Interview Summary Form

Interview Details

Interviewee Name:	**CAPT Joseph Paradis**	Date:	**8/24/10**	Time:	**9:00am**
Interviewee Title:	**Initial COTP, FOSC and Incident Commander during event**	Interviewee Job Location	**Morgan City**		
Interviewer Name(s):	**Team**	Interview Location:	**New Orleans, LA**		

Interview Questions

Initial Question1: What were your jobs/roles and how did it evolve (if at all) during the DWH Incident?

- Initially, CAPT Paradis was on his way back from leave when the rig caught fire Tuesday. The XO was acting as COTP and FOSC in his absence. He returned Thursday to Morgan City, assumed the FOSC and COTP role (just before the rig sank) and then was the initial IC (for 14 days, then relieved by CAPT Staunton, due to a change of command). He chose Houma as the location of the ICP and worked with BP to establish the organization there.
- Recently, served as Deputy IC for 15 days (returned last Tuesday), and is going back next Wednesday as Deputy IC to Houma.
- Served as COTP for 3 years in Morgan City (recently underwent a command change).

Focus Area:	**Question 1:**	How well did the area committee planning process equate into the earlier response process? If it didn't, why not? How would you do it differently? Follow-up: a. What plans did you use in the response process? b. How does the state participate in the Area Plan, because each parish has its own plan separate from the Area Plan?
Area Committee Representative Involvement (Barbara P.)		

Area Committee and Area Contingency Plans

- There is a robust AC and ACP. CAPT looked at the plan when he arrived at MSU Morgan City. The plan transformed to One Gulf Plan, and the individual ACPs became annexes.
- CAPT's AOR has over 3,000 spill reports in a year, so the AC works together regularly due to the number of spill responses (key members coordinate very frequently, on a daily basis). The entire AC meets once per year.
- Member of the AC include: DEQ, LOSCO, OSROs, MSRC, ES&H, and a lot of local companies (small petroleum, etc.). For an offshore pipeline spill last year (63,000 gallons), dispersants were applied.
- For the DH incident, the ACP was used right away. Morgan City has a full-time oil spill planner on staff (Brian Black) who then worked ES issues.
    - The first concern was containment and recovery of the oil offshore, but needed to plan for oil coming onshore.
    - There were pre-approved areas for dispersant (first 24-48 hrs), which the CAPT talked with the BP IC.
    - He, Brian Black, and the BP IC coordinated with the RRT and discussed with USCG District 8 on the use of dispersants and identification of ESAs (ESAs were mentioned to be pre-designated; almost everything in that area is ES).
    - There were no pre-approved booming strategies (general strategies only, not specific to the plan), so they needed to prioritize which sensitive areas to lay out boom.
    - CAPT set up a Shoreline group to look at annexes from the One Gulf Plan – to look at entire coastline (multiple states) on what to protect, what can/can't be protected right now.
    - Looking at alternative strategies via plans – in situ (staff looked for fire boom & had it when ready to implement)

State and Parish Participation

How does the state participate in the plans?

- The State is the largest partner in the AC, and is continuously involved with planning. The State also has its own plan (DEQ and LOSCO would have more details on this). The CAPT was not familiar with the contents of the State's plan.

How do parishes participate in ACs and responses?

- Parishes were always invited to AC meetings, but the CAPT did not recall any representatives showing up.
    - When a response occurred, parishes were engaged. USCG always contacted parishes involved in an incident, and they were always invited to ICPs during an incident.
    - If a parish did not show up, they were contacted via telephone to let them know what was going on. He did not recall parish representatives showing up at the ICP. If they were involved, it would be pretty minor, unless there was a clear impact on their community, requiring evacuation, water safety, etc. Instead, USCG often checked in with them to feed information, not the other way around. Parishes were typically fine with that since they did not have an active role in the response (because it was a CG or RP response). They wanted to know the impact on them, but since there wasn't often any impact, they did not become active participants, and only wanted information exchange.
    - State OSC (SOSC) was not empowered by the Governor's office to perform their intended function and make decisions in the Unified Command and the ICP

Do you rely on the State to take care of the locals and their concerns?

