# United States Coast Guard

# REPORT OF INVESTIGATION INTO THE LOSS OF LIFE ONBOARD THE ATLANTIC OCEANIC (1163367) WHILE MOORED AT PORTSMOUTH MARINE TERMINAL IN PORTSMOUTH, VIRGINIA, ON OCTOBER 26TH, 2024.

**MISLE ACTIVITY NUMBER: 8026695**

U.S. Department of Homeland Security
United States Coast Guard

Commandant
United States Coast Guard

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16732/IIA #8026695
21 October 2025

**FALL OVERBOARD AND SUBSEQUENT LOSS OF ONE LIFE FROM THE OFFSHORE SUPPLY VESSEL ATLANTIC OCEANIC (O.N. 1163367) WHILE MOORED AT THE PORTSMOUTH MARINE TERMINAL IN PORTSMOUTH, VIRGINIA ON OCTOBER 26, 2024**

## ACTION BY THE COMMANDANT

The record and the report of investigation completed for this marine casualty have been reviewed by the Office of Investigations & Casualty Analysis. The record and the report, including the findings of fact, analyses, and conclusions are approved. This marine casualty investigation is closed.

[redacted]

E. B. SAMMS
Captain, U. S. Coast Guard
Office of Investigations and Casualty Analysis (CG-INV)

U.S. Department of Homeland Security

United States Coast Guard

Commander
United States Coast Guard
East District

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16732
September 24, 2025

**LOSS OF LIFE ONBOARD THE ATLANTIC OCEANIC (1163367) WHILE MOORED AT PORTSMOUTH MARINE TERMINAL IN PORTSMOUTH, VIRGINIA, ON OCTOBBER 26TH, 2024.**

**ENDORSEMENT BY THE COMMANDER, COAST GUARD EAST DISTRICT**

The record and the report of the investigation convened for the subject casualty have been reviewed. The record and the report, including the findings of fact, analysis, conclusions, and recommendations are approved. It is recommended that this marine casualty investigation be closed.

**ENDORSEMENT ON RECOMMENDATIONS**

**Administrative Recommendation 2**. Recommend this investigation be closed.

**Endorsement:** Concur. The Coast Guard East District agrees with the analysis and conclusions of the Investigating Officer and the endorsement of the Officer in Charge, Marine Inspection. No further action is required by the Coast Guard.

[redacted]

MATTHEW J. MESKUN
Captain, U.S. Coast Guard
Chief, Prevention Division

Enclosures: (1) Endorsement by the Officer in Charge, Marine Inspection
(2) Executive Summary
(3) Investigating Officer's Report

U.S. Department of Homeland Security
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16732
2 Sep 2025

**LOSS OF LIFE ONBOARD THE ATLANTIC OCEANIC (1163367) WHILE MOORED AT PORTSMOUTH MARINE TERMINAL IN PORTSMOUTH, VIRGINIA, ON OCTOBER 26TH, 2024**

**ENDORSEMENT BY THE OFFICER IN CHARGE, MARINE INSPECTION**

The record and the report of the investigation convened for the subject casualty have been reviewed. The record and the report, including the findings of fact, analysis, conclusions, and recommendations are approved. It is recommended that this marine casualty investigation be closed.

[redacted]
Captain, U.S. Coast Guard
Officer in Charge, Marine Inspections

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United States Coast Guard

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16732
2 Sep 2025

**LOSS OF LIFE ONBOARD THE ATLANTIC OCEANIC (1163367) WHILE MOORED AT PORTSMOUTH MARINE TERMINAL IN PORTSMOUTH, VIRGINIA, ON OCTOBER 26TH, 2024.**

## EXECUTIVE SUMMARY

On Saturday, October 26, 2024, the Offshore Supply Vessel (OSV) ATLANTIC OCEANIC (ON: 1163367) was moored at Portsmouth Marine Terminal where contractors were working to remove equipment and prepare the vessel for eventual departure from the Coastal Virginia Offshore Wind Project (CVOW). An individual was contracted to conduct general labor to support the vessel's completion of contract with the CVOW. The contractor was working in the vicinity of the stern of the vessel when his escort was called away to clean a tank under the deck. The supervisor charged with oversight of the contractor took a work-related phone call and took their eyes away from the contractor. There was no visual contact with the contractor during that time and a hard hat was later observed floating in the water in the vicinity of stern of the vessel. The vessel crew and contracting crew conducted a search of the vessel and the facility areas and subsequently contacted the Port of Virginia and the U.S Coast Guard, who conducted a search of the area via surface and air assets. The Port of Virginia employed a side scan sonar as well as a remotely operated vehicle to search the sea floor below and around the vessel. The missing contractor was recovered, deceased, approximately nine days later, on November 4, 2024, by Virginia Marine Resources Commission (VMRC) and delivered to Port Authority Police. Based on the available evidence, it is likely that the individual drowned after falling into the water from the ATLANTIC OCEANIC.

As a result of its investigation, the Coast Guard determined the initiating event for this marine casualty was the contractor falling into the water from the stern of the ATLANTIC OCEANIC, which resulted in the death of the contractor. Causal factors that contributed to this casualty include: (1) Failure of escort to properly oversee the contractor, (2) Use of dangerous drugs, (3) Removal of the stern bulwark onboard the vessel, (4) Failure of the management to require life jackets while working near sides without railings/bulwarks, (5) Failure of escort to maintain location knowledge of individual without TWIC, (6) Inability of Contractor #1 to swim, (7) Loud and complex work environment.

U.S. Department of Homeland Security
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16732
2 Sep 2025

**LOSS OF LIFE ONBOARD THE ATLANTIC OCEANIC (1163367) WHILE MOORED AT PORTSMOUTH MARINE TERMINAL IN PORTSMOUTH, VIRGINIA, ON OCTOBER 26TH, 2024.**

**INVESTIGATING OFFICER'S REPORT**

## 1. Preliminary Statement

1.1. This marine casualty investigation was conducted, and this report was submitted in accordance with Title 46, Code of Federal Regulations (CFR), Subpart 4.07, and under the authority of Title 46, United States Code (USC) Chapter 63.

1.2. The Coast Guard was the lead agency for this investigation. The Coast Guard, the Portsmouth Police Department, the Port of Virginia, and the Occupational Safety and Health Administration (OSHA) assisted each other in the investigation with initial casualty scene response and collecting witness statements and evidence. No other persons or organizations assisted in this investigation.

1.3. All times listed in this report are in Eastern Standard Time using a 24-hour format and are approximate.

## 2. Vessel Involved in the Incident

*Figure 1 Photograph of Vessel's starboard side underway. Source: Google*

| | |
|---|---|
| Official Name: | ATLANTIC OCEANIC |
| Identification Number: | 1163367 |
| Flag: | United States |
| Vessel Class/Type/Sub-Type | Offshore Supply Vessel |
| Build Year: | 2004 |
| Gross Tonnage: | 2045 GT |
| Length: | 234 Feet |
| Beam/Width: | 54 Feet |
| Draft/Depth: | 19 Feet |
| Main/Primary Propulsion: (Configuration/System Type, Ahead Horsepower) | Diesel Reduction |
| Managing Owner: | Atlantic Oceanic LLC<br>New Bedford, MA United States |

## 3. Deceased, Missing, and/or Injured Persons

| Relationship to ATLANTIC OCEANIC | Sex | Age | Status |
|---|---|---|---|
| Contractor (#1) | Male | 36 | Deceased |

## 4. Findings of Fact

4.1. The Incident:

4.1.1. On October 26, 2024, at approximately 0600, the ATLANTIC OCEANIC was moored at Portsmouth Marine Terminal conducting demobilization operations from the Coastal Virginia Offshore Wind Project (CVOW).

*Figure 2 ATLANTIC OCEANIC underway in port with CVOW equipment installed. Source: Google*

4.1.2. Coastal Services Inc. was subcontracted to provide general labor to assist in the demobilization of the vessel.

4.1.3. The weather conditions were clear with <1-foot seas and air temperature of 77°F and water temperature of 64.9°F.

4.1.4. Contractor #1 arrived at Portsmouth Marine Terminal at approximately 0600 with a job working on ATLANTIC OCEANIC.

4.1.5. Contractor #1 did not possess a Transportation Workers Identification Card (TWIC).

4.1.6. Contractor #1 was being escorted by Contractor #2, who did possess a TWIC.

4.1.7. Contractor #1's job involved sweeping and general labor to support the vessel's demobilization from work with CVOW.

4.1.8. The ATLANTIC OCEANIC's cargo deck boards were being replaced, and part of the stern bulwark was removed as containers and equipment were being removed from the vessel to return it to pre-contract conditions.

4.1.9. Contractor #1 was working in the vicinity of the stern of the vessel while sweeping and conducting other general labor.

4.1.10. Contractor #2 was informed by the Coastal Services supervisor to assist in cleaning a cargo tank approximately 30' forward of the stern of the vessel. The supervisor stated that he would take over escort duties for Contractor #1 due to their lack of TWIC.

4.1.11. The Coastal Services supervisor took a work-related phone call at roughly 1220 and did not have visual contact with Contractor #1 for approximately 15-30 minutes.

4.1.12. At approximately 1230, the Coastal Services supervisor noticed Contractor #1 missing from the cargo deck area where he was working. The supervisor asked another contractor (Contractor #3) if she had seen Contractor #1.

4.1.13. On October 26, 2024, multiple missing persons, searches were conducted onboard the ATLANTIC OCEANIC and surrounding area by the crew and local law enforcement.

4.1.14. A hat matching the description of the one Contractor #1 was wearing was discovered floating in the water in the vicinity of the ATLANTIC OCEANIC.

*Figure 3 The ATLANTIC OCEANIC moored with CAPE STARR at Portsmouth Marine Terminal. Source: USCG personnel*

4.1.15. The US flagged cargo vessel, CAPE STARR (ON: 1335005) was moored approximately 150 yards astern of the ATLANTIC OCEANIC.

4.1.16. On November 4, 2024, at approximately 2300, the body of Contractor #1

was discovered floating next to the pier in the vicinity of the CAPE STARR (ON: 1335005), approximately 100 yards from the location of where the ATLANTIC OCEANIC was moored at the time of the incident.

4.2. Additional/Supporting Information:

4.2.1. The ATLANTIC OCEANIC is an offshore supply vessel (OSV) built in Mobile, Alabama by Bender Shipyard. The vessel was owned and operated by Atlantic Oceanic LLC from 12/2/2022 until 03/14/2025. The vessel's managing ownership changed to Leviathan Offshore LLC on 03/14/2025 while the vessel's operator remains Atlantic Oceanic LLC.

4.2.2. The ATLANTIC OCEANIC was on a time charter with DEME Group to support the construction of the CVOW project. The vessel went off charter on October 30, 2024.

4.2.3. The ATLANTIC OCEANIC was owned and operated by Atlantic Oceanic LLC and on a time charter to DEME Group while working in support of the Coastal Virginia Offshore Wind Project.

4.2.4. DEME Group is a Belgium based offshore energy, dredging, marine infrastructure, and environmental works construction company.

4.2.5. The ATLANTIC OCEANIC was moored at Portsmouth Marine Terminal where it was undergoing demobilization efforts to return it to the condition it was in prior to going on a time charter with DEME Group.

4.2.6. Contractor #1 arrived for the first day of work at Portsmouth Marine Terminal, a federally regulated facility, and did not possess a TWIC, requiring an escort to enter both the facility and board the vessel.

4.2.7. Contractor #1 relayed to multiple coworkers that he was tired from being up late the night before. Contractor #1 was also noted by coworkers to be lethargic throughout the morning.

4.2.8. Contractor #1 did not know how to swim.

4.2.9. The security plan at Portsmouth Marine Terminal and the security plan onboard the ATLANTIC OCEANIC required all crewmembers and employees without a TWIC to be escorted by an individual with a TWIC.

4.2.10. The ATLANTIC OCEANIC had a Safety Management Certificate issued by the American Bureau of Shipping (ABS) which covered the following:

*"The Company are required to make a suitable and sufficient assessment of the risks to health and safety of workers arising in the normal course of their activities or duties, for the purpose of identifying:*
*a) Crew members and other workers at particular risk in the performance of their duties; and*
*b) The measures to be taken to comply with the employer's duties.*
*The assessment should extend to others on board the ship who may be affected by the acts or*

*omissions of the Company.*


*Figure 4 Stern of vessel during initial vessel search for Contractor #1. Source: Contractor #2 video*

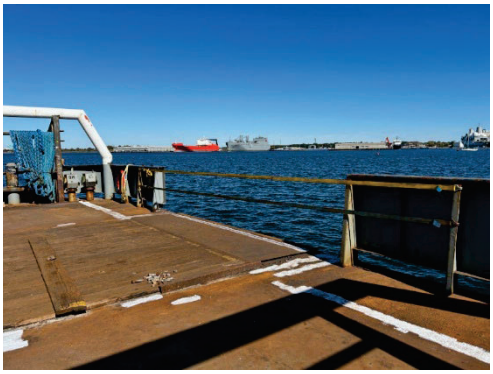

*Figure 5 Stern of ATLANTIC OCEANIC with straps installed moored at Portsmouth Marine Terminal. Source: USCG personnel*

4.2.11. The ATLANTIC OCEANIC's stern bulwark was removed to support work on the vessel to return it to pre-contract status.

4.2.12. There was no evidence illustrating the standard of fall protection at stern of the ATLANTIC OCEANIC prior to the determination that Contractor #1 was missing. During and after the searches for Contractor #1, there were initially one and later two straps positioned across the center of the stern as illustrated in Figure 4 and 5.

4.2.13. Contractor #1's blood was tested as a part of postmortem examination and was found to contain approximately .16 mg/L of methamphetamine, .046 mg/L of amphetamine and his blood alcohol concentration was of .039%.

4.2.14. Methamphetamine metabolizes to amphetamine and can remain testable through a blood test for up to 3 days.

4.2.15. Symptoms of the use of methamphetamines include short term euphoria quickly leading to a "crash" and slower reaction time (reduced motor speed).

## 5. Analysis

5.1. *Failure of escort to properly oversee the actions of Contractor #1.* Individuals without TWIC are required to be escorted on federally regulated facilities. The assigned escort for Contractor #1 was working with him through the morning laying deck boards to replace the decking. The assigned escort (Contractor #2) was tasked cleaning inside fuel tank #4S, located approximately midway between the front and back of the cargo deck on the starboard side. While in the tank, his duties were transferred to another individual (Coastal Services supervisor) who took a work phone call. During this call, Contractor #1 went missing from his work on the deck. Regulations require people without TWICs to be monitored while on federally regulated facilities. If the individual monitoring Contractor #1, Coastal Services supervisor, was properly carrying out his escorting duties, it is probable that he would have been able to prevent Contractor #1 from standing near the side and subsequently falling overboard.

5.2. *Use of dangerous* drugs. Contractor #1 was engaged onboard the ATLANTIC OCEANIC in general labor which included sweeping dirt onboard the cargo deck of the vessel. Coworkers of Contractor #1 stated that he was displaying signs of drug use. The toxicology report was positive for methamphetamine and alcohol. It is probable that impairment as a result of alcohol and dangerous drugs use, contributed to Contractor #1 falling overboard. If Contractor #1 had not been under the influence of alcohol and dangerous drugs, it is reasonable to assume that he may not have fallen overboard.

5.3. *Unapproved removal of the stern bulwark onboard the vessel.* The ATLANTIC OCEANIC is an Offshore Supply vessel and subject to both US and international regulations. These regulations include the requirement for bulwarks (guardrails) around the cargo deck. Any deviation from this requirement shall be approved by the flag state or recognized organization, American Bureau of Shipping (ABS). The vessel was being demobilized from its contracted operations and the stern bulwarks were removed without authorization from any regulatory agency. There were no equivalent structures installed to prevent people from falling over the stern of the vessel. If the stern bulwark or an equivalent structure was installed on the stern while work was being done on the cargo deck, it is likely Contractor #1 would not have fallen overboard while working near the stern.

5.4. *Failure of the management to require life jackets while working near sides without railings/bulwark.* The safety management system (SMS) onboard the ATLANTIC OCEANIC required the vessel to ensure the safety of the crew and other workers and actions taken to reduce risks onboard, however did not specifically require individuals to wear working vests or life jackets while on deck. The stern bulwark was removed during the demobilization of the vessel and there was minimal if any equivalent structure to prevent individuals from the potential of drowning after falling overboard. This risk could be mitigated by using life jackets for those working in areas at risk of falling overboard. There was no use of life jackets for the contractors working in the vicinity of the stern of the vessel. If Contractor #1 was wearing a life jacket as part of his required safety equipment, it is likely that he would have stayed afloat long enough to be rescued before drowning.

5.5. *Failure of escort to maintain location knowledge of Contractor #1 without TWIC.* Contractor #1 did not possess a TWIC and was required to be escorted at all times while on the regulated facility and the inspected vessel. The first individual (Contractor #2) charged with escorting Contractor #1 was tasked by a supervisor to clean a fuel tank. When he stated that he was required to watch Contractor #1, the supervisor responded that he would take over his escort duties. The supervisor then took a work phone call while assigned to watch Contractor #1 and the contractor left their field of view. If the supervisor had kept Contractor #1 in sight, it is likely that he would have noticed Contractor #1 falling overboard and been able to sound an appropriate alarm and engage a recovery team in time to prevent death by drowning.

5.6. *Inability of Contractor #1 to swim.* The family of Contractor #1 stated that he was unable to swim. Contractor #1 was working on the cargo deck in the vicinity of the stern, wearing two sweatshirts, a reflective vest, pants, belt, underwear, shirt,

protective boots, and two pairs of socks. While working near the stern, it is likely he fell into the water fully clothed. The weight and bulkiness of his clothes combined with his lack of swimming ability likely limited his capability to keep his head above the water. If Contractor #1 was proficient in swimming, it is probable that he could have kept his head above the water at least long enough to alert crewmembers of his situation or swim to the pier and exit the water.

5.7. *Loud and complex work environment.* The ATLANTIC OCEANIC was being demobilized from work on the Coastal Virginia Offshore Wind Project. This work involved welding, cutting, sweeping, and a variety of other actions common in shipyards and docks to prepare vessels for work. These activities generally produce a substantial amount of noise and dust. These activities also require significant concentration on the part of workers carrying out the efforts. If Contractor #1 was able to make himself heard and seen during or after his fall, it stands to reason that someone might have heard him and activated the vessel's man overboard plan – outlined in the vessel's SMS.

## 6. Conclusions

6.1. Determination of Cause:

6.1.1. The initiating event for this casualty occurred when Contractor #1 fell from the stern of the ATLANTIC OCEANIC into the water. The causal factors leading to this event were:

6.1.1.1. Failure of the escorts to properly oversee the actions of Contractor #1.

6.1.1.2. The use of dangerous drugs and alcohol.

6.1.1.3. Unapproved removal of the stern bulwark onboard the vessel.

6.1.2. Contractor #1's fall into the water resulted in the following subsequent event: The death of Contractor #1. The causal factors which contributed to this event were:

6.1.2.1. Failure of management to require lifejackets while working near sides with railings/bulwark.

6.1.2.2. Failure of escorts to maintain location knowledge of individuals without a TWIC.

6.1.2.3. Inability of Contractor #1 to swim.

6.1.2.4. Loud and complex work environment.

6.2. Evidence of Acts(s) or Violation(s) of Law by Any Coast Guard Credentialed Mariner Subject to Action Under 46 USC Chapter 77: There was no Evidence of Act(s) or Violations(s) of Law by any Coast Guard Credentialed Mariners Subject to Action Under 46 USC Chapter 77.

6.3. Evidence of Act(s) or Violation(s) of Law by U.S. Coast Guard Personnel, or any other person: No enforcement action for these offenses is recommended.

6.4. Evidence of Act(s) Subject to Civil Penalty: This investigation identified evidence of acts subject to a civil penalty. A Notice of Violation was issued to the Owner/operator of the vessel for failure to implement a TWIC program.

6.5. Evidence of Criminal Act(s): There was no evidence of Criminal Act(s).

6.6. Need for New or Amended U.S. Law or Regulation: This investigation identified no matters needing new or amended U.S. law or regulation.

6.7. There were no unsafe Actions or Conditions that Were Not Causal Factors.

## 7. Actions Taken Since the Incident

7.1. The US Department of Labor's local Occupational Safety and Health Administration (OSHA) office issued DEME and Coastal Services citations each for $33,100 for failure to conduct a hazard assessment and provide PFDs or guarding on the stern.

## 8. Recommendations

8.1. Safety Recommendation:

8.1.1. There were no proposed actions to add new or amend existing U.S. laws or regulations, international requirements, industry standards, or U.S. Coast Guard policies and procedures as part of this investigation.

8.2. Administrative Recommendations:

8.2.1. Recommend this investigation be closed.

[redacted]

Lieutenant, U.S. Coast Guard
Investigating Officer