loss of a firearm if dropped. Afloat Training Group subject matter experts stated that sidearms are tethered to prevent loss of the weapon over the side of a ship during transitions from ship-to-shore or ship-to-ship.It is unclear if and how the situation would have changed if the USS MAHAN's Petty Officer of the Watch's sidearm had been tethered, but

[127] Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1; Navy Tactics, Techniques, and Procedures, 3-07.2.1, Section 7.2.2 – Appendix D13.
[128] Officer of the Deck USS MAHAN, Witness Interview – Appendix C18.
[129] Commander Naval Surface Forces Pacific/Commander Naval Surface Forces Atlantic 3300.1A (4)(c) – Appendix D14; Petty Officer of the Watch, USS MAHAN, Witness Interview – Appendix C1.
[130] Commander Naval Surface Forces Pacific/Commander Naval Surface Forces Atlantic 3300.1A (4)(c) – Appendix D14; Navy Technical Requirements Publication 3-07.2.2, Section 2.1.4 – Appendix D15.
[131] Commander Naval Surface Forces Pacific/Commander Naval Surface Forces Atlantic 3300.1A (4)(c) – Appendix D14; Navy Technical Requirements Publication 3-07.2.2, Section 2.1.4 – Appendix D15.

it would not have likely prevented Mr. Savage from being able to gain control of the weapon and fire it.

- The first notification to the Waterfront Security Operations Center of an incident that evening was the radio call from the quarterdeck of the USS MAHAN stating that an unidentified individual was on Pier 1.[132] There was a significant time delay between the Pier 1 Entry Control Point sentry 's radio call to the USS MAHAN quarterdeck watchstander and their follow-on radio call to the Waterfront Security Operations Center. This delay was caused by the USS MAHAN watchstanders obtaining a visual on Mr. Savage, watching his actions to assess his intent, attempting to communicate with him to stop and produce identification, observing Mr. Savage attempt to open some storage lockers, and the Officer of the Deck calling the Command Duty Officer in his stateroom to confirm his intent to notify the Waterfront Security Operations Center.

- The next radio communication to the Waterfront Security Operations Center was the post-incident "shots fired" radio call from USS MAHAN. The Waterfront Security Operations Center operator was not able to communicate with the Norfolk Naval Station Security Department Watch Commander via landline because the line was busy.[133] Therefore, a runner from the Waterfront Security Operations Center was sent to the Security

[132]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5; Naval Station Norfolk Waterside Alpha Section Leader, Witness Interview – Appendix C5.
[133]Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.

Department police precinct to provide notification of "shots fired" and initiate appropriate response efforts.[134]

4.7 Findings

The following investigative findings are provided:

- USS MAHAN and its Immediate Superior In Command (Commander, Destroyer Squadron TWO) understood their responsibilities to protect USS MAHAN.[135]

- On the day of the incident, USS MAHAN was adequately equipped, trained, and manned for its shipboard and pier Entry Control Pointsentry purposes.

- USS MAHAN had an effective Force Protection plan. Though this incident sadly resulted in the loss of life, unauthorized access to the interior of the ship was not achieved. Actions of the watch team on the quarterdeck and topside rover, along with actions of the Chief of the Guard and Chief of the Guard (Under Instruction) prevented a shipboard security breech.

- There are no USS MAHAN shipboard standard pre-planned responses addressing unidentified person or persons (e.g., an individual that has not shown identification), on a homeport pier or ship brow and quarterdeck

[134] Naval Station Waterside Alpha Section Leader, Witness Interview – Appendix C5.
[135] Commander, Destroyer Squadron TWO, Witness Interview – Appendix C24; Force Protection Officer, Destroyer Squadron TWO, Witness Interview – Appendix C28.

otherwise not manifesting a threat to protected personnel or assets.USS MAHAN Instructions implypier penetration procedures require the unidentified person to present a threat.

- USS MAHAN watchstanders did not execute the pre-planned response for a reported pier penetration because the watchstanders did not believe Mr. Savage to be a threat until he demonstrated a hostile act by attempting to disarm the Petty Officer of the Watch.[136]

4.8 Recommendations

The Investigation Team's recommendations for improving shipboard and ship-provided pier Entry Control Point Force Protection are as follows:

1) Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet should consider adding a requirement for quarterdeck personnel other than the Petty Officer of the Watch to be properly equipped with non-lethal and/or lethal capabilities sufficient to prevent unauthorized ship incursions. Had the Officer of the Deck also been armed, he may have had the capabilities to apply non-lethal force to prevent Mr. Savage's entry onto USS MAHAN's quarterdeck and the capabilities to apply additional non-lethal or lethal force, if required, to prevent Mr. Savage's acquisition of the Petty Officer of the Watch's weapon.

[136] USS MAHAN Instruction 5530.1G, encl. 13 (Pier Penetration) – Appendix D16.

2) Commander, U.S. Fleet Forces Command, and Commander, U.S. Pacific Fleet should consider the feasibility of purchasing and implementing locking barrier gate mechanisms for standard U.S. Navy brows.

3) Commander, U.S. Fleet Forces Command should consider improving shipboard Pre-Planned Responses for lower-end security threats such as unidentified personnel confrontations.

4) Commander, U.S. Fleet Forces Command should consider the re-implementation of "Antiterrorism Officer" billets in ship Immediate Superior in Commands (e.g., Destroyer Squadrons, Amphibious Squadrons) to align with Commander, U.S. Pacific Fleet.

5) Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet should consider adding a requirement for all Naval Security Force watchstanders issued sidearms to be equipped with a lanyard. A lanyard is used to retain a weapon from falling overboard and not from being taken away from the watchstander; however, equipment standardization is appropriate.

5.0 Shipboard and Shore Installation Force Protection Integration

As described in Chapters 3 and 4, the efforts of the Naval Station Norfolk's Naval Security Force and the shipboard watchstanders compose a layered defense to preclude access to government facilities and navy ships.

5.1 Levels of Integration

There are at least three levels of integration that must be effectively maintained and trained to in order to ensure appropriate security and incident response.

The first level of integration is between the Naval Station and external security agencies (such as the Federal Bureau of Investigation or the Norfolk Police Department). The second level of integration is between the various elements that make up the Naval Station Norfolk's Security Department's Naval Security Force. The third level of integration is between the ships themselves and security forces from the Naval Station that are responsible for security on the pier. Additionally, ships supply trained sentries for the pier Entry Control Points who are under the authority of the Chief of the Guard.

5.2 Incident Assessment

- There is a lack of communications integration between the various elements of Naval Station Norfolk's Security Department's Naval Security

Force and the shipboard watchstanders. The Landside units communicate on a separate frequency from the Waterside security forces, ships, pier Entry Control Points and seaboard sentries. When an incident occurs on a pier, the Waterfront Security Operations Center would communicate with the Watch Commander via landline.