- The state links to parish representatives through the Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP). LOSCO, USCG, and GOHSEP all disseminate info directly to parish presidents.
    - If requested, parishes would have come to the ICP, though the incidents have never risen to the point where we needed them present in the ICP.
- Did the parishes participate differently in this incident? (CAPT Stanton and other parish representatives should comment on this as well)
    - In the early days the primary focus was on Lower Jefferson Parish, Tarabone, LaFouche, and St. Mary Parish. The CAPT reached out to Parish President of Tarabone and other parish presidents, and all were engaged and cooperative. The Tarabone Parish president was given a tour of ICP. All parishes were very engaged and no problems were experienced. At that point they wanted to know how USCG was preparing and what was being done to prevent oil from coming ashore. They also offered resources to help keep oil offshore.

Focus Area: Integration of Regional and Area Contingency Plans for a Regional Oil Spill Response (John T.)	**Question 2:**	With an understanding that there is a One Gulf Plan, BP Regional Plan, parish emergency plans, separate Area Plans – how were they used and integrated for use and response?

- The CAPT was not sure how BP used their response plan. Talked to first IC at BP – CAPT did not see or ask for the plan; he was more focused on using the ACP.
- Have not seen State plan, and does not know what it contains. Does not think there are any parish plans related to spill response.

Were there any conflicts with multiple plans (state, BP, parish)?

- The CAPT did not feel conflict; there was just so much going on that they were just trying to get the right person in the room. There has been a lot of change in the state since the spill happened. Mr. Guidry is not in the same role that he used to be, he was replaced at the State level. The reps at ICP in Houma were not empowered to make decisions that were and still are a problem.

Environmentally Sensitive Areas

- How were sensitive areas decided on? How did you know how to prioritize allocation of resources to those areas? Had staff, state organizations and BP working together to discuss priorities of areas needing protection because resources were finite. The ACP is not as specific as is needed with respect to ESAs. They approached the entire coastline of the

state is an ESA.

Did you use the plan for other things, other response technologies?

- The plan was used for use of dispersants and an in-situ burn. Staff was focused on that with everything going on, went and located fire boom, and were pulling in specialists, as well as response technologies.

Focus Area: Use of Dispersants (John C.)	**Question 3:**	Was the dispersant pre-planning and approval process appropriate for this size and scale of incident? How well did it prepare you for this type of event? What lessons learned did you take away from this process that you would like to use for improvements for the next event?

Was the dispersant approval process adequate and timely for this event?

- Yes. It was used last summer when there was an offshore spill (63k gallons) and dispersant was applied. So the response organization had recent experience. The checklist was used and the RRT was notified. The process was quick and streamlined. There were no issues with that part of the response.

At that time, was there any, or did the plan identify, an upper limit on the amount of dispersants to apply?

- That was not included in the plan and it was not considered. Dispersant use in District 8 is preapproved, but there is no limit for quantity. There was never a thought or conversation related to the limits or the ceiling for dispersant application. The RRTs should consider limits on use of dispersants. That said, dispersants reduced the amount of shore impact. The threshold should be high. If there wasn't pre-approval, we likely would not have gotten it approved in enough time to keep the oil offshore. The RRTs should look at the limits of the amount of dispersant applied, but they should not withdraw pre-approval of dispersant use. If the RRT is going to get involved with the approval of dispersant use at all, they need to do it measurably, such as for a certain size large spill. If the RRT went through the approval process each time there was a spill that would not be ineffective.

Did you use or apply SMART protocols? Were they effective? Would you have any recommended changes?

- They worked well. It provided the command an early indication if the dispersants were effective. The command did not want to use dispersants if they were not effective. There was an initial glitch related to monitoring. However, after that initial issue, monitoring worked well. It indicated that the dispersant application was effective.

What about monitoring of the fate and effects of dispersants long-term? Was there any conversation related to the long-term impacts of where the dispersants were going?

- This is probably something that needs to be looked at for inclusion all plans going forward. Also, there is a need to educate the public about dispersant use. There were some issues with EPA, but the message got out. This needs to be addressed it in the future. The CAPT does not think dispersants were designed for a spill of this magnitude. No one envisioned applying dispersants to a spill of this size. There was an attempt to get the message out that the dispersants were safe, but the public had perception that dispersants were doing more harm than good. This needs to be addressed in the planning process.

When/how was the decision made to deploy dispersants undersea?

- That decision was made after the CAPT left, but it was made in Houston. Part of the decision to apply subsurface dispersants was made by the team looking at the source.

Discuss the use of subsurface dispersants.

- The CAPT was not aware of any ACPs that have ever referenced this as an option. Captain mentioned an academic paper on the application of subsea dispersants

Were dispersants applied by vessels?

- The CAPT was not aware of dispersants applied by vessels.

Was there any discussion on your watch about 24 hour application of dispersants?

- SLIR was not available. Therefore, there was not a tool available that could be used to find oil at night. The command did not want to be out dumping dispersants on people, boats or areas without oil. The tools that we did have available to take nighttime pictures were classified, so they could not be shared with others because of the classified status even if they were used.

Discuss the in-situ burning protocols. How did they work? Any way to make them work better? Was the In Situ Burn protocol appropriate? How well did it prepare you for this event? Any lessons learned you would take away?

- In situ burning was unique. They went to the RRT to get approval, but the primary concerns were how to do it? It had never been done in a real-world event in the U.S. The discussion was "Can we even do this; Do we have the right weather window; will the fire boom hold up; and, do we have the needed resources?" The process worked as designed, the only issue was the uncertainty related to having never done this before.

Focus Area: Unified Area Command/ICPs (Bruce J.)	**Question 4:**	This incident started out as an explosion and fire, then a SAR, then an oil spill. As these parameters changed, describe how you ramped up during that time, to where you ended up in a Unified Area Command/ICP. Follow-up: a. When did you go to 24-hour operations and how did you handle it? b. How did all the stakeholders embrace this organization build-up?

- The CAPT arrived early in the morning and he and the BP IC agreed that their gut feeling was that this was going to be a huge spill, and a quick ramp-up of resources was needed. At that point in time, there were about a dozen BP reps and almost all of the CAPT's staff, and an ICS structure was formed by that afternoon, with all sections stood up. One of the main priorities was discussing long-term sustainability of the response operations due to the size of the incident. The setting was chaotic but operated. The CG had a good working relationship with BP from the very beginning at the ICP.
- When the UAC was stood up, there was confusion on who was in charge. The CAPT was the FOSC and IC, directing resources and developing the IAP out of Houma. There was discussion whether ADM Landry would be FOSC, and he would change to an FOSC-R, but the outcome was unclear. The CAPT was unsure of his role or "lane" that he should be operating within, and says that if he could do it again, he would have gone to ADM Landry and ask her for clarification of the roles early on. The situation continued until after CAPT Stanton took over. It did not cripple the response but made it personally frustrating at times. It didn't change the response objectives, and the IAPs still got signed. The CAPT had never exercised a UAC, so it was new to him (and others).
- The UAC was necessary because the ICP could not manage the political and public affairs pressures as well as manage the operational aspects of the incident. However, for certain issues, the UAC made tactical decisions, which confused those at the ICP. Sometimes the CAPT could make certain decisions, other times he could not, and it was not clear what, when, and why things kept switching back and forth. He and CAPT Stanton were sometimes stripped of their tactical decision making abilities.

Was UAC stood up before there were multiple ICPs?

- The UAC stood up even before some of the ICPs stood up. Initially, the CAPT was hesitant about other ICPs standing up, but it worked out as they coordinated management. In hindsight, they could have "pulled the trigger sooner" on opening additional ICPs. The CAPT thought the oil would not come ashore, then it became evident it was not going to be kept offshore, so ICPs needed to be opened.

Was the work in Houston under your operations section in Houma?

- The CP in Houston was working independently and talking mainly about source control. They were briefing the Houma ICP but they had their own sections chiefs. Eventually the Houston information was incorporated into the Houma IAP.

When did you start 24-hour operations?

- 24 hour operations began immediately. Shifts were 12 hours.
- The IAP was covered 24 hour operational period

- The ICP deviated from the Planning P a bit because they were not sure everyone had the full picture, so they held the 0900 all-hands meetings to update everyone, to help each person understand that their piece fit into the big picture. Parishes showed up for those meetings, integrated where they could, but were not part of planning meetings. The UAC did not participate, it was internal to the ICP.

When the UAC was established, did you have the same COP?

- Several versions of a COP were developed, and none were integrated for awhile (Houma COP, Houston COP, UAC COP, other agencies, etc.). People did not have all the information, and what they did have many times did not match up.
- One lesson learned is that the response organization needs to decide what COP is going to be, institutionalize it, and then use it. Other responders had different COPs as well (NOAA, O'Brien's, etc.)
- The CAPT mentioned that the COP did not drive operational and tactical decision-making, because it was not real-time or just-in-time. So having a more complete COP would just act as situational awareness.
- The ERMA tool was adopted later to assist in developing a more integrated COP.

How did the UAC get involved in making tactical decisions?

- There was discussion of having an operations section at the UAC, which was of great concern, because it is too tactical for an entity such as the UAC, and they did not have the right expertise or operating picture at the UAC to do it correctly. There was a better view and expertise at the ICP. The UAC got too involved in in situ burning issues, dispersants, who could sign IAPs, etc.

In the early stages where you can't use the IAP without going to the UAC, can you think of a tactical decision that was delayed but you went out and did anyway?

- Dispersant use was an issue, regarding whether we could go ahead and apply it. There were some delays the in situ burn issue getting that off the ground, and this was after talking to the RRT.

In terms of media relations nearly on, had own section? That was elevated and UAC took over JIC operations from ICP? Did the ICP not talk to media anymore?

- The ICP was not constrained from talking to the media but the message was very controlled. Early on BP was not talking to the media. The UAC was directing and limiting the message and ability to talk to the media, which became very frustrating. UAC controlled information released to media; IPC was forced to refer media requests to UAC.
- The UAC took over the JIC functions from the ICP. There is a need for the UAC (public affairs, govt outreach) to relieve the burden from the ICP's during a large incident.

Focus Area: Lessons Learned (Barbara P.)	**Question 5:**	Describe how the SONS 2002 lessons learned and other exercises were integrated into the area planning process?

- The CAPT was not consciously using any lessons learned (LL) to make decisions, but had read the AAR from Cosco Busan (CB) as well as reports from other spills. He incorporated it into the planning and decision-making processes.

How well did the electronic planning process work for you and integrate in with Environmental Resource Management Application (ERMA) and the COP?

- The ERMA system was not implemented during the CAPT's time there. It seemed to collect the information they already had, and he was not sure how the IAP reflects ERMA. It is probably not completely accurate, but better than it used to be. Once a COP is adopted, it will likely improve. Where it is now, in terms of how the IAP is reflected in ERMA, the IC was signing the IAP, and he never had time to sit down and do a cross-walk to see what was in ERMA and what in the COP.

Did the state rep or SOSC bring that power to speak for and bind the state?

- The state rep at the ICP was not empowered to sign the IAP, and no one else above them was signing it from the state's

side. They had to elevate it to someone else in the state for signature, and the plans were stuck at the state. The state operational are phenomenal, but the levels above in the state have not been a cooperative player, and it is unclear if that is the Governor or his oil spill designee. So things are proceeding without the state's signature.		
Focus Area:	**Question 6:**	At which point did the plans not able to address the response priorities?

Final Question 1:	What were the top 2 "best practice(s)" during this incident, from your perspective?

- Partnership between USCG and RP was excellent from the start. BP personnel were trained in ICS, knew what information was needed, built the organization quickly, and there was a spirit of cooperation. They couldn't have responded as well if this good coordination was not present.
- At the UAC level, a decision was made to use the NCP for the response instead of a Stafford Act declaration. It was a very good decision to make it an NCP response, especially since the state is not playing well.

Final Question 2:	What do you assess to be the top 2 "areas needing improvement" (or downright "failures") from your perspective, and do you have any related recommendations regarding these areas?

- The delay in deciding what the ultimate organization would look like in the response, whether there would be a SONS, determining who would be FOSC. It took too long to determine a chain of command. The CAPT thinks he should have taken the initiative to go to the ADM and say he needed more clarification on my role.
- The UAC is a new concept that has been difficult to execute, and more experience is needed with the concept. It may be beneficial to have another look at how the system works together, and at the UAC training.

Final Question 3:	Is there anything else we should know?

N/A

Final Question 4:	Who else should we interview?

Roger Laferrier, Roland Guidry, Pat Brough (LA DEQ), Keith Seilhen (BP), Rusty Wright (MMS), ADM Landry, CAPT James Hansley, CAPT Tom Hooper

Notes