- Landside patrol units do not communicate directly with any personnel on the Waterside including ships berthed on board the Naval Station, the Waterfront Security Operations Center, pier Entry Control Points, or other Naval Security Force personnel assigned to the Waterside.

- Landside Naval Security Force police units dispatched to the piers are not required to communicate with pier sentries or ship watchstandersvia radio in all circumstances, even though their radios can be channelized to the Waterfront Security Operations Center/Waterside radio frequency.

- Pier Entry Control Point sentries are trained and qualified by their ship's Force Protectionteam, however, the training is not integrated with Naval Station Norfolk for specific pier requirements.

- On March 24, the first Landside Naval Security Force police units dispatched to Pier 1 post-incident were not able to communicate with the Pier 1 Entry Control Point sentry or ship's quarterdecks before their response arrival creating potential for a blue on blue or friendly fire incident.

5.3 Findings

- The integration between Naval Station security forces and the ships can be significantly improved. Integrated training is limited or non-existent between Naval Station security forces and ships at the watchstander level. Training and procedural compliance with the requirements to wear body armor is also required.

- Lack of communications integration and lack of standardization complicated the response to this incident and created the conditions for blue-on-blue or friendly fire incidents.

- There is no Pre-Planned Response to manage unidentified individuals on the pier.

- Entry Control Point physical and material discrepancies contributed to this incident, and therefore require multiple watchstanders to effectively control. Assigned Naval Security Force Master-at-Arms personnel may be better able to integrate the requirements of the post.

5.4 Recommendations

1) Although pier security is the responsibility of the Naval Station Norfolk, increased integration between ships and Naval Station personnel is recommended. Commanding Officer, Naval Station Norfolk and Commander,

Navy Region Mid-Atlantic, in concert with the Type Commander and the Afloat Training Group, should develop a Pre-Planned Response for an "unidentified and presumably unauthorized individual with unknown intentions on the pier and/or brow."

2) The Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk should consider funding and manning the pier Entry Control Points with active duty Master-at-Arms personnel to improve standardization and communications integration.

3) The Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk should develop and exercise an integrated Force Protection and Physical Security communications plan to eliminate incompatibility and the lack of integration between shore and ship personnel.

4) The Commander, U.S. Fleet Forces Command should retain the requirement for multiple pier Entry Control Point sentries at all times unless the pier Entry Control Point can be effectively operated and secured by a single sentry (such as a pier with turnstile access only).

5) All commanders should reinforce the requirement for all military and civilian Naval Security Force to have required equipment on them prior to Guardmount. An inspection of each watchstander should take place and individuals not wearing the proper equipment must not be allowed to take a post.

6) The Commanding Officer, Naval Station Norfolk should ensure the training of pier Entry Control Point sentries on available communications and duress equipment, and how to properly operate them. Additionally, Naval Station Norfolk should develop standardized pier procedures and training for pier Entry Control Point sentries.

7) The Commander, U.S. Fleet Forces Command, and Commander, Navy Installations Command should review the application of these investigation recommendations during the June 2014 Security Review of Naval Station Norfolk.

6.0 Summary of Recommendations

Recommendations for improving Force Protection and Physical Security policies and procedures as a result of this incident are detailed below by category as follows: Category A: Naval Station Norfolk and other U.S. Navy installations Force Protection and Physical Security; Category B: USS MAHAN and other U.S. Navy ships Force Protection; and Category C: U.S. Navy ships and shore installation Force Protection and Physical Security integration.

Category A: Naval Station Norfolk and other U.S. Navy installations Force Protection and Physical Security

1) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should address the lack of seniority of the Naval Station Norfolk Security Officer. Although billeted and funded as a Lieutenant Commander (O-4), the billet is filled by a Lieutenant (O-3) who had no U.S. Navy installation facility experience prior to assuming duties at Naval Station Norfolk. The Investigation Team also recommends a minimum of a Commander (O-5) with at least one previous shore facility security tour be immediately assigned as Naval Station Norfolk's Force Protection Officer immediately superior to the Naval Station Norfolk Security Officer.

2) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should immediately address the lack of mid-level Naval Station

Norfolk Security Department civilian supervision and re-assess the validity of the Mission Profile Validation - Protection. The Naval Station Norfolk Precinct Commander civilian Lieutenant Colonel billet was vacant for a period of up to six months in 2013 due to alleged medical leave and it became permanently vacant two weeks after the incident following the individual's early retirement. This position should be filled immediately. Additionally, the Naval Station Norfolk Security Department's third-in-command civilian Major billet, although authorized and funded, has been unfilled for over a year but should be filled immediately. Appreciating hiring freezes and the effects of Sequestration in 2013, the lack of mid-level management contributed to a lack of supervision for the Naval Station Norfolk Security Department's police force.

3) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should immediately address the lack of procedural compliance, accountability, and oversight of the civilian police force by targeted infusion of motivated mid-level personnel and proper oversight by both civilian and military supervisors.

4) The Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic should address the lack of integration between Naval Station Norfolk's civilian police force, active duty Master-at-Arms, and Auxiliary Security Force personnel.

5) The Commanding Officer, Naval Station Norfolk, should address the lack of seniority within Naval Station Norfolk's Waterfront Security Operations Center.

The senior person assigned to the evening watches is a Petty Officer Second Class which is inconsistent with the level of responsibility and the number of Officers and Chief Petty Officers available.

6) The Commanding Officer, Naval Station Norfolk, should address the lack of seniority of personnel assigned to Chief of the Guard duties in accordance with the NAVSTA OPORD AT-3300 (Change 3) which directs a First Class Petty Officer and preferably a Chief Petty Officer.

7) The Commander, Navy Installations Command should consider increasing the pay grades of the Department of the Navy police forces. The GS-3s and GS-5s hired by the Navy are one pay grade lower than those hired by other military Services and this may contribute to the lack of capability and professionalism.

8) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should improve the training and professionalism of naval installation Department of the Navy police forces. For example, the Naval Station Norfolk night watchstanders never stand watch in the daytime and thus do not receive the same level of oversight and training as other watch shifts. Creating a watch rotation that rolls through the 24hour clock would enhance supervision, training, and professionalism.

9) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should validate the availability of required Force Protection and Law Enforcement equipment such as

vests, communications, and weapons for the watchstanders. Missing equipment, ill-fitted equipment (particularly for female watchstanders), and incompatible equipment contributed to a lax environment where watchstanders chose not to wear or use their equipment greatly increasing risk.

10) The Commanding Officer, Naval Station Norfolk; Commander, Navy Region Mid-Atlantic; and Commander, Navy Installations Command should immediately repair broken Naval Station Norfolk equipment and fixtures such as cameras, turnstiles, access control gates, and duress buttons. As an example, half of Naval Station Norfolk's pier cameras and pier Entry Control Point duress buttons were inoperable on the day of the incident. Additionally, consideration should be given to improving Physical Security at pier Entry Control Points to include gates and turnstiles or creating a waterfront enclave.

11) The Commander, Navy Region Mid-Atlantic Inspector General should investigate the conduct of the Naval Station Norfolk Security Department Deputy Commander senior civilian for possible time and attendance violations for not coming to work for several months and the fact he only re-appeared when Commanding Officer, Naval Station Norfolk personally intervened. His absence contributed to the lack of supervision and laxity of standards by the Naval Station Norfolk police force.

12) Although the Transportation Worker Identification Credential was not used to access the Naval Station Norfolk, Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station

Norfolk should retain the new policy of banning access to holders of a Transportation Workers Identification Credential who have a conviction in the last ten years, or a misdemeanor within the last five years for crimes of violence; larceny, drugs; habitual offenders; and convictions for sex offenses. Additionally, Directive Type Memo (DTM) 09-12 directs Department of Defense entities to honor the Transportation Worker Identification Credential; the Department of Defense should therefore engage the Department of Homeland Security to ensure Transportation Worker Identification Credential holders are vetted to the same standard.

13) Commanding Officer, Naval Station Norfolk should review, sign, and update Operation Order and Post Orders to include the development of a Standard Operating Procedure for securing all gates when required.

14) Commanding Officer, Naval Station Norfolk should institute standardized Personnel Qualification Standards or Job Qualification Requirements for Department of Navy police officers. Additionally, level of knowledge training at Guardmount and during supervisor oversight should be required and properly documented.

15) The Memorandum of Understanding (MOU) with local authorities is dated and should be updated with current guidance.

Category B: USS MAHAN and other U.S. Navy ships Force Protection

1) Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet should consider adding a requirement for quarterdeck personnel other than the Petty Officer of the Watch to be properly equipped with non-lethal and/or lethal capabilities sufficient to prevent unauthorized ship incursions. Had the Officer of the Deck also been armed, he may have had the capabilities to apply non-lethal force to prevent Mr. Savage's entry onto USS MAHAN's quarterdeck and the capabilities to apply additional non-lethal or lethal force, if required, to prevent Mr. Savage's acquisition of the Petty Officer of the Watch's weapon.

2) Commander, U.S. Fleet Forces Command, and Commander, U.S. Pacific Fleet should consider the feasibility of purchasing and implementing locking barrier gate mechanisms for standard U.S. Navy brows.

3) Commander, U.S. Fleet Forces Command should consider improving shipboard Pre-Planned Responses for lower-end security threats such as unidentified personnel confrontations.

4) Commander, U.S. Fleet Forces Command should consider the re-implementation of "Antiterrorism Officer" billets in ship Immediate Superior in Commands (e.g., Destroyer Squadrons, Amphibious Squadrons) to align with Commander, U.S. Pacific Fleet.

5) Commander, U.S. Fleet Forces Command and Commander, U.S. Pacific Fleet should consider adding a requirement for all Naval Security Force watchstanders issued sidearms to be equipped with a lanyard. A lanyard is used to retain a weapon from falling overboard and not from being taken away from the watchstander, however, equipment standardization is appropriate.

Category C: U.S. Navy ships and shore installation Force Protection and Physical Security integration

1) Although pier security is the responsibility of the Naval Station Norfolk, increased integration between ships and Naval Station personnel is recommended. Commanding Officer, Naval Station Norfolk and Commander, Navy Region Mid-Atlantic, in concert with the Type Commander and the Afloat Training Group, should develop a Pre-Planned Response for an "unidentified and presumably unauthorized individual with unknown intentions on the pier and/or brow."

2) The Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk should consider funding and manning the pier Entry Control Points with active duty Master-at-Arms personnel to improve standardization and communications integration.

3) The Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk should develop and exercise an integrated Force Protection and Physical Security communications

plan to eliminate incompatibility and the lack of integration between shore and ship personnel.

4) The Commander, U.S. Fleet Forces Command should retain the requirement for multiple pier Entry Control Point sentries at all times unless the pier Entry Control Point can be effectively operated and secured by a single sentry (such as a pier with turnstile access only).

5) All commanders should reinforce the requirement for all military and civilian Naval Security Force to have required equipment on them prior to Guardmount. An inspection of each watchstander should take place and individuals not wearing the proper equipment must not be allowed to take a post.

6) The Commanding Officer, Naval Station Norfolk should ensure the training of pier Entry Control Point sentries on available communications and duress equipment, and how to properly operate them. Additionally, Naval Station Norfolk should develop standardized pier procedures and training for pier Entry Control Point sentries.

7) The Commander, U.S. Fleet Forces Command, and Commander, Navy Installations Command should review the application of these investigation recommendations during the June 2014 Security Review of Naval Station Norfolk.

PRIVACY ACT SENSITIVE

7.0 Fault, Neglect, Responsibility, and Accountability

This report concludes that several applicable Force Protection, Physical Security, and Law Enforcement policy and procedural requirements were not fully complied with on the night of the incident. In addition to these deficiencies, the Investigating Officer also concluded that several personnel responsible for other acts or omissions that either directly or indirectly contributed to the incident should be held accountable as well.

To analyze individual fault, neglect and responsibility, the Investigating Officer applied the legal concepts of intentional acts, strict liability, and the degrees of negligence. An "intentional act" means the person had the mental state to consciously desire the physical result(s) of his or her act(s) or omission(s). In other words, the individual knowingly and intentionally intended to violate a given law, regulation, policy, or procedure regardless of its likely result(s).

"Strict liability" is the assignment of liability for the physical result(s) for wrongful acts or omissions by any person regardless of the individual's intent or mental state. In the naval service this standard is usually reserved for the absolute responsibility and accountability of Commanding Officers for the acts and omissions of their subordinates.

"Negligence" is defined as the failure of a person to exercise reasonable care normally expected under the circumstances resulting in an unintended harm. Negligent conduct may consist of either an act, or an omission to act when there is a duty to do so (e.g., applicable regulatory, policy or procedural requirements). The primary factors considered in ascertaining negligence are the existence of a duty or obligation to exercise reasonable care; that is, a failure to exercise the level of care someone of ordinary prudence would have exercised under similar circumstances, and harm resulting as a proximate cause of the negligent conduct.

"Gross negligence," an extreme and therefore more culpable form of negligence, is generally defined as acting consciously in disregard of or with a reckless indifference to the likely and reasonably foreseeable harmful consequences.

The following provides the Investigating Officer's determination of individual fault, neglect and responsibility as well as recommended accountability corrective actions:

The Investigation Team reviewed the requirements and actions the Commanding Officer, Executive Officer, Antiterrorism Tactical Watch Officer, Pier 1 Entry Control Point sentry (under the authority of the Chief of the Guard but provided

by the ship), the Command Duty Officer, quarterdeck watchstanders (Officer of the Deck, Petty Officer of the Watch), and Topside Rover.

Much has been made of the decision by the quarterdeck watchstanders to not sound either a Security or Force Protection Alert, however, the actions of Mr. Savage were not deemed threatening until he inexplicably wrestled for the Petty Officer of the Watch's weapon. Additionally, the quarterdeck watch made a conscious escalation of the continuum of force with the Officer of the Deck applying visible presence on the brow followed by a decision to show Mr. Savage that the quarterdeck was armed and ready to escalate if necessary. An interim course of action such as non-lethal application of pepperspray or baton may have been more appropriate, but was consciously avoided due to the failure of Mr. Savage to comply with verbal directions, the confines of the quarterdeck with fear of a man overboard, and the lack of additional security personnel beyond those on the quarterdeck.

Accordingly, it is the opinion of the Investigation Team that given the lack of threat exhibited by Mr. Savage, a high amount ofcivilian traffic on the pier that evening, and the natural assumption that Mr. Savage must have been authorized to be on base if he entered the main gates, the policies and actions of the shipboard personnel were appropriate.

PRIVACY SENSITIVE

Naval Station Norfolk Personnel

The actions of the Naval Station Norfolk Gate 5 police officers were negligent and indicative of significant gaps in supervision and the enforcement of standards as outlined in the investigation report and the list of recommendations.

(b)(5), (b)(7)(C) b)(6) (b)(5), (b)(7)(C) (b)(5), (b)(7)(C) Although properly trained and aware of his duties and required actions, (b)(6) (b)(5), (b)(7)(C) he failed to properly demand identification of Mr. Savage, failed to execute vehicle turnaround procedures, failed to notify either Security Dispatch or the Waterfront Security Operations Center that Mr. Savage did not execute a U-turn as expected, and failed to pursue Mr. Savage in a timely manner.

(b)(5), (b)(7)(C) (b)(6) (b)(6) b)(5), (b)(7)(C) (b)(5), (b)(7)(C) Although aware of the vehicle failing to execute a U-turn and the lack of procedural compliance by (b)(6) he too failed to follow procedures and take reasonable and expected actions when he had full knowledge of the potential ramifications of an unidentified individual on the installation. (b)(5), (b)(7)(C) (b)(5), (b)(7)(C) (b)(6) (b)(5), (b)(7)(C) (b)(5), (b)(7)(C)

PRIVACY SENSITIVE

Since a major finding of this investigation is the lack of supervisory oversight of the Gate 5 police officers, the Investigating Officer recommends appropriate administrative disciplinary actions against (b)(6), (b)(6) (b)(6) and (b)(6)

Naval Station Norfolk Leadership

(b)(5), (b)(7)(C)

(b)(5), (b)(7)(C) (b)(6)

(b)(5), (b)(7)(C)

(b)(5), (b)(7)(C) (b)(6) (b)(5), (b)(7)(C)

(b)(5), (b)(7)(C)

8.0 Conclusions

Ultimately, the success of a Force Protection plan is based upon success to deter attempts to threaten the Force, or success in thwarting an attack if it comes. In the case of the incident with Mr. Savage on March 24, 2014, there were significant failures, however, the layered defense worked and precluded more serious access to USS MAHAN beyond the quarterdeck. In spite of the tragic loss of life, the Naval Station forces and those of USS MAHAN were able to stop the threat once known.

In spite of the success demonstrated in precluding Mr. Savage's access to USS MAHAN beyond the quarterdeck, the incident illuminated a number of errors and discrepancies that require remedy. This report outlined the findings from the incident as viewed through the lens of the Naval Station, the ship, and from a perspective that examines the integrated capabilities of all the required forces. Many of the discrepancies are pervasive and disturbing.

The individual failures that cascaded into other errors are probably the most egregious. The failures of mid-level leadership to provide appropriate supervision also contributed to this incident. For example, senior personnel have developed watch routines that place only junior personnel on watch at night coupled with watch models that limit training and direct supervision. This problem was exacerbated by a significant decline in funding and manning in order to decrease costs while absorbing risk. Those bearing the risk, however, are not aligned with

those controlling funding or manning, and it is the opinion of the Investigating Officer that this balance between risk and funding limitations must be constantly reviewed and should be addressed by Navy leadership as part of the upcoming review of Naval Station Norfolk security in June 2014.

Finally, the individual failures of key individuals were matched by the heroism of a Petty Officer of the Watch who was prepared to engage a gunman with only a baton after numerous shots were already fired, or that of a selfless Master-at-Arms who gave his life shielding that same Petty Officer of the Watch and the crew of the USS MAHAN.

We must learn from any errors of that night of March 24, to reduce the risk of such an event happening again, and to honor the memory of the brave Sailor who gave the last full measure of devotion.

Tab A: U.S. Navy Force Protection and Physical Security

General

The U.S. Navy Force Protection of property, information, or people is accomplished by a system of layered defenses and response capabilities meant to address both external and internal threats. The system of defenses addresses threats by preventing unauthorized personnel from gaining access to protected assets and by screening and monitoring authorized personnel to ensure they can be trusted to have access to protected assets. Response capabilities act to contain and eliminate active threats and mitigate damage, should the defenses fail.

Physical Security systems are designed to deter, detect, and deny unauthorized personnel and material (e.g., weapons) from accessing protected assets.Physical Security systems are made up of physical barriers (e.g., fences and guards), operational measures (e.g., Antiterrorism measures) and administrative measures (e.g., escort policies, access badges). These measures are intended to work together to prevent unauthorized access.

Installation Force Protection, Physical Security, and Law Enforcement

U.S. Navy Force Protection mission is accomplished by employing the integrated implementation of programs such as Antiterrorism, Physical Security,Law

Enforcement, and access control. This subsection provides a general overview of Force Protection, Physical Security, and Law Enforcement regulatory policies and procedures applicable to U.S. Navy installations.

Installation Regulatory Force Protection Requirements and Responsibilities

The regulatory basis for Antiterrorism programs is found in Department of Defense Instruction2000.12 (DoD Antiterrorism Program), andDepartment of Defense Instruction 2000.16 (DoD Antiterrorism Standards), both of which are implemented in Secretary of the Navy Instruction (SECNAVINST) 3300.2B (Department of the Navy Antiterrorism Program); Chief of Naval Operations Instruction (OPNAVINST) F3300.53C; Navy Antiterrorism Program; Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.1, Antiterrorism; and U.S. Fleet Forces Command AntiterrorismOperation Order 3300-11 (Commander, U.S. Fleet Forces Command Antiterrorism Operation Order). The Department of Defense and Department of the Navy instructions prescribe minimum program elements and require commands to establish an Antiterrorism program tailored to the local mission, conditions, and terrorist threats.

The basis for access control on Department of Defense installations is Homeland Security Presidential Directive 12 and Department of Defense Directive-Type Memorandum 09-012 (Interim Policy Guidance for DoD Physical Access Control), which implements the requirements of Homeland Security Presidential Directive 12. Commander, Navy Installations Command Instruction 5530.14A (Ashore

Protection Program) implements Department of Defense access control requirements and promulgates access control standards for all Navy installations.

Commander, Navy Installations Command; Commander, Navy Region Mid-Atlantic; and Commanding Officer, Naval Station Norfolk have established local access control requirements in Commander, Navy Installations Command Instruction (CNICINST) 5530.14A, Commander, Navy Region Mid-Atlantic Instruction 5530.14, and Naval Station Norfolk Operation Order AT-3300.

Fundamentals of Installation Force Protection

OPNAVINST F3300.53C (Navy Antiterrorism Program) defines Antiterrorism as defensive measures, including limited response and containment by local military and civilian forces, used to reduce the vulnerability of individuals and property to terrorist acts. Antiterrorism is a defensive component of Force Protection that stresses deterrence of terrorist incidents through preventive measures common to all combatant commands and services. The five goals of Antiterrorism are to (1) deter, (2) detect, (3) defend against, (4) mitigate, and (5) recover.

Under NTTP 3-07.2.1 (Navy Antiterrorism Program; Navy Tactics, Techniques, and Procedures), the elements of an Antiterrorism program include the following: (1) risk management, (2) planning, (3) training and exercises, (4) resource application, and (5) comprehensive program review. An explanation of these elements follows.

Risk Management: Antiterrorism risk management processes are designed to identify, assess, and control risks arising from terrorist activities; and to assist in planning and conducting the Force Protection mission. The risk management process should be embedded into all operations and identified in respective protection plans.

Planning: The planning process provides the commander or Commanding Officer with a means to sequentially organize, plan, and execute operational activities. An integral element of an installation's Antiterrorism plan is the implementation of Random AntiterrorismMeasures. Random AntiterrorismMeasures are the random implementation of higher Force Protection Condition security measures and other Physical Security measures which present a robust security posture from which a terrorist cannot easily discern patterns and routines. The Random Antiterrorism Measureprogram serves to deter, detect, and disrupt potential terrorist attacks.

Training and Exercises: Antiterrorism training includes formal schoolhouse training, drills and exercises, and internet-based individual training with the aim to develop the tactical capabilities to successfully execute the Antiterrorism mission. The Antiterrorism training and exercise programs serve to train and assess the command's ability to execute the Antiterrorism mission.

Resource Application: Resource application is the process of identifying and submitting requirements through existing planning, programming, budgeting, and

execution processes to ensure sufficient funding for Antiterrorism program elements.

Program Review: Antiterrorism vulnerability assessments provide a vulnerability based analysis of a command's Antiterrorism program. The assessment validates the command's Antiterrorism plans, identifies vulnerabilities that may be exploited, and suggests options that may eliminate or mitigate those vulnerabilities.

Installation Regulatory Physical Security and Law Enforcement Requirements and Responsibilities

The regulatory basis for Physical Security and Law Enforcement on Department of Defense installations is found in 18 U.S. Code § 930; DoDI 5200.08 (Security ofDepartment of Defense Installations and Resources, Department of Defense Physical Security Review Board; and Department of Defense Instruction 5200.08R (Physical Security Program).

OPNAVINST 5530.14E (Navy Physical Security and Law Enforcement Programs) implements Department of Defense Physical Security and Law Enforcement policy, and requires installation Commanding Officers to establish and maintain a Navy Security Program that implements requirements from the higher headquarters.

SECNAVINST 5500.29C (Use of Deadly Force and the Carrying of Firearms by Personnel of the Department of the Navy in Conjunction with Law Enforcement, Security Duties and Personal Protection) implements Department of Defense Directive (DoDD) 5210.56 (Use of Deadly Force and the Carrying of Firearms by DoD Personnel Engaged in Law Enforcement and Security Duties) and establishes the policy for the carrying of firearms and the use of deadly force. CNICINST 5530.14A (CNIC Ashore Protection Program) implements the OPNAV Physical Security and Law Enforcement requirements for all Navy installations. USFF AT OPORD 3300-13 (Commander, U.S Fleet Forces Command Antiterrorism Operations Order) provides reporting requirements.

Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.3 (Law Enforcement and Physical Security) provides Department of Navy tactics, techniques, and procedures governing the conduct of Physical Security and Law Enforcement. OPNAVINST 3591.1F (Small Arms Training and Qualification) provides firearms training requirements.

Unified Facilities Criteria (UFC) provide Department of Defense requirements for planning, design, construction, sustainment, restoration, and modernization criteria pertaining to physical structures on Naval installations. UFC 4-022-01 (Security Engineering: Entry Control Facilities/Access Control Points) and UFC 4-022-03 (Security Engineering: Fences, Gates, and Guard Facilities) are applicable to Physical Security standards.

Fundamentals of Installation Physical Security and Law Enforcement

Physical Security and Law Enforcement programs safeguard personnel, property, and material by enforcing rules, regulations, and law at Navy installations and activities. OPNAVINST 5530.14E defines and describes key elements of these programs below.

Physical Security

Physical Security measures protect personnel; prevent unauthorized access to installations and assets; and safeguard against espionage, sabotage, damage, and theft by means of physical measures. Physical Security plans include elements of Physical Security, Antiterrorism, and Law Enforcement as part of an integrated system. Navy Tactics, Techniques, and Procedures are used in Physical Security plans and in development of security procedures.

Physical Security Surveys, Inspections, and Assessments: Each command's review and assessment program includes Physical Security surveys, inspections, and assessments. These products are used to guide Commanders in determining what assets require protection, what security measures are in effect, and where improvement is needed. They also guide Commanders in setting security priorities.

Mission Profile Validation–Protection: The Mission Profile Validation–Protection is the U.S. Navy's tool for determining manpower requirements of the Naval Security Force, and is managed by Commander, Navy Installations Command. The Mission Profile Validation–Protection is based on actual observation of operations and validates security force manpower requirements based on the installation's size, number of access gates, physical configuration, and assets to be protected. The total number of Naval Security Force personnel required at a given installation is that which is required to man all validated posts and all additional support personnel such as trainers, administrators, and armory personnel.
Law Enforcement Procedures: U.S. Navy Law Enforcement personnel conduct operations using three types of procedures: (1) Post Orders that provide guidance for standing a given post or watch; (2) Standard Operating Procedures that establish how routine operations are conducted; and (3) Pre-Planned Responses that provide security force members detailed procedures for response to emergency situations.

Restricted Areas: Restricted areas are designated by installation commanding officers to protect mission critical or sensitive assets; security interests; classified material; and conventional arms, ammunition, and explosives. Restricted areas have specific physical boundaries, entry control requirements, visitor controls, and security clearance requirements.

Fundamentals of Installation Access Control

The objective of installation access control is to restrict and control entrance to installations only to authorized individuals. These objectives are accomplished by ensuring all unescorted persons entering Department of Defense installations have a valid purpose to enter and their identity is vetted and verified.

Personnel with Common Access Cards: Military, civilian, and contractors possessing Department of Defense-issued Common Access Cards have their identity verified at the card issuance site and vetted according to applicable Department of Defense personnel security standards. As such, military, civilian, and contractors possessing a Common Access Card can properly gain access to installations via either an electronic physical access control system or through a manned security post.

Personnel without Common Access Cards: Visitors who do not possess a valid Common Access Card have their identity verified and vetted at the installation's designated Pass Office prior to being issued an unescorted installation pass. Visitors must provide an authorized form of identification. Their need for access is validated by Pass Office personnel, who also control visitors by using an authorized data source (The National Crime Information Center database) to perform a requisite criminal background check.

Personnel with Navy Commercial Access Control System Cards: Contractors and vendors who do not possess a Department of Defense Common Access Card may participate in the Navy Commercial Access Control System to enable routine access for up to one year. Navy Commercial Access Control System participants have their identity verified by the Pass Office and are vetted by a Commander, Navy Installations Command authorized contractor (EID Passport) prior to being issued an Navy Commercial Access Control System identification card that can be scanned to verify access privileges at manned security posts.

Personnel with a Transportation Workers Identification Credential (TWIC): Individuals who regularly transport goods and cargo can apply for and receive a Transportation Workers Identification Credential. The Department of Homeland Security conducts a vetting of individuals who apply for this credential. Directive-Type Memorandum09-012 directs Department of Defense (including the Department of the Navy) to allow drivers who have a valid Transportation Workers Identification Credential to have access to Navy installations who have a reason to access the base. In 2011, the U.S. Navy further defined "a reason to access the installation" as a valid Bill of Lading or an order to pick up a cargo load. Transportation Workers Identification Credentials cannot be scanned by the U.S. Navy's currently implemented handheld scanners.

Personnel Debarment Process: Installation Commanding Officers can debar individuals and have their credentials confiscated as a result of inappropriate behavior. Installations use the U.S. Navy's Consolidated Law Enforcement

Operations Center database to document individuals who have been debarred from an installation. Prior to granting entry, installations use Consolidated Law Enforcement Operations Center to ensure personnel requesting installation entry have not been previously debarred.

Shipboard Force Protection

This subsection provides a general overview of Force Protection policies and procedures applicable to U.S. Navy ships.

Shipboard Regulatory Force Protection Requirements and Responsibilities

The regulatory foundation for Department of Defense Antiterrorism programs is found in Department of Defense Instruction 2000.12 (Antiterrorism Program), and DoDI 2000.16 (Antiterrorism Standards), both of which are implemented in SECNAVINST 3300.2B (Department of the Navy Antiterrorism Program); OPNAVINST F3300.53C (Navy Antiterrorism Program); Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.1, Antiterrorism); Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.2, Force Protection Weapons Handling Standard Procedures and Guidelines; Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.3, Law Enforcement and Physical Security; USFF-AT OPORD 3300-13 (Commander, U.S. Fleet Forces Command Antiterrorism Operations Order); and COMNAVSURFPAC/COMNAVSURFLANTINST 3300.1A (Antiterrorism Program). Department of Defense and Department of the Navy instructions prescribe

minimum program elements and require commands to establish an Antiterrorism program tailored to the local mission, conditions, and terrorism threats.

Fundamentals of Shipboard Force Protection

COMNAVSURFPAC/COMNAVSURFLANTINST 3300.1A defines roles and responsibilities of the Type Commander, Destroyer Squadrons, and afloat units. Type Commanders utilize the Afloat Training Group as their executive agent in its assessment of a ship's Force Protectionprogram for content and certification. Navy Tactics, Techniques, and Procedures (NTTP) 3-07.2.1, 3-07.2.2 and 3-07.2.3 provide tactics, techniques, and procedures at the shipboard level, to include models for the use of force continuum and deadly force triangle. Ships are required to develop an overarching Force Protection program that will "deter, detect, defend and mitigate and conduct consequence management" from terrorist and/or criminal incidents.

Although the Commanding Officer of a U.S. Navy ship is responsible for the security of their vessel regardless of locale, Commander, U.S. Fleet Forces Command exercises tactical control for Force Protection of all Navy personnel, resources, infrastructure, information, and equipment within the United States Northern Command area of responsibility. Thus, while in port in the Continental United States, each U.S. Navy ship must adhere to an inport security plan either promulgated or approved by U.S. Fleet Forces Command. Inport security plans are tailored by installation and type of ship, such that in the case of this incident, USS MAHAN was subject to the directed inport security plan for Naval Station

Norfolk for frigates, destroyers, cruisers, and amphibious ships. The inport security plan is designed to supplement ship and installation Force Protection and Antiterrorism plans and in no way relieves CommandingOfficers, ashore or afloat, of their responsibilities to defend their units. The inport security plan coordinates the efforts of the ships and installation Commanding Officers. Its purpose is to align the collective efforts of both afloat and shore forces to the Force Protection mission of ships berthed in Navy controlled ports.

The standard shipboard quarterdeck watchstanders are normally an Officer of the Deck and Petty Officer of the Watch. The Officer of the Deck is required to report to the Antiterrorism Tactical Watch Officer on all security matters. The Petty Officer of the Watch "shall assist the [Officer of the Deck] in controlling access to the ship and detecting unauthorized intrusions." Various watchstanders are required to be armed, and there are different qualification criteria for Navy personnel who are issued weapons. The Officer of the Deck, when required to be armed,is deemed Category I and is issued a sidearm primarily for self-defense. The Petty Officer of the Watch, Topside Rover, and Entry Control Point sentries are qualified as Category II and issued weapons for security of Department of Defenseassets.

In the security of Department of Defense assets and self-defense, personnel are trained and required to employ deadly force if required. Prior to employing deadly force, a shipboard watchstanders or assigned pier Entry Control Point sentries are trained to move through the "use of force continuum"consisting of (1) presence, (2) verbal, (3) restraining techniques (soft control), (4) compliance

techniques (hard control), (5) intermediate weapons (pepper spray and baton strikes), and (6) deadly force. Additionally, they must find that the situation meets the "Deadly Force Triangle" including (1) intent; (2) capability; and, (3) opportunityto justify the use of the use of force.

U.S. Navy ships also implement Force Protection and Security Alerts in response to Force Protection threats. A Force Protection Alertis initiated when a security threat is identified to exist outside the lifelines of the ship. This focuses the vigilance of watchstanders, alerts the ship's crew, and positions response teams for potential future required actions. A Security Alert is initiated when a security threat is determined to be aboard the ship. This action dispatches armed watchstanders to locate and secure the threat.

Shipboard Force Protection Manning, Training, and Equipment

This sub-section provides an overview of U.S. Navy-wide Force Protection manning, training, and equipment resourcing.

Shipboard Manning

The ship's Antiterrorism Officer and Master-at-Arms personnel are the primary duty Force Protection billets aboard U.S. Navy ships. Antiterrorism Officers are required to be a second-tour Division Officer or higher on all cruiser-destroyer and amphibious ships. They are required to be a graduate of the U.S. Navy's Antiterrorism Officer Level II course (J-830-0015). The Chief Master-at-Arms

/Independent Duty Master-at-Arms is a professional military active duty policeman and is required to be from the Master-at-Arms rating. The seniority of the position is determined by the ships' manning document. The Chief Master-at-Arms /Independent Duty Master-at-Arms is required to carry the 9501 Navy Enlisted Classification Code and be a graduate of the U.S. Navy's Antiterrorism Officer Level II course. All other ship security positions are filled by members of the crew on a watchbill rotation.

Shipboard Training

U.S. Navy ship Force Protection training is accomplished through formal schooling onboard and ashore as well as Personnel Qualification Standards, ship drills, and Afloat Training Group basic phase stages. Certification is conducted by Afloat Training Group and Commander, Strike Force Training Atlantic. Comprehensive Force Protection training is conducted during the Fleet Response Plan training cycle and is designed to prepare a ship for Force Protectionemploying its own Entry Control Point as it would in a non-U.S. Navy port. Ships are trained and certified to meet the Force Protection requirements set forth in the Ships Force Readiness Manual through the execution of Certification Exercises and Repetitive Exercises. Tracking and monitoring the ships completion of repetitive exercises is accomplished through the Training and Operational Readiness Information Services (TORIS). Integrated Force Protection/Antiterrorism training with the Naval Station Norfolk security structure is not currently required nor generally accomplished except for one or two ships that participate as part of an annual exercise.

Shipboard Equipment

Required shipboard Force Protection equipment is spelled out in the Allowance Equipment List. The equipment required for a specific watch station or watchstander is dependent on the situation, location and Force Protection condition. Additionally, measures may be taken to raise the arming level or manning level as directed by the Commanding Officer or higher authority.

ShipboardForce Protection Program Execution and Oversight

The execution of a ships' Force Protection program is ultimately the responsibility of the Commanding Officer. Type Commander oversight is provided by Afloat Training Group through the Fleet Response Training Plan. The basic phase provides initial certification in this warfare area. Individual ships are then required to maintain certification through established training and scenario based drills.

Oversight of the program, including certification continuity, is the responsibility of the ship's Immediate Superior In Command, who continues to assess Antiterrorism and Force Protection training for each of their respective assigned ships.

Tab B: Media Executive Summary

Incident Summary

At approximately 11:00 p.m. on March 24, 2014, Mr. Jeffrey Savage, an unauthorized civilian, breached Naval Station Norfolk's Gate 5, Naval Station Norfolk's Pier 1's Entry Control Point and USS MAHAN's (DDG 72) quarterdeck. Onboard USS MAHAN, Mr. Savage physically assaulted and disarmed a USS MAHAN quarterdeck watchstander and used that weapon to shoot and kill a Naval Station Norfolk Chief of the Guard before being shot and killed by a USS MAHAN watchstander and a Naval Station Norfolk security officer. In spite of the tragic loss of life, the Naval Station layered security was ultimately successful in preventing an outside threat from penetrating the interior of the ship.

Scope of Investigation

On March 25, 2014, Commander, U.S. Fleet Forces Command directed an investigation into the facts and circumstances related to the March 24, 2014 shooting incident, in order to determine fault, neglect, responsibility, and recommend administrative or disciplinary actions. Commander, U.S. Fleet Forces Command specifically directed an inquiry into all relevant aspects of Naval Station Norfolk and USS MAHANshipboard Force Protection policies and procedures, including, but not limited to, installation access; pier Entry Control Point access;

infrastructure; and security manpower, training, and equipment. Additionally, Commander, U.S. Fleet Forces Command directed a line of duty opinion and recommendation concerning the death of the Chief of the Guard. By letter approval dated April 16, 2014, Commander, U.S. Fleet Forces Command removed the line of duty requirement for the Chief of the Guard because Commander, Navy Region Mid-Atlantic was the appropriate determination authority. Commander, Navy Region Mid-Atlantic determined the Chief of the Guard's heroic death was incurred in the line of duty and not due to his own misconduct.

Methodology

This investigation attempted to answer several core questions all with an eye to preventing similar future incidents. These core questions are:

--What happened?
--Why did it happen?
--Was this the result of an insider threat?
--Was this a failure of layered defense?
--What potential gaps in security must be addressed?
--Have we learned from other similar security incidents?
--Who is accountable and should anyone be disciplined?
--What is the way ahead for the security of Naval Station Norfolk?

A summary of these core questions follows:

What happened?

Late in the evening of March 24, 2014, Mr. Savage, a civilian truck driver, drove his employer's semi-tractor cab onto Naval Station Norfolk via Gate 5. Since neither Mr. Savage nor his private employer had a legitimate reason to enter Naval Station Norfolk, Mr. Savage's intent or motive to attempt access remains unknown. Despite stopping at Naval Station Norfolk's Gate 5, a Department of the Navy civilian police officer sentry failed to determine Mr. Savage's intent or purpose for attempting access at Gate 5, and neither requested nor confirmed Mr. Savage's identification and authorization to enter the installation. Despite Mr. Savage having in his possession a valid Transportation Worker's Identification Credential (TWIC), it was not a factor in his entry onto Naval Station Norfolk because the Gate 5 civilian police officer never required Mr. Savage to produce any form of identification or authorization to enter the installation.

Believing Mr. Savage wanted to execute a U-turn and exit Gate 5, and failing to execute proper vehicle turnaround procedures, the Gate 5 civilian police officer allowed Mr. Savage to go through the gate onto the installation. Mr. Savage failed to execute the turnaround and continued to drive away from Gate 5. The Gate 5 civilian police officer failed to ensure Mr. Savage exited Gate 5, failed to deploy the hardened anti-access control system, and failed to pursue Mr. Savage in a timely manner, notify Naval Station Norfolk Security department dispatch, or

execute any Standard Operating Procedures required in response to an unauthorized individual on Naval Station Norfolk.

Mr. Savage drove his truck cab from Gate 5 to Pier 1 where he then walked through the pedestrian gate while the internal Pier 1 Entry Control Point sentry (supplied by USS MAHAN) was coordinating adjacent vehicle gate access to the pier for the Chief of the Guard (a Naval Station Norfolk Security Department Master-at-Arms responsible for the security of all the station's piers). The Pier 1 Entry Control Point sentry saw Mr. Savage walk through the unmanned pedestrian gate and called after him to stop and produce required identification but Mr. Savage proceeded onto Pier 1. Reportedly talking into a wireless cellular phone headset earpiece and apparently intoxicated or otherwise impaired, Mr. Savage displayed no weapons, issued no verbal threats, exhibited no harmful manifestations, and displayed no indications of malicious intent. Following required procedures, the Pier 1 Entry Control Point sentry radioed USS MAHAN's quarterdeck watchstanders that an individual had entered the pier without showing identification.

Mr. Savage proceeded near the brows of USNS COMFORT (T-AH 20) and USS MAHAN and opened various tool boxes that were located on the pier. Since USNS COMFORT was on Pier 1 and because USS MAHAN was undergoing a maintenance availability, a large number of civilian maintenance personnel as well as civilian mariners had access to the pier. Given the lack of a radio broadcast by the Gate 5 civilian police officer, the volume of civilian personnel transiting the pier, and the

fact that Mr. Savage appeared to be an intoxicated mariner or a civilian worker not posing a threat, the watchstanders onboard USS MAHAN observed Mr. Savage on the pier and radioed the Naval Station Waterfront Security Operations Center that they had an individual on the pier who had not shown his identification and was not responding to their verbal calls for identification.

The Chief of the Guard and a Chief of the Guard (Under Instruction), who were at this time already on Pier 1, responded to USS MAHAN's radio call to the Waterfront Security Operations Center for assistance by then driving their van back towards the USNS COMFORT and USS MAHAN ship brows. With the approach of the security van, Mr. Savage walked past the brows, turned, and started up the USS MAHAN's brow. Mr. Savage was followed up the brow by the Chief of the Guard and Chief of the Guard (Under Instruction) shouting for Mr. Savage to stop, which Mr. Savage failed to do. Simultaneously, onboard USS MAHAN the Officer of the Deck and the Petty Officer of the Watch repeatedly called for Mr. Savage to stop and identify himself, a request Mr. Savage also failed to comply with.

Although Mr. Savage did not exhibit a threat towards any personnel, the watch team on USS MAHAN appropriately chose to execute the required use of force continuum with the Officer of the Deck exhibiting presence on the ship's end of the brow backed up by an armed Petty Officer of the Watch and an armed USS

MAHAN Topside Rover who had taken up station near the quarterdeck as part of the response to the ongoing disturbance.

When the USS MAHAN's Officer of the Deck stepped back to show Mr. Savage the presence of the armed quarterdeck watchstanders, Mr. Savage walked aboard USS MAHAN onto its quarterdeck, failed to comply with repeated requests to provide identification, and exhibited no threatening behavior until he inexplicably attempted to wrestle a weapon away from the Petty Officer of the Watch.

When Mr. Savage acquired the weapon, the Chief of the Guard, who by this time arrived on the quarterdeck, pushed the Petty Officer of the Watch clear and stood between the Petty Officer of the Watch and the now-armed Mr. Savage. Walking toward the Chief of the Guard and the Petty Officer of the Watch, Mr. Savage shot the Chief of the Guard killing him. In response, the Chief of the Guard (Under Instruction) and USS MAHAN's Topside Rover shot and killed Mr. Savage.

Pier and shipboard procedures were followed to include the use of force continuum, and the Chief of the Guard executed his duties appropriately in responding to an unidentified individual on the pier,selflessly sacrificing his life to protect that of the Petty Officer of the Watch and the other Sailors onboard USS MAHAN.

Why did it happen?

Mr. Savage's motive and intent that evening are both unknown, will likely remain unknown, and outside the scope of this inquiry.

Was this an insider threat?

An insider threat is defined as one where the use of appropriate credentials or identification allows access to the government facility. Mr. Savage was an outsider threat because he never had proper authorized access to Naval Station Norfolk. Mr. Savage's unauthorized access via Gate 5 was due to the civilian police officer's failure to implement and enforce required Force Protection and Physical Security procedures. Despite Mr. Savage's possession of a valid Transportation Worker Identification Credential (TWIC), he did not use that identification credential, or any other means of identification, to access Naval Station Norfolk on the evening of March 24, 2014. Even if proper identification procedures were followed that evening at Gate 5, Mr. Savage's Transportation Worker Identification Credential would not have been sufficient by itself to gain access to the Naval Station Norfolk.

Was this a failure of layered defense?

The protection of our ships relies on multiple layers of defense. In spite of the egregious failure by Gate 5 security personnel, the actions of the Pier 1 Entry

Control Point sentry and those of the Chief of the Guard, Chief of the Guard (Under Instruction), and USS MAHAN watchstanders were appropriate and reasonable under the circumstances. As tragic as the regrettable loss of life is, the layers of defense ultimately protected the interior spaces of the ship and minimized personal injury and the loss of life.

What potential gaps in security must be addressed?

This investigation identified several supervisory gaps and integration issues that require remedy and will be addressed by the respective executive agents. These issues are detailed in the final investigative report so as to not unnecessarily compromise Force Protection details.

Have we learned from other security incidents?

Unlike the 2013 Washington Navy Yard and 2009 Fort Hood shootings, this incident was the result of an outsider threat. Nonetheless, there are significant lessons to be learned concerning Force Protection, Physical Security, and Law Enforcement policies and procedures. Commander, Navy Region Mid-Atlantic and Commanding Officer, Naval Station Norfolk have appropriately integrated and responded to the lessons of other security incidents to include completion of the directed security self-assessment as well as procedural changes designed to enhance Force Protection and security.

Who is accountable and should anyone be disciplined?

Specific recommendations for accountability corrective actions are detailed in the final investigative report and are exempt from release under applicable federal statutory and regulatory requirements.

What is the way ahead for security of Naval Station Norfolk?

Security and Force Protection are critical for our Navy. It is well known that eternal vigilance is the price of safety, and, fortunately, the individual failures of Gate 5 access were compensated at other points in the layered defense of our ships. An upcoming Commander, U.S. Fleet Forces Command and Commander, Naval Installations Command Assessment of Naval Station Norfolk will have the opportunity to holistically review all aspects of security and Force Protection in the mandate to ensure the safety of our Sailors, civilians, and capital assets